

SPECIAL COMMISSION OF INQUIRY  
INTO  
CHILD PROTECTION SERVICES IN NEW SOUTH WALES

Before The Hon James Wood AO, QC, Commissioner

At Courtroom 8A, John Maddison Tower  
88 Goulburn Street, Sydney

On Friday, 28 March 2008 at 10.00am

Counsel Assisting: Ms Gail Furness  
Also present: Ms Barbara Alvos  
Solicitor to the Inquiry  
Ms Pru Sawyer, Solicitor

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1 FORUM - OVERSIGHT AGENCIES  
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PUBLIC FORUM - ROLE OF OVERSIGHT AGENCIES

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3 THE COMMISSIONER: Good morning, and welcome again to one  
4 of our forums. As I understand it, we have present this  
5 morning Jennifer Mason, the new director general of DoCS;  
6 Children's Guardian, Kerryn Boland; Gillian Calvert,  
7 Commissioner For Children and Young People. From the  
8 Ombudsman's Office, we have Mr Steve Kinmond, Deputy  
9 Ombudsman Community Services Division, and Ms Anne Barwick,  
10 Assistant Ombudsman for Children and Young People. We  
11 have Mr John Merrick from the State Coroner's Court;  
12 Mr Philip Berry and Mr Anthony Lean from the Department of  
13 Premier and Cabinet; and Andrew McCallum from the  
14 Association of Children's Welfare Agencies.  
15

16 We have published a facts sheet, which I think  
17 outlines the general background for the overview structure  
18 and we have an agenda with a number of questions. I guess  
19 we could start probably first with the review of children's  
20 deaths.  
21

22 One of the problems I think that some of those who are  
23 present will face is the fact that the DoCS submission on  
24 this topic remains confidential. I must say I don't think  
25 it is necessarily very helpful for the forums that any of  
26 these submissions from the major agencies be confidential  
27 because it doesn't give anybody a chance to respond to  
28 them. I think the only way around that this morning, in  
29 particular, as we deal with particular items, is for DoCS  
30 to disclose its position on them so far as that is  
31 possible. I would actually ask that the major agencies  
32 review any policies they have had so far on making these  
33 submissions confidential. It also affects today the  
34 Children's Commission submission.  
35

36 MS CALVERT: Justice Wood, can I say that the other  
37 agencies have copies of the submission.  
38

39 THE COMMISSIONER: Have the DoCS submissions been  
40 circulated to the other agencies?  
41

42 MS MASON: No, they have not. As you would appreciate,  
43 there have been problems with the transition of director  
44 general. I am in the process of discussing that. I think  
45 we will make some changes to that.  
46

47 THE COMMISSIONER: If that is released, I will have that

1 published on our website.

2

3 MS MASON: Yes, and we are happy for that to happen.

4

5 THE COMMISSIONER: In relation to the reviews of child  
6 deaths, maybe the best way to focus the debate, quite  
7 frankly, is to ask DoCS to disclose its position, its  
8 concerns in relation to this system. They relate to a  
9 number of areas that I can indicate, and you may or may not  
10 want to add to them.

11

12 The concerns that DoCS have, I guess, relate in one  
13 sense to the width of the definition of "reviewable deaths"  
14 that the Ombudsman needs to look at in that it is very wide  
15 and it effectively will bring in children who have been  
16 reported to DoCS or whose siblings have been reported to  
17 DoCS within a period of three years prior to the death.

18

19 That does raise, of course, the possibility that a  
20 report about a child has been a minimal report or something  
21 entirely inconsequential so far as the safety of that child  
22 is concerned, because of the wide construction of the  
23 mandatory reporting obligations and the practice of some  
24 agencies, particularly Police, to report all and sundry.  
25 For example, in relation to domestic violence, making a  
26 report, even though it may have had nothing do with the  
27 child and the child may not have even been in the house at  
28 the time that there was some exchange of verbal abuse.  
29 That is one area that is of concern.

30

31 I think DoCS would like to see the review situation  
32 brought back to a point where there has to be some link  
33 between the death and child protection issues, not merely  
34 the coincidence of the fact that the child has been known  
35 to DoCS, in the broad sense which is given to that, and the  
36 fact of the death, because the two things may have  
37 absolutely no relationship.

38

39 The other thing which I think DoCS has a concern about  
40 really arises from one of the submissions concerning the  
41 cycle of reporting in relation to children's deaths. It is  
42 a one-year cycle which does not allow for trends, practices  
43 changes, et cetera.

44

45 A third interest, I guess, of DoCS relates to the  
46 issue which is critical as to whether there should be one  
47 key body reviewing children's deaths rather than several,

1 which exist at the moment including the Coroner, the Child  
2 Death Review Team, the Ombudsman, and so on. A possible  
3 model was developed in the submission by DoCS concerning a  
4 single panel comprising senior representatives of the  
5 various agencies which would respond to the internal  
6 investigation of the situation.  
7

8 Another question which I think arises in relation to  
9 the DoCS submission concerns the position of the Ombudsman  
10 in making recommendations - this is not confined just to  
11 death cases but also to its review role generally - to the  
12 point that it can make recommendations without necessarily  
13 having regard to resource implications or the necessary  
14 ministerial decision as to allocation of resources, which  
15 is critically a matter for agencies to determine.  
16

17 I think the suggestion has been put forward that the  
18 Health Care Complaints Act, section 91, might provide an  
19 alternative approach, which would require recommendations  
20 to take into account resource implications and resource  
21 allocation issues.  
22

23 I am not sure whether that clearly states the position  
24 so far as DoCS is concerned. There may be further matters  
25 you want to raise in relation to your general submission.  
26

27 MS MASON: That was probably stated more elegantly than we  
28 put in our submission. I think that is a fair summary of  
29 the issues. I don't think it is any secret or indeed, if  
30 it is, it is a fairly poorly kept secret, that there have  
31 been some colourful exchanges between DoCS and the  
32 Ombudsman in the past. Whether that has been productive or  
33 not is another issue. It has been certainly DoCS's view  
34 that it would be helpful if the annual report in particular  
35 was more clearly linked to child protection issues in terms  
36 of assaults, suspicious circumstances and neglect rather  
37 than the whole spectrum of the "known to DoCS" category.  
38

39 As you would appreciate, I am more closely linked into  
40 criminal justice thinking still. For the sake of the  
41 argument, a juvenile known to DoCS who died in custody in  
42 Kariong this afternoon would conceivably be in that  
43 spectrum. I fail to see how analysing that particular  
44 circumstances would have any relevance to the way the  
45 office does its work. Admittedly that is not the whole  
46 purpose of the Ombudsman's report.  
47

1 In regard to the question of what is looking at child  
2 deaths - again, coming fairly fresh to it - it is not an  
3 issue that I as director general have a really concluded  
4 view on an ideal model, but I will say that, coming fresh  
5 to it, the number of bodies and the number of reports  
6 perplexes me. Without pushing any particular model  
7 particularly vehemently, I would say that there has to be  
8 scope for making it simpler, while still having due respect  
9 to those legitimate interests of the various accountability  
10 agencies and the value of the recommendations they make.  
11

12 Obviously as the director general, my major concern  
13 is, first, for the welfare of the clients; and, second, for  
14 the welfare of my staff. I don't necessarily see it as  
15 helpful to have conceivably the same matter canvassed  
16 possibly through our own internal investigations, through  
17 the Coroner, possibly through criminal proceedings, and  
18 then through a couple of other investigatory processes.  
19

20 As I say, coming fresh to it, that seems to me like a  
21 recipe for increasing the stress on some young 21-year-old  
22 caseworker or indeed on the families who are potential  
23 witnesses. That is, in a nutshell, our position.  
24

25 THE COMMISSIONER: I guess one of the questions that  
26 arises is that in 1(a), whether the individual inquiries  
27 which are made internally by DoCS on behalf of the Coroner  
28 or the Ombudsman or the Child Death Review Team - although  
29 it will not investigate directly reviewable death, but it  
30 takes into account in its overall analysis - contribute to  
31 the understanding of systemic issues in a way which is  
32 cost-effective. The need for DoCS in particular to respond  
33 to the other bodies takes up time and resources.  
34

35 One thing that is apparent at the moment is that DoCS  
36 is extremely hard pressed to apply resources in the field  
37 to actually deal with child protection issues as distinct  
38 from filling out a myriad of reports and documents to  
39 external agencies, to government bodies, but also as a  
40 result of - I will be careful with the expression - the  
41 extremely demanding and inappropriate KIDS system which we  
42 have learnt effectively takes most caseworkers out of the  
43 field for well over half of their time. That is something  
44 we will look at separately.  
45

46 The question is really is this system involving all  
47 the agencies a cost-effective and productive system? Does

1 it produce results which justify the expenditure of  
2 resources by all of those involved? I don't know where to  
3 start. Perhaps we might start, Ms Calvert with you and ask  
4 whether you have any views about this.  
5

6 MS CALVERT: I'm pleased that you noted the Child Death  
7 Review Team was somewhat different than an investigative  
8 agency because in fact we are. We are interested. The  
9 purpose of the Child Death Review Team is to identify  
10 trends and patterns in deaths of all children across the  
11 whole of NSW and make recommendations to try to prevent or  
12 reduce those deaths. Therefore, the CDRT looks at a wider  
13 set of systemic issues than service systems. For example,  
14 we look at community attitudes, parenting practices,  
15 environmental impacts such as smoking as part of the  
16 systems, if you like, that we might make some  
17 recommendations about.  
18

19 Notwithstanding that, if there are systemic issues  
20 relating to services that are relevant to the research  
21 question that we are trying to answer, we will look at  
22 those service systems. I think you can see that in our  
23 work with our sudden and unexpected deaths of infants where  
24 we look at the service system and made recommendations  
25 about the service system, not only because the service  
26 system needed some change and refinement, but also because  
27 that's a mechanism for collecting information which in turn  
28 we can then use to provide much more robust  
29 recommendations. So I think the fact that we look beyond  
30 service system issues is an important issue.  
31

32 The other thing that is unique to the CDRT is that we  
33 analyse the whole population of deaths which provides a  
34 context for the subpopulations to refer to and to use in  
35 understanding what they are doing. So, for example, if you  
36 took the work of the Ombudsman, you might say that in fatal  
37 assault matters you might find that there are far more  
38 males who are killed than females. You could draw some  
39 conclusions from that by just looking at that  
40 subpopulation. However, if you look at the wider  
41 population you can see that that is a pattern that is  
42 across all causes of deaths, both external and natural, and  
43 therefore it has a different meaning. It may not be  
44 specific to fatal assault, but it may be much more a  
45 reflection of the interaction of the biology, environment  
46 and social context in which boys and girls are born and  
47 raised. So I think they are two unique things that the

1 Child Death Review Team does that the other agencies don't  
2 do.

3  
4 The Ombudsman, as I understand it, does look at child  
5 deaths from a service point of view, and that's appropriate  
6 because it fits with the context of that agency's overall  
7 task, which is to look at services. The coroner determines  
8 the manner and cause of death which is appropriate to their  
9 overall purpose, and us looking at all children's deaths is  
10 appropriate to our purpose, which is to promote the  
11 wellbeing of all children and young people in NSW. So I  
12 think that the teams or the activities or the child death  
13 review activity does reflect the broader agency and fits  
14 with the broader agencies, and I do think they do different  
15 things.

16  
17 MS FURNESS: Why wouldn't the Child Death Review Team  
18 functionally fit well within the Ombudsman's Office?

19  
20 MS CALVERT: Because the Ombudsman's purpose is to  
21 oversight public administration, if you like, and that is  
22 not the purpose of the Child Death Review Team. The  
23 purpose of the Child Death Review Team is to look at all  
24 deaths, not just those covered by public sector agencies.

25  
26 Its purpose also is to, as I said, look at all of the  
27 systems and the issues about that death that we can  
28 identify to try to prevent deaths. Again, it fits with the  
29 idea of promoting children's wellbeing, if you like, rather  
30 than the overlooking of public sector agencies. So that's  
31 why it wouldn't fit, because it has a different purpose.  
32 The purpose is different to the agency's purpose.

33  
34 MS FURNESS: It wouldn't, however, be inconsistent with  
35 the Ombudsman's functions for it to consider, within its  
36 role of looking at reviewable deaths, the trends and  
37 patterns with respect to deaths generally.

38  
39 MS CALVERT: Well, I think if you go back to why the two  
40 were separated in the first place, you probably have the  
41 answer to that, which is that when you are focussed on  
42 reviewing deaths of a particular group, it tends to absorb  
43 the resources, it tends to be the focus of the report,  
44 whereas what the Child Death Review Team is focussed on  
45 currently and, as a result of the separation, is in fact  
46 the epidemiological issues and surveillance and trying to  
47 identify patterns that might prevent children's deaths. So

1 I don't think they fit as well as you do with the review  
2 function of certain groups of deaths as opposed to a  
3 surveillance and epidemiological approach to all deaths,  
4 nor do I think that the purpose of the team fits well with  
5 the purpose of the Ombudsman.

6  
7 THE COMMISSIONER: Ms Boland, do you have any views on  
8 this? Perhaps I should ask, as part of your accreditation  
9 work I would assume that you would consider in relation to  
10 agencies any material which might emerge in relation to the  
11 death of a child in out-of-home care. I'm wondering  
12 whether that involves additional work by you or whether you  
13 rely on the work, say, of the Ombudsman or the Child Death  
14 Review Team or otherwise - I suppose the Ombudsman really.

15  
16 MS BOLAND: By and large we rely on the investigation of  
17 the Ombudsman, and obviously the internal work of the  
18 Department of Community Services. I mean, there is no  
19 overlapping in effect of our functions and the other  
20 agencies. Simply to say that I think that the internal  
21 DoCS' processes are significantly important in the manner  
22 in which they investigate and consider child deaths, and I  
23 would say that that same process might extend further  
24 beyond death into critical events and be seen more as an  
25 organisational process fed back into the training and  
26 development of the organisation. That is an observation  
27 from outside the agency.

28  
29 THE COMMISSIONER: Let's perhaps go back, Ms Calvert. We  
30 didn't address the other issue, whether the "reviewable  
31 death" definition at the moment, so far as the Ombudsman's  
32 involvement is concerned, is too wide or not wide enough or  
33 perfectly placed?

34  
35 MS CALVERT: In our submission, in the joint submission  
36 that I did with Dr Cashmore and Professor Scott we do make  
37 a recommendation that the focus the reporting be on child  
38 abuse and death or death in suspicion circumstances, and  
39 that the reporting period be extended from one year to  
40 three years. The reasons for that is that we think that  
41 there is insufficient time for change to occur within one  
42 year, and if you extend the reporting time frame, then you  
43 do allow for change to occur and for the Ombudsman to then  
44 more meaningfully comment on the impact of the work of  
45 whatever agency it is implementing the recommendation.

46  
47 The reason we have suggested that the reporting should

1 focus on child abuse and neglect is because of the  
2 misunderstanding that has continued for 10 years now about  
3 the meaning of "known to DoCS" or, if you like, "vulnerable  
4 children", and despite my best efforts as the convenor of  
5 the Child Death Review Team, and I know the Ombudsman's  
6 best efforts as a convenor of the Child Death Review Team,  
7 we still continue to get that fundamental misunderstanding  
8 of the meaning of "known to DoCS", if you like. We do cite  
9 an example of that in our formal submission.

10  
11 MS FURNESS: Although the current requirement is that the  
12 Ombudsman reviews deaths of children or their siblings in  
13 respect of whom a report was made within a period of three  
14 years immediately preceding the child's death. Are you  
15 suggesting that should be reduced to one year or changed in  
16 some other way?  
17

18 MS CALVERT: We haven't made a submission on that. I do  
19 think it is a very long period of time, and I would see  
20 that a shortening of that period of time - well, it depends  
21 actually. If they are restricted to reporting on child  
22 abuse and neglect or suspicious circumstances, then a  
23 longer period of time may be justified. If, however, they  
24 keep the broad definition that they currently have of who  
25 they report on, then a shorter time is desirable.  
26

27 THE COMMISSIONER: Or a different definition of with more  
28 detail than the mere fact of a report, because as I pointed  
29 out the report can be a relatively trivial matter, and  
30 nothing happened at all in relation to that child, and not  
31 further report made within three years.  
32

33 MS CALVERT: That is a very good point. The point you  
34 come back to is there is a range of ways you could put that  
35 together, if you like, that scope together in terms of the  
36 basis of the report, the cause of the death, and the length  
37 of time since a report, or whatever, to the department.  
38

39 I guess the prior step to that is what are we trying  
40 to achieve by having the Ombudsman oversight these deaths.  
41 Having been around at the time the Child Death Review Team  
42 was originally established in 1985, it was a proposal by  
43 the Child Protection Council and it was proposed because  
44 they wanted someone to review why these children were dying  
45 both from a demographic point of view, but also from a  
46 service system point of view.  
47

1 MS FURNESS: Can I understand your position? Currently  
2 the Act requires the Ombudsman to review deaths of children  
3 in a number of circumstances, including where there has  
4 been a report within three years and including where the  
5 death is or may be due to abuse or neglect. Is your  
6 position that it should only be in respect of abuse or  
7 neglect, and whether or not there is a report should not be  
8 a criteria for reviewing a death?

9  
10 MS CALVERT: It should be on child abuse and neglect and  
11 suspicious circumstances, and the existence of the report  
12 is irrelevant to that, because we know that one out of  
13 three deaths of child abuse and neglect have not been  
14 reported to the Department of Community Services, but they  
15 may in fact have had, and are likely to have had, contact  
16 with other agencies who the Ombudsman overlooks and there  
17 is benefit in us looking at why a report was not made, for  
18 example.

19  
20 MS FURNESS: If that was the case, then ordinarily  
21 one would expect the discretion to lie with the Ombudsman  
22 as to whether or not the death was due to abuse or neglect  
23 in order to enliven his jurisdiction. Is that how you see  
24 it?

25  
26 MS CALVERT: Yes, that would be his role to determine  
27 that, although we do work closely with the Ombudsman in  
28 determining cause of death, the Child Death Review Team and  
29 the Ombudsman share that information.

30  
31 Determining what was child abuse and neglect would  
32 probably be less difficult than determining what is a  
33 suspicious circumstance. That is where you would have to  
34 allow the Ombudsman to determine what a suspicious death  
35 was, but it would have to be suspicious of child abuse and  
36 neglect.

37  
38 MS FURNESS: I take it, Ms Mason, that you would be  
39 generally happy with the child being "known to DoCS" being  
40 effectively removed from the jurisdiction so that it was  
41 limited to abuse and neglect?

42  
43 MS MASON: It is a position that I think we would find  
44 very attractive, although I'd have to look at the exact  
45 consequence. There is also, of course, mixed into that the  
46 role of the coroner and other issues. It is also relevant  
47 to mention - although we are certainly not promoting this -

1 that the Victorians, I think, have a three-month window, so  
2 if it was known to DoCS or reported to DoCS in the last  
3 three months. It is not a position we are advocating but  
4 it is an interesting comparison.

5  
6 THE COMMISSIONER: If there were changes in this regard it  
7 doesn't mean that the death would be overlooked because the  
8 Child Death Review Team would be still looking at deaths of  
9 all children. The real question is whether the Ombudsman's  
10 requirement for review at the moment is too wide, and  
11 whether it is productive of results commensurate with the  
12 expense and delay which inevitably follows because the  
13 Ombudsman has to wait often for the coroner.

14  
15 Ms Boland, did you want to say anything more about the  
16 definition requirement for reviewable deaths?

17  
18 MS BOLAND: No.

19  
20 THE COMMISSIONER: Ms Barwick?

21  
22 MS BARWICK: No.

23  
24 THE COMMISSIONER: Mr Kinmond?

25  
26 MR KINMOND: I would like to deal with a couple of issues.  
27 First, I agree with the proposition that our child death  
28 review function and the function of the Commissioner for  
29 Children and Young People are quite distinct. So from our  
30 perspective there is built into the legislation provisions  
31 to ensure that there is an overlap. From the perspective  
32 of the administrative practice, in terms of the coding of  
33 deaths, we have come to arrangements whereby the system  
34 operates efficiently.

35  
36 In terms of this broader question as to whether our  
37 jurisdiction should be restricted, it essentially comes  
38 backs to a fundamental question as to whether one wants to  
39 put the Ombudsman's Office in a position where they can  
40 make solid judgements about the child protection system, or  
41 whether one believes that in fact the Ombudsman's Office  
42 should be somewhat restricted in that regard.

43  
44 If you look at the comments that were made at the time  
45 of us being provided with jurisdiction, it was clear that  
46 the intention was that the Ombudsman was well placed to  
47 look at child protection system, and it is about dealing

1 with the issue of not just whether in fact in relation to a  
2 particular case DoCS should have known that a child might  
3 die; it is about looking at the system from the perspective  
4 of saying that a solid child protection system is one that  
5 identifies risks generally.  
6

7 Now, the subgroup that we look at are children who are  
8 known to the department within three years of the time of  
9 their death. That involves us then having a very broad  
10 understanding as to issues in connection with the child  
11 protection system. From that broad understanding we then  
12 are placed to make judgments about strengthening the child  
13 protection system.  
14

15 If, for example, the pool of matters that we reviewed  
16 was limited, you run the very real risk that our vision is  
17 going to be quite restricted and we will not be well placed  
18 to make observations about child protection practice more  
19 generally.  
20

21 So it ultimately gets back to a question as to whether  
22 you want to put the Ombudsman's Office in a strong position  
23 in terms of understanding the child protection system.  
24 With the current jurisdiction we would argue that we are  
25 well placed to do that and our reports, our annual reports  
26 reflect that.  
27

28 MS FURNESS: You are equating effectively vision and  
29 strength with a period of time that a report may have  
30 existed in respect of a child.  
31

32 MR KINMOND: And also the breadth of the jurisdiction. So  
33 if, for example, it is limited to abuse and neglect,  
34 suspicious circumstances, then we'd probably look at  
35 between 30 and 40 matters per year. In those circumstances  
36 the question would have to be asked as to whether we would  
37 actually be well placed to make judgments about the child  
38 protection system.  
39

40 If we operate from the assumption which is pretty well  
41 established that in many cases one is not going to be well  
42 placed in the lead-up to, or the department won't be well  
43 placed to predict those children who are going to die, then  
44 essentially what one needs to do is to build a strong child  
45 protection system.  
46

47 Now, an oversight body looking at the adequacy of

1 DoCS' response in this situation should not be seeking to  
2 speculate whether in a particular case DoCS should or  
3 should not have known that there was a high risk that the  
4 child was going to die. A strong system from an oversight  
5 point of view is a system that examines the strength  
6 generally of DoCS dealing with child protection matters.  
7  
8 MS FURNESS: Why then would you require a period of three  
9 years?  
10  
11 MR KINMOND: It is interesting, I think about 80 per cent  
12 of the matters we review involve children who were notified  
13 within a 12-month period of their death.  
14  
15 MS FURNESS: I thought it was 70 per cent, but it is  
16 nevertheless high.  
17  
18 MR KINMOND: It is high. In that regard there could be  
19 scope for restricting the period of time. That  
20 restriction, however, would involve then us looking at a  
21 slightly less range of matters. In those circumstances the  
22 question then would be would that restrict to some extent  
23 our capacity to make judgments about child protection  
24 practice based on the assumption that strong child  
25 protection practice in this area is the best form of  
26 prevention, not only in terms of deaths but also in terms  
27 of protecting children's fundamental human rights.  
28  
29 MS FURNESS: Although the fact of a report, as you no  
30 doubt are well aware, may mean nothing in respect of the  
31 child's safety.  
32  
33 MR KINMOND: That is true in terms of individual matters.  
34 Individual reports may not mean a great deal, and in those  
35 circumstances there is a system in place for us to review  
36 those reports. I'm not aware of any significant resource  
37 burdens on DoCS in that regard. It is not information they  
38 provide to us. We access their KIDS system if we look at a  
39 particular matter and decide that the child protection  
40 history is irrelevant in terms from a systems point of view  
41 or irrelevant from the perspective of the child's death,  
42 then DoCS won't have any resources that it needs to apply  
43 to the matter.  
44  
45 MS FURNESS: You will, of course.  
46  
47 MR KINMOND: We will, but that is an exercise

1 notwithstanding the difficulties of the KIDS system, but it  
2 is not particularly onerous from a resourcing perspective,  
3 and it certainly does not impact upon the department.  
4

5 THE COMMISSIONER: One thing arises from that. In those  
6 cases where you think DoCS had no involvement or  
7 responsibility or anything to do with this particular death  
8 but it is a reviewable death because of the Act which  
9 excludes the Child Death Review Team from looking at it, in  
10 an investigative sense, what actually happens? Because you  
11 may decide at an initial look at it that this is one of  
12 those unfortunate accidents, no-one is at fault, the system  
13 has not failed. What then happens so far as the Child  
14 Death Review Team is concerned? Is it excluded from  
15 looking at it more closely in a systemic way because of the  
16 statutory prohibition on its right of involvement? So  
17 might this have an impact on limiting the Child Death  
18 Review Team's work?  
19

20 MR KINMOND: When we are looking in the context of some  
21 600 deaths per year that the Child Death Review Team deals  
22 with, it is true that there would be a percentage of those  
23 matters that we would deal with where the child protection  
24 history was not particularly significant. We would argue  
25 that the numbers would not be significant, but it is an  
26 issue that is worthy of consideration.  
27

28 THE COMMISSIONER: Might it be a situation whereby in those  
29 cases the prohibition on the Child Death Review Team  
30 looking at it might be waived?  
31

32 MR KINMOND: That is correct.  
33

34 THE COMMISSIONER: But it would be unfortunate if this  
35 system, of a wide reviewable net for you, actually impacted  
36 adversely on the Child Death Review Team's work.  
37

38 MR KINMOND: That is true. In addition to that we are  
39 more than happy to make available, and do make available to  
40 the Child Death Review Team, our data, and in fact perform  
41 a function of reviewing the KIDS system on behalf of the  
42 Child Death Review Team, so whilst it is a theoretical  
43 problem, I don't think --  
44

45 THE COMMISSIONER: It is not theoretical because there is  
46 a statutory prohibition on the Child Death Review Team  
47 investigating.

1  
2 MR KINMOND: Investigating? I'm not sure in terms of  
3 investigating.  
4  
5 MS CALVERT: I think there is a requirement for the  
6 minister to seek the Ombudsman's view if the Child Death  
7 Review Team wishes to conduct research primarily on  
8 reviewable deaths. So what is defined as a reviewable  
9 death does impact to that extent. So narrowing what was a  
10 reviewable death would ease that somewhat, but it is not an  
11 insurmountable burden as it currently exists.  
12  
13 MR KINMOND: The current provision requires that if there  
14 is research to be conducted into the matter, that is a  
15 limitation, but in those circumstances the minister seeks  
16 our views prior to making a decision.  
17  
18 THE COMMISSIONER: But the question which arises is what  
19 does research mean as distinct from investigate.  
20  
21 MR KINMOND: That is true. I can put that to Gillian, but  
22 that is true, I agree, but, once again, I don't think it is  
23 not an insurmountable issue.  
24  
25 THE COMMISSIONER: Okay. Does the Coroner have a view  
26 about this, or concerns in this area as to how the system  
27 is working?  
28  
29 MR MERRICK: We certainly do have views. From the outset  
30 I might say that we feel quite comfortable with the current  
31 provisions regarding reviewable deaths, but it comes at  
32 some cost for families, I believe. Clearly we are referred  
33 matters where the cause and manner of death are known to  
34 us, and we are forced to put deceased children through very  
35 invasive postmortem examinations and accordingly lengthy  
36 delays of postmortem reports, and that is a concern that  
37 the Coroner does have.  
38  
39 We believe that the terms of reference for reviewable  
40 deaths could be somewhat more limited in terms of abuse and  
41 neglect, but we would probably pick those matters up anyway  
42 because of untoward circumstance, suspicious circumstances,  
43 and that is covered in the Act anyway.  
44  
45 MS FURNESS: It affects you in terms of what is mandatory  
46 to report to the Coroner --  
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MR MERRICK: Yes.

MS FURNESS: -- and if the definition was to be amended in respect of the Ombudsman, it would be consistent to amend your legislation which is almost in identical terms.

MR MERRICK: That is right.

MS FURNESS: So do you have a particular view as to whether or not it should be mandatory to report to the state coroner or a deputy state coroner deaths in respect of children whose reports may have been made in a period of time shorter than the three years currently prescribed?

MR MERRICK: I think currently it works relatively well, although a number of deaths are reported to us quite sometime later, so investigative functions are somewhat hampered by the fact that the police aren't aware or the health system is not aware that these deaths should be most properly reported to a deputy or state coroner. It becomes an issue to pick up these deaths two or three months down the track, and then we would contact the families and explain to them that the matter is being investigated by a deputy or state Coroner and often that is a great shock for families, I would argue. We would not be uncomfortable with a change of 12 months. Three years to me seems a bit lengthy.

MS FURNESS: And, of course, it doesn't affect your discretion in holding an inquest.

MR MERRICK: No, it does not.

THE COMMISSIONER: Thank you. Does anybody from the Department of Premier and Cabinet have a view you want to express in relation to this?

MR LEAN: Probably at this point no. We have heard all the views that have been raised and we will wait to see what comes out of the commission before we finalise our position.

MR McCALLUM: There are a couple of more general comments. When we are looking at child deaths in this regard we question does the oversight and review function result in a better outcome for children and families at the end of the day. What are we actually achieving in terms of the

1 resources that are going into the overall review and  
2 function.

3  
4 The other problem is when we actually tend to focus on  
5 child deaths as a policy driver, we end up also driving  
6 practice in general, and that is always a concern for us.  
7 People then take more conservative views in the general  
8 wellbeing of families than out in the system generally, and  
9 that needs to be looked at. When we actually have this  
10 heavy focus and heavy public focus on child deaths they  
11 tend to use a lot of resources and direct policy in a way  
12 that may not be productive for them or the general child  
13 welfare population.

14  
15 Gillian has pointed out there is a role for a more  
16 overarching approach to the drivers of wellbeing and to  
17 child deaths in the state, and there is a function that is  
18 necessary within the statutory bodies, i.e., DoCS, to  
19 actually review its own functions when things go wrong. I  
20 think that is important. The actual collection of what  
21 else should be the oversighting of child deaths, I'm not  
22 sure at this point in time. There probably is some sense  
23 of review on the broadness of that. My major point is what  
24 do we extrapolate from deaths and how does that drive the  
25 system.

26  
27 THE COMMISSIONER: Subpoint (c) in relation to question 1  
28 is whether the mode of inquiry and of reporting appropriate  
29 or whether it can be any way streamlined to progress the  
30 inquiries more speedily and with less demand on the  
31 resources. Does anybody have a view about that? It does  
32 seem to be the situation that, for the reviewable deaths,  
33 because of the parties involved, including Police  
34 investigations and Coroner's, and so on, some of these  
35 things do take a long time to come to a result. In the  
36 meantime the possibility of practice reform may have been  
37 missed, with adverse consequences for other children.

38  
39 Do you have any views about how the process can be  
40 streamlined assuming that the general network, subject to  
41 some modification of the definition of "reviewable conduct"  
42 being made, could be streamlined?

43  
44 MS MASON: Ms Rygate is probably more of an expert than I  
45 am at this point. I would say that, as far as our own  
46 internal investigations go, I don't think those kinds of  
47 situations delay us engaging in appropriate investigation

1 and engaging with staff just because of the manner in which  
2 the investigations are done in a very, I suppose,  
3 non-inquisitorial way, deliberately for that reason.  
4 People are able to engage, there is no concern about  
5 prejudicing future criminal proceedings.

6  
7 I don't think, as far as our own internal  
8 investigations are concerned, that that is particularly a  
9 problem unless there are actual criminal charges in view,  
10 but as far as the external agencies, I think what we have  
11 already been saying is the situation. Do you have anything  
12 to add?

13  
14 MS RYGATE: The focus of our internal reviews, as you  
15 know, is all about trying to learn from these sorts of  
16 terrible events and do what we can to improve our systems  
17 and practices to increase the chance of them not happening  
18 again. I would agree with what Jennifer just said. Our  
19 system is not constrained by waiting for all of those other  
20 processes to happen before we can get in and have a look at  
21 a death.

22  
23 THE COMMISSIONER: Is it the practice, because of the  
24 possibility of police action and inquiries, do you feel  
25 constrained from interviewing staff immediately? Do you  
26 routinely wait for the police to take relevant statements?  
27

28 MS RYGATE: No, we don't. It is not always the case, in  
29 fact it is relatively rare that the police would interview  
30 our staff in relation to a child death matter. It has  
31 happened, and we are aware of that and try and fit the  
32 timing so that we don't in any way cut across what they are  
33 trying to do or prejudice the evidence they might gather.  
34 In most of the child deaths that occur, the police don't  
35 interview our staff. We do get out there as quickly as we  
36 can and interview our staff.

37  
38 I should put on record the fact that our internal  
39 review function is relatively new and it is being refined  
40 as we go. We have seen very positive results so far and as  
41 we develop better systems, it will mean that we can address  
42 these things more quickly and we expect we can get even  
43 better at that.

44  
45 On the broader issue that you were referring to of how  
46 long all of the different processes around a child death  
47 take, I think the point has already been made that this can

1 be incredibly onerous for families when they are waiting  
2 for a period of years until all of the local processes and  
3 inquiry processes around a death are finished and it can be  
4 very onerous for staff. Anything that we can do to address  
5 those issues is probably a good thing.

6  
7 The other point I would make on that, and it is a  
8 little bit contradictory, possibly, is that many of the  
9 issues that are identified in reviewing child deaths, many  
10 of the systemic issues in reviewing child deaths, and in  
11 fact other sorts of activities where there has not been a  
12 death, are the sorts of things that don't lend themselves  
13 to a quick fix, so there has to be some kind of balance, I  
14 think.

15  
16 THE COMMISSIONER: Are there any other views about the  
17 process with the mode of inquiry, collecting evidence and  
18 reporting, which could be streamlined?

19  
20 MS FURNESS: Can I just ask whether the investigations are  
21 generally done in parallel or whether your investigation  
22 often is done first and then the Ombudsman uses, to  
23 whatever extent he thinks desirable, your report to conduct  
24 his own investigation?

25  
26 MS RYGATE: The latter situation has been increasingly  
27 what we have been doing. So the Ombudsman's Office will  
28 say that they are interested in a death. We will say "Yes,  
29 we are going to have a look at that one." More and more we  
30 have been getting feedback from the Ombudsman that they  
31 would be happy to look at our review before they finalised  
32 whatever they are doing.

33  
34 MS FURNESS: That certainly sounds sensible, Mr Kinmond,  
35 doesn't it?

36  
37 MR KINMOND: Yes, I would agree.

38  
39 THE COMMISSIONER: Are there any other views about the  
40 process? Perhaps we can move on then to the review of the  
41 situation of children in care both by the Ombudsman and the  
42 Children's Guardian. As the summary of facts points out,  
43 there is a dual role, but the primary role, I guess, for  
44 the Children's Guardian is both in initial accreditation  
45 and in the compliance audit process. I think there are  
46 some holes, for example, in relation to children in  
47 voluntary care and some concerns in relation to people who

1 are in kinship or relative care.  
2

3 A possible question has been raised as to whether  
4 there's an incompatibility and potential conflict between  
5 the Children's Guardian accreditation and monitoring with  
6 the policies which DoCS has recently developed in relation  
7 to the performance-based contracting for out-of-home care  
8 and also the performance monitoring framework which may  
9 have an impact on agencies if they have to, in effect,  
10 answer to two separate bodies and provide different sets of  
11 information to satisfy either DoCS, on the one hand, or the  
12 Children's Guardian on the other, which might also have a  
13 spin-off for funding and resource allocation for both of  
14 them.  
15

16 I think a further question might arise as to the  
17 absence of a memorandum of understanding between DoCS and  
18 the Children's Guardian, which I think has been addressed  
19 in your submission, Ms Boland, hasn't it?  
20

21 MS BOLAND: Yes.  
22

23 THE COMMISSIONER: The other question, which actually  
24 intrigues me a little bit, is the role of the official  
25 community visitors who, in effect, are employed by the  
26 Ombudsman, report to the Ombudsman, but neither the  
27 Children's Guardian nor DoCS become informed of their  
28 views, although for DoCS that would be a very important  
29 part of any decisions with regard to granting new contracts  
30 and for the Children's Guardian it would be important for  
31 its auditing process and in its accreditation process so  
32 far as it might want to impose conditions upon particular  
33 agencies.  
34

35 That raises, to my mind, two questions: what really do  
36 the official community visitors contribute to the scheme?  
37 Should they be direct employees of the Ombudsman or should  
38 there be a clearer system for reporting both to the  
39 Guardian and to DoCS of their actual findings or  
40 recommendations?  
41

42 There are a number of questions which arise in  
43 relation to that. I probably have not identified all of  
44 those which are raised because I think Ms Boland has  
45 identified a number of other possible amendments of the Act  
46 or the repeal of certain provisions of the Act, which we  
47 might have to look at. But so far as DoCS is concerned, do

1 you want to indicate your view at this stage in relation to  
2 the various procedures for reviewing by way of oversight  
3 the situation of children who are in out-of-home care?  
4

5 MS MASON: Just in brief, I think it is fair to say that we  
6 have a very productive relationship with the Children's  
7 Guardian. I think it is common ground between us that  
8 there is room for streamlining those procedures somewhat,  
9 and that the regulatory framework at the moment needs  
10 updating in terms of being more outcome-focused rather than  
11 being quite so intricate and complex, as it currently is.  
12

13 We don't have particular issues, as far as I am aware  
14 at this early stage, between the fact that the Children's  
15 Guardian and the Ombudsman both have a role. The  
16 Ombudsman, in my understanding - Steve might correct me if  
17 I am wrong - tends to actually go out and do site visits  
18 and interviews, whereas the Children's Guardian is more on  
19 a paper-file compliance. They are not tramping into each  
20 other's ground, as far as I am aware, although maybe they  
21 have a different view. Although my understanding is that  
22 DoCS has had issues in the past when the Ombudsman began to  
23 investigate matters that the Children's Guardian was  
24 already well advanced in looking at. That may be  
25 incorrect.  
26

27 We are very keen to avoid duplication. I must admit  
28 I haven't turned my mind to the official community  
29 visitors. I am told that the Ombudsman sends us  
30 intelligence they gather from those; is that correct,  
31 Steve?  
32

33 MR KINMOND: Yes, we do pass on information, but with the  
34 consent of the visitors. The thing with the visitors is  
35 that they are independent agents in that sense. We  
36 facilitate the scheme but they are essentially the  
37 minister's visitors.  
38

39 MS FURNESS: They are independent insofar as they are not  
40 employed by the Ombudsman, but you tell them when to go and  
41 where to go, don't you?  
42

43 MR KINMOND: There is a fine line between things which are  
44 administrative arrangements in nature and providing strong  
45 guidance in particular areas, I would agree.  
46

47 MS FURNESS: But do you tell them when to go and where to

1 go?  
2  
3 MR KINMOND: No, we organise a visiting schedule, and in  
4 connection with the visiting schedule, that's based on a  
5 formula. It is based on a formula which relates to  
6 ensuring that all services are visited. That is a good  
7 administrative approach. Visitors will come to us from  
8 time to time, though, and indicate that they may need to  
9 increase their visiting to a particular service and we are  
10 receptive to that.  
11  
12 THE COMMISSIONER: You also maintain a sort of data bank  
13 for their reports.  
14  
15 MR KINMOND: Yes.  
16  
17 THE COMMISSIONER: So it is centralised information  
18 gathering that you actually conduct?  
19  
20 MR KINMOND: Yes. We do have a database. We are in the  
21 process of seeking to improve the quality of the database  
22 and have entered into discussions with the Children's  
23 Guardian in that regard to ensure that the nature of the  
24 information that is collected is consistent with the types  
25 of areas that the Children's Guardian is interested in and  
26 is not inconsistent with the accreditation scheme.  
27  
28 MS FURNESS: Why would there be any limitations on  
29 providing the direct information given to you by the  
30 visitors to other interested public sector agencies such as  
31 the Children's Guardian and DoCS?  
32  
33 MR KINMOND: It is interesting because the visitors'  
34 information technically is not our information and the Act  
35 is specific that visitors can make complaints to us. The  
36 Act is indeed silent on the visitors being able to provide  
37 information elsewhere, other than obviously through to the  
38 minister.  
39  
40 MS FURNESS: But, as a matter of policy, is there any  
41 reason you can see why there should be any limitations on  
42 that information being made available to properly  
43 interested public sector bodies?  
44  
45 MR KINMOND: I think it would be worthwhile considering  
46 whether we would be entitled to pass on the information of  
47 the visitors without their consent to another player. We

1 will often use visitor information that we have received as  
2 a result of inquiries or concerns they have raised with us  
3 as a part of our complaint-handling function and in order  
4 to discharge our functions, and it may well be a part of us  
5 considering whether we need to do a systemic review. We  
6 have often used that information and have passed that  
7 information on to other parties to assist us under our  
8 powers to do our job effectively.  
9

10 From a legislative perspective, I think it is somewhat  
11 patchy in this area. In discussions with the visitors  
12 their view is that they would like to have their say as to  
13 what information is passed on to other agencies. That is  
14 their position. I think it is important for me to put that  
15 on the table.  
16

17 THE COMMISSIONER: I understand that. I am just a little  
18 intrigued as to what they actually contribute in the sense  
19 that they are confined to residential out-of-home care  
20 services, residential services for people with disabilities  
21 and licensed boarding houses, which is only, of course, a  
22 very small part of the actual out-of-home care system.  
23 They are not going to the agencies, the non-government  
24 agencies, who are providing individual foster carers.  
25

26 MR KINMOND: No, they are restricted in the children's  
27 area, the out-of-home care children's area, to looking at  
28 residential services.  
29

30 THE COMMISSIONER: That's right.  
31

32 MR KINMOND: So their role is quite restricted in that  
33 regard. We have some 30 community visitors. The vast  
34 majority of them conduct visits to funded disability  
35 services and boarding houses. There is a small pool of  
36 visitors who in fact visit residential centres for  
37 children.  
38

39 THE COMMISSIONER: Again, I can see there may be a role  
40 for the other bodies, but this is a bit of an overlap with  
41 the Children's Guardian so far as those children who are in  
42 residences who are in care. More importantly, the whole  
43 concept of the official visitors seems in recent years to  
44 have been narrowed. It has been taken away from the  
45 corrections system. I don't know what other official  
46 visitors there are now.  
47

1 More importantly, I haven't the faintest idea what the  
2 background of the visitors is or what expertise they have,  
3 for example, in relation to children and the quality of  
4 that expertise. My understanding is that from time to time  
5 advertisements appear in the paper inviting people to be  
6 visitors for this or that. They are obviously well-minded  
7 community people with some experience of life and of good  
8 standing. They are no doubt well-meaning, and I don't want  
9 to denigrate them in any way or fashion, but what expertise  
10 they have at the moment is not within my ken.

11  
12 MR KINMOND: One of the pleasing things for us is that  
13 when those advertisements appear, we get a large number of  
14 applications. I have to say that the quality of the  
15 applicants is very good. We are looking for people with  
16 relevant industry experience and/or other relevant  
17 experience. I must say we have identified very good  
18 people.

19  
20 Quite often people who tend to apply for community  
21 visitor positions are people who have had an extensive  
22 history in the community services or other relevant fields  
23 during their career. They are getting towards the end of  
24 their career and feel this is something that would be a  
25 worthwhile social activity they could engage in. As a  
26 result, I think the quality of the people we attract has  
27 been fairly high. I am happy to provide the Commission  
28 with general information in support of that claim.

29  
30 THE COMMISSIONER: Thank you. That would be good. Again,  
31 I don't know to what extent they are privy to the  
32 out-of-home care standards and the mandatory requirements,  
33 and so on, and the good practice guidelines which have been  
34 developed for out-of-home care.

35  
36 MR KINMOND: We ensure that there is ongoing training of  
37 community visitors. There is a significant investment on  
38 our part to ensure that those who are visiting out-of-home  
39 care services are acquainted with the existence of the  
40 standards, what the standards mean. We have a situation in  
41 place where when visitors first commence, there is an  
42 induction program and mentoring of them. It is not simply  
43 individuals applying for a position, having five minutes  
44 worth of training and going out and doing the job.

45  
46 I would also say that the visiting scheme, from my  
47 perspective, is very useful because they go out to the

1 coalface. They get to see what's happening where children  
2 are residing or where people with disabilities are  
3 residing, and they are often very skilled at getting good  
4 practical solutions. In terms of the general scheme, my  
5 view is that it achieves some good practical outcomes.  
6

7 THE COMMISSIONER: Could the same result be achieved if  
8 the Children's Guardian was to use its staff to do the same  
9 visits as part of the auditing program? I guess this  
10 really is an oversight auditing type of exercise.  
11

12 MR KINMOND: I suppose it gets back to the fundamental  
13 question as to whether we see the visitor's role as being a  
14 distinct role. One of the benefits one could argue with  
15 the visitors' scheme is that, because they are not linked  
16 to an accreditation system, their job is about grassroots  
17 resolution of matters, but they are well placed, given  
18 their experience, given their skills, to achieve practical  
19 outcomes. As to whether that system is preferable to  
20 employees of the Children's Guardian engaging in the same  
21 activities, I think that is a matter I am happy to leave  
22 with the Commissioner.  
23

24 THE COMMISSIONER: It is not a huge issue. Ms Boland, do  
25 you have any views about that?  
26

27 MS BOLAND: Obviously, we have spent some time in our  
28 written submission outlining various aspects of the system.  
29 In relation to the community visitors, when we assess  
30 accreditation and make accreditation decisions, we are  
31 looking at systems of care. My understanding of the  
32 community visitors is that they do look at individual  
33 matters and attempt to resolve individual matters. When  
34 individual matters come to our attention during the  
35 accreditation process, there is a referral process back to  
36 the Ombudsman or back to the designated agency or back to  
37 DoCS. So we are looking at systems, we are very focused on  
38 looking at how the system operates, not on resolving  
39 individual matters.  
40

41 Having said that, there is obviously some information  
42 at a higher level which could be of interest to us and we  
43 have made some submissions in relation to that. We have  
44 made submissions in relation to the review of the CS CRAMA  
45 legislation of the parliamentary joint committee, that we  
46 consider that the exchange of that information would assist  
47 us in making our accreditation decisions.

1  
2 THE COMMISSIONER: So your preference would be for that  
3 program to continue but for the legislation to make sure  
4 that you get informed of the results of their visits?  
5  
6 MS BOLAND: Yes.  
7  
8 MS CALVERT: Could I say in relation to sharing of  
9 information to a third party that because it is often about  
10 an individual child, I think their consent or their  
11 knowledge that it could be passed to a third party is also  
12 important. It is not just the visitor consent issue here.  
13 I think there is a child consent issue as well.  
14  
15 THE COMMISSIONER: They are not mandatory reporters, I  
16 assume.  
17  
18 MS CALVERT: No, but my understanding of the community  
19 visitors is that they are in institutions, if you like. I  
20 understand there are also community visitors in Juvenile  
21 Justice. In those institutions, the nature of the  
22 institution means they are at greater risk. They are  
23 generally closed systems. Children don't have other people  
24 to turn to to make a complaint. Children don't generally  
25 make complaints anyway in a formal sense. The community  
26 visitors were a strategy to try to open up a closed system  
27 so children would be able to let someone know about their  
28 worries. When they are in a closed system, children also  
29 feel very vulnerable. They worry that if they tell, there  
30 will be trouble or there will be retribution, even in a  
31 care setting at times. It is important that children  
32 understand if they are going to give certain information  
33 about the quality of care, even if it is not a reportable  
34 matter, if it is about a quality of care issue, that it  
35 will not result in their having recriminations against  
36 them. If there's a third party involved, they need to know  
37 that so they can decide what to tell or what not to tell.  
38  
39 THE COMMISSIONER: The only problem with that is that  
40 there is not much point collecting information about  
41 concerns on the quality of care unless those concerns are  
42 communicated to the appropriate body that can then address  
43 them without necessarily disclosing the source.  
44  
45 MR KINMOND: Commissioner, the way in which the system  
46 really operates is that, for the vast majority of matters,  
47 they are dealt with on the spot. They are raised with the

1 service in a report that the service receives and the  
2 visitor then tracks the outcome. It really is a grassroots  
3 resolution system at the coalface. I think that is  
4 probably its strength.  
5

6 MS MASON: If I could just confirm that, and I can  
7 scarcely believe that I am arguing for a proliferation of  
8 scrutiny mechanisms, which is against my general theme. In  
9 Juvenile Justice, it is the case that it can be very  
10 valuable. It is a rather old-fashioned mechanism, but it  
11 is a way in which relatively powerless young people can  
12 have their issues resolved by somebody who is from outside  
13 the system. So it is valuable for that reason. The  
14 question of what is done with any information they may  
15 have, I guess, is an issue that is for other others to  
16 think about.  
17

18 THE COMMISSIONER: I guess there are two issues:  
19 communicating results, but also particularly, communicating  
20 to someone the situation where the problem is not resolved  
21 on the ground. That would seem to be undesirable if the  
22 visitors identify problems which are not resolved but are  
23 not then reported either to the Guardian or to DoCS.  
24

25 MR KINMOND: In those circumstance, they are well aware of  
26 their capacity to make complaints to the Ombudsman's Office  
27 and they exercise that regularly. We have staff who are  
28 dedicated to providing that support to them. We are also  
29 aware that visitors will raise matters directly with the  
30 department and on occasions will raise matters with the  
31 minister direct.  
32

33 THE COMMISSIONER: That is one aspect of the out-of-home  
34 care, but I think both DoCS and the Children's Guardian  
35 have, in a fairly general way, suggested that there should  
36 be some reform of the regulatory framework and audit  
37 process and perhaps a different approach taken in relation  
38 to people in voluntary care and relative and kinship care.  
39 I don't think either of you actually identified  
40 specifically what it is that needs to be done by way of  
41 reform, although there are some recommendations in the  
42 submission of the Children's Guardian on amending some  
43 provisions of the Act. I might just ask each of you if you  
44 could indicate what you see as desirable to happen in  
45 relation to these areas.  
46

47 MS MASON: I think you're probably correct in saying that

1 what we have done is identify processes and problems rather  
2 than actually where we think we should end up. In  
3 appendix 3 to our submission which, as previously discussed  
4 we arranged to be released, there is some detailed  
5 discussion of what we think as to the reform of the  
6 process, the standards, and how to make it less  
7 process-focused and more outcome-focused and also in terms  
8 of making it more meaningfully weighted at the end of the  
9 child protection as opposed to governance issues. I don't  
10 know if that answers your question.

11  
12 THE COMMISSIONER: I would imagine that the Guardian has  
13 seen that document? Do you have views about that?

14  
15 MS BOLAND: Yes.

16  
17 THE COMMISSIONER: Also do you want to speak to any of  
18 your suggested changes which, I guess, are picked up in the  
19 closing part of your submission, that is the summary of the  
20 recommendations?

21  
22 MS BOLAND: I will respond, if I might, to the  
23 accreditation and quality improvement program and the case  
24 file audit and its current operation. Without repeating  
25 what is in our written submission, I think we have provided  
26 the Commission with an extensive amount of material about  
27 our review process recommendations in relation to our  
28 regulation. We undertook a substantial questionnaire or  
29 survey of all participants in the accreditation quality  
30 improvement program last year and the year before of all  
31 participants in the case file audit program.

32  
33 Again, I think it is fair to say that the system we  
34 operate now is, to use a term that has been used today,  
35 quite young. We refer to it as a foundation system. It is  
36 also fair to characterise it as a compliance-focused  
37 system. In fact it is referred to amongst the sector as a  
38 pass/fail system: you need to meet a standard or  
39 particular aspect of the standard in order to be  
40 accredited.

41  
42 That system has been operating. There has been an  
43 ongoing commitment that that would be reviewed and that has  
44 now occurred. The issues that DoCS has raised in its paper  
45 which were given to us at the time of the review have also  
46 been raised by other agencies, in particular, the resource  
47 onus on agencies in complying with the system, and in

1 particular, the inflexibility of the system. We have taken  
2 on board all of those comments.

3  
4 I think we have outlined in considerable detail what  
5 our proposal is in relation to those changes. Broadly  
6 speaking, it is to move the system from a pass/fail system  
7 into one that is focused on continuous quality improvement.  
8 It is one that will allow for more flexibility and  
9 innovation by services. It will allow the Guardian to take  
10 into account other sources of information. At the moment  
11 it is a paper-based system. It is our intention that we  
12 would undertake site visits and talk to staff and look at  
13 requirements ourselves.

14  
15 Our intention is to streamline the standards, refocus  
16 them on outcomes, primarily, the safety, wellbeing and  
17 welfare of children in care. As you have probably realised  
18 there is considerable repetition and people have made  
19 submissions to us that that repetition is resource  
20 intensive. I think we all concede that and are more than  
21 willing to change that.

22  
23 We are also looking at weighting standards and in fact  
24 weighting aspects of our case file audits. I don't think  
25 there is any disagreement in relation to how the system  
26 might be reconfigured. I think there is general consensus  
27 amongst not only the government sector but also the  
28 non-government sector as to the approach that we are going  
29 to take.

30  
31 I suppose I should add in relation to that, because it  
32 is part of the question, a few comments on the value of the  
33 system. Again, in the review and questionnaire and  
34 surveys. I think the value of the system has been that it  
35 has actually brought people up to where they have some  
36 criteria where they have policies and procedures in place.  
37 Then we look at their practice to see if their practice  
38 reflects those policies and procedures.

39  
40 I think at the beginning of the process of the  
41 accreditation quality improvement program, 14 per cent of  
42 agencies had no real systems in place for looking at  
43 quality or reviewing their policies and practices or their  
44 casework. The impact of the system is to ensure that  
45 people are working towards meeting the standards and they  
46 are in fact achieving those standards over time.

1 I will not go through the extensive detail about what  
2 people thought of particular aspects except to say that  
3 there is a high correlation between improving policies,  
4 procedures and practices reported to us by the agencies who  
5 operate the system and they feel that that has enabled them  
6 to better improve the outcomes for children and young  
7 people in their care.

8  
9 I should also say that accreditation systems operate  
10 to look at systems of care. If they are properly  
11 implemented, they will ensure the safety of children and  
12 young people in care and they will improve their welfare  
13 and wellbeing. It is also important that we say that  
14 achieving better outcomes for children is a shared  
15 responsibility. It is one that's shared by DoCS, NGOs,  
16 oversight agencies, and we all have a role. I think we all  
17 work reasonably collaboratively to achieve that role. It  
18 is also dependent on other factors. We may well accredit  
19 systems, but poor staffing decisions may be made which will  
20 affect how the system is implemented and the practice.

21  
22 There are a number of factors that operate that are  
23 not the intention of the accreditation system to resolve  
24 but sit with the NGO, in a performance monitoring sense, or  
25 with the funder, being DoCS. There is a distinction there.  
26 In our submission, we have gone into some detail about the  
27 work that we have done with DoCS in terms of lining up what  
28 our standards and accreditation system will look like  
29 vis-a-vis the performance monitoring system which DoCS has  
30 proposed in relation to its contracting.

31  
32 THE COMMISSIONER: So work has been done in relation to  
33 that, has it?

34  
35 MS BOLAND: I am happy to provide this, but we have  
36 actually benchmarked, if you like, or compared so we are  
37 assured that there is no real overlap.

38  
39 THE COMMISSIONER: I noticed in your submission you raised  
40 the question as to possible compatibility between the two  
41 and the potential for additional requirements.

42  
43 MS BOLAND: Yes. That was something at the time of  
44 writing, and again we have raised that again with DoCS. We  
45 have also spoken to the non-government agencies. They  
46 have expressed some concern that there will be a multiple  
47 impact on them. I understand, and I am just speaking on

1 information that I have been given, that in fact a tool has  
2 been piloted with some non-government agencies - that's the  
3 performance monitoring tool - and the initial report back  
4 to us is that they don't feel there is conflict.

5  
6 THE COMMISSIONER: We would like some information on that  
7 from either or both of you as to what has been achieved.

8  
9 MS MASON: We are happy to get that.

10  
11 THE COMMISSIONER: Similarly with the memorandum of  
12 understanding. Has that been progressed?

13  
14 MS BOLAND: With DoCS?

15  
16 THE COMMISSIONER: Yes.

17  
18 MS BOLAND: I think what we have said is that we would  
19 like to finalise our system and then we will reconvene  
20 discussions with DoCS on the MOU. Initially, I think it  
21 was thought that we could do that by exchange of letters.  
22 Further on down the track it was considered appropriate for  
23 an MOU. We have a draft, and we are continuing to work on  
24 that draft with DoCS. I don't think there is any issue  
25 about having one.

26  
27 THE COMMISSIONER: Do you see any overlap or conflict  
28 between the dual potential roles of both you and the  
29 Ombudsman in looking at out-of-home care, or are you happy  
30 with how it exists?

31  
32 MS BOLAND: I have taken a very specific focus on reviews  
33 and reviews of specific children. In relation to  
34 conditions that we may place on agencies, and an example is  
35 a condition that children under 12 should not be placed in  
36 residential care, if they are placed in residential care we  
37 do, I suppose, monitor their circumstances. There have  
38 been other individual children that we would monitor in  
39 relation to whether they were non-designated agencies. So  
40 our capacity to review individual children is very much  
41 constrained to the accreditation process.

42  
43 I suppose the overlap is absolutely minimal. To date  
44 it has not caused any problem that I am aware of. DoCS has  
45 referred to one incident. In our last 2006-2007 audit we  
46 took an audit of the whole system. The Ombudsman is also  
47 looking at a category that we were looking at, and that is

1 a zero to 5s. So I think that is a conflict - the possible  
2 overlap that has been talked about. We are looking at  
3 particular aspects of practice, and I understand from the  
4 Ombudsman that they look more in detail at the individual  
5 matters.

6  
7 THE COMMISSIONER: Except they did a wider one on this  
8 occasion.

9  
10 MS FURNESS: I think of 49 children there are five, so it  
11 was in some ways narrow. Was there consultation between  
12 each agency before the one who did the most recent?

13  
14 MR KINMOND: The most recent?

15  
16 MS FURNESS: Yes, the most recent review. I'm not sure of  
17 the timing, although I suspect the Children's Guardian  
18 started first.

19  
20 MR KINMOND: You are talking about the under 5s?

21  
22 MS FURNESS: Yes.

23  
24 MR KINMOND: There was consultation throughout the process.  
25 I would need to double check in terms of the lead-up to the  
26 process. One of the things is, looking at this area in  
27 terms of coming here today, I had a look at the MOU. Now  
28 the MOU talks about if it is appropriate the Ombudsman  
29 should consult with the Children's Guardian in relation to  
30 in care reviews that are conducting. My view is that  
31 provision is inappropriate, and that in fact it should be  
32 that in all cases where we are conducting in care reviews  
33 we should talk to the Children's Guardian.

34  
35 In addition the Children's Guardian has suggested to  
36 me recently the value of reconvening regular meetings  
37 between the department and the oversight agencies. One  
38 benefit of that would be that if there is any potential  
39 overlap that is emerging, that would give the department  
40 the opportunity to put its cards on the table as well.

41  
42 MS MASON: We would welcome that.

43  
44 THE COMMISSIONER: Again, there would seem to be a need to  
45 rationalise these kind of reviews so you are not trampling  
46 over each other or duplicating effort, because it is  
47 resource intensive for everybody in a resource scarce

1 system.

2

3 MS BOLAND: On a point of clarification, in the case file  
4 work that we undertook we identified a particular program.  
5 We have had considerable discussions with the Ombudsman in  
6 relation to the areas that we need to look at in more  
7 depth, and they are the health and education of kids in  
8 care. We have had discussions with DoCS, but we are very  
9 mindful of possible overlap there. I think that is why we  
10 have had such early discussions.

11

12 THE COMMISSIONER: There are a couple of areas which seem  
13 to me at the moment to be areas to be aware of where there  
14 is a gap in service. I'm not quite sure who is looking at  
15 that or reporting on it other than obviously us, but the  
16 first of those is a situation of adolescents, some of whom  
17 have been in care, others of whom probably should be in  
18 care but who are homeless. From what we hear around the  
19 country, the services, the refuges or the residences, or  
20 whatever, for those people are substantially lacking. As a  
21 consequence there are many runaways who have nowhere safe  
22 to reside, who, because they are transient, are difficult  
23 for DoCS and the police to trace, and who are uncomfortable  
24 with living in out-of-home care with individual foster  
25 carers, and certainly very often can't go home because of  
26 abuse or neglect, and so on.

27

28 It is one thing to have a system that reviews actual  
29 services that exist; it is another thing to have someone  
30 reviewing services that don't exist. I'm not quite sure to  
31 what extent the Commission For Children and Young People  
32 caters for young people, or the Guardian or DoCS or anybody  
33 is addressing that particular significant gap in the  
34 availability of services.

35

36 MS CALVERT: I thought the federal government had made a  
37 strong start on that.

38

39 THE COMMISSIONER: They promise things, but whether it is  
40 delivered is entirely separate, or has been in past, but  
41 hopefully won't be in the future.

42

43 MS CALVERT: The supported accommodation assistance  
44 program, as I understand it, is the program that would  
45 cover a number of those children, and that's the  
46 responsibility of the Department of Community Services to  
47 administer. So it may be that that is the place where you

1 would start to look at gaps in services.  
2  
3 MS FURNESS: I think the issue is that there is very  
4 little doubt that there is a gap in relation to residential  
5 care for adolescents. I think the question the  
6 commissioner is interested in having answered is where  
7 responsibility lies for identifying that there may well be  
8 such gaps. It is quite clear that DoCS has the SAAP  
9 program and can fund such services; this is a somewhat  
10 broader question.  
11  
12 MR McCALLUM: It covers a number of issues - the issue of  
13 actually kids being discharged from care and what happens  
14 to those kids. It is fairly common practice in many ways -  
15 kids get discharged inadvertently or not into homelessness  
16 of some sort and end up coming back to organisations  
17 through homelessness. So there is that hiatus that needs  
18 dealing with. I know from in my submissions with Tony  
19 Nicholson who will be conducting a review on homelessness,  
20 that that has preoccupied his mind and that there is an  
21 opportunity for us to actually look at it through that  
22 avenue - what happens to kids who are exiting care and are  
23 homeless.  
24  
25 THE COMMISSIONER: Just pausing there. Who is doing this  
26 review?  
27  
28 MS CALVERT: Tony Nicholson from the Brotherhood of  
29 St Laurence will be conducting the review of homelessness  
30 in Australia for the federal government. He is concerned  
31 about that particular issue as well as the exiting of kids  
32 from care nationally.  
33  
34 THE COMMISSIONER: In a sense, the advocacy for this might  
35 be right and squarely in your court, Ms Calvert.  
36  
37 MR BERRY: Commissioner, there is some work being done by  
38 the state government in developing a homelessness strategic  
39 framework, which is designed ultimately to work with what  
40 the Commonwealth Government has commenced doing. So the  
41 Department of Premier and Cabinet is involved in sharing  
42 interagency working group, in the development of the  
43 strategic framework.  
44  
45 THE COMMISSIONER: Is it intended that DoCS will be the  
46 beneficiary of funding and support to extend those services  
47 which, as I say, are very thin on the ground at the moment?

1  
2 MR BERRY: Certainly DoCS are an important part of the  
3 working group and the SAAP program is recognised as a key  
4 program. The focus of the work is currently on other  
5 things than identifying service gaps, and on more  
6 efficiently utilising and coordinating government services  
7 rather than at the moment necessarily thinking about  
8 whether there is a need for additional resources, but  
9 ultimately that is something which will have to be explored  
10 in the context of the work the federal government is doing,  
11 and the state government is involved with that.

12  
13 THE COMMISSIONER: From what we are hearing the problem is  
14 not simply confined to children who have self-exited from  
15 care, but it is also critical for those families where a  
16 mother who is afflicted with domestic violence has to go  
17 into a refuge and has a number of children, but the refuge  
18 can't take the children because it is either full or  
19 because some of the children are above an age that a refuge  
20 can accommodate. So it is not just a situation that  
21 affects individual children who may have self-exited from  
22 care or who should have been in care but have been  
23 overlooked. It is very much a problem for families where  
24 the family can't go into a refuge because it just doesn't  
25 exist with the capacity to take either children or it is  
26 full because it has one or two other families with a large  
27 number of young children, so I hope that has been  
28 identified. It is something that is of concern to us  
29 because of the spin-off for those children who have been  
30 forced out of their home because of domestic violence and  
31 who end up either in care and being spread amongst a number  
32 of foster care positions simply because there is nowhere  
33 for them to go.

34  
35 MS MASON: DoCS will certainly be vigorously advocating on  
36 that front. It is undoubtedly the case that it is a major  
37 source of difficulty on the ground for our caseworkers.  
38 The number of spaces are restricted and maybe because of  
39 their past behaviour there may be particular refuges they  
40 are unable to go to or because they have been sexually  
41 offending, for example, and then they end up bouncing  
42 between DoCS and the juvenile justice system or DoCS and  
43 various disability services, and everyone is scampering to  
44 try to find locations for them.

45  
46 THE COMMISSIONER: There is another spin-off arising from  
47 their involvement with juvenile justice. Very often

1 magistrates will give children bail on the condition that  
2 they take up accommodation approved by DoCS, but there is  
3 nowhere that DoCS can place them, and that is something I  
4 trust that the Premier and Cabinet will look at as well.  
5

6 This is a wider question, but coming back to where we  
7 started, my concern is as to whether any of the oversight  
8 agencies or advisory agencies, including the three who are  
9 present here, are investigating, reporting on this kind of  
10 problem.  
11

12 MR KINMOND: In terms of our child death review role, we  
13 have highlighted adolescents consistently. Many of those  
14 adolescents don't die in circumstances of abuse, neglect or  
15 suspicious circumstances but we have been able to identify  
16 due to the breadth of our jurisdiction. Only recently we  
17 have had discussions - and I will not name the agency -  
18 with a particular agency that is well placed to comment in  
19 this area in terms of the ongoing concerns that that agency  
20 has about at risk young people.  
21

22 We have also pursued with the department now over  
23 several years the long standing issue of the need for the  
24 department to settle an agreement with the SAAP services to  
25 reach a memorandum of understanding concerning the  
26 respective roles of DoCS and the SAAP services in relation  
27 to these young people, so it is an area that we would agree  
28 is an area that needs to be addressed. One of the  
29 important things coming from today's meeting is the need  
30 for us to have some discussions with some others at the  
31 table to have a look at what can be done.  
32

33 THE COMMISSIONER: I don't know to what extent the Coroner  
34 has an interest in these cases, but if I can cite one case  
35 which has come before us of a young girl who was in care  
36 but didn't find herself able to remain with the foster  
37 carers who moved from refuge to refuge. She was eventually  
38 ejected from one refuge because she wouldn't comply with  
39 the non-smoking policy, and within 24 hours was dead in a  
40 stolen motor vehicle. The Coroner had the case referred to  
41 them, but for several reasons the matter wasn't  
42 investigated. I simply bring that to attention as a  
43 situation where it may be in a case such as that there  
44 could have been some further investigation, whether it came  
45 before the child death review, whether it came before the  
46 Ombudsman, I'm not sure, but my understanding is that  
47 eventually no-one looked at that particular case. It may

1 be that the Coroner didn't feel it necessary to do so  
2 because the cause of death was obvious, namely, injury  
3 sustained in a stolen motor vehicle which was involved in  
4 an accident. Anyway, it just highlights part of the  
5 problem for homeless children.

6  
7 MS CALVERT: The Child Death Review Team did look at six  
8 years of data where children had died from suicide and/or  
9 risk taking. Homelessness did not emerge as one of the  
10 issues, but there was a group of children who died in the  
11 context of enduring family difficulties, which is where you  
12 would expect to pick up these children. I will go and have  
13 a look at homelessness as an issue in relation to that  
14 10-year data study.

15  
16 THE COMMISSIONER: Thank you. That would be very helpful  
17 to us. The other area is this question of who looks at or  
18 reviews the situation of children who are in voluntary care  
19 or in relative kinship care. I'm not sure of the extent or  
20 ramifications of this. Maybe I'm not understanding what is  
21 the position, but what is DoCS's position in relation to  
22 that? There are a number of children who are placed in  
23 voluntary care, and even though they have been at risk and  
24 in a sense that relieves DoCS of immediate responsibility,  
25 and there are some situations where they are not formally  
26 in statutory care but some support is provided.

27  
28 MS MASON: I suppose it is an area that is growing. The  
29 number of persons in receipt of the supported care  
30 allowance, and so on, is growing. One would not  
31 necessarily be wanting to invite the full force of the  
32 oversight agencies into every grandmother's home who is  
33 looking after a young grandchild, so I think there is a  
34 philosophical issue that has not been particularly teased  
35 out well.

36  
37 MS RYGATE: I don't have anything in particular to say.  
38 Obviously we have talked already today about the resource  
39 constraints in the system and the fact that we are seeking  
40 to devote our resources to families where there are child  
41 protection issues. As the director general has said, many  
42 of the children who are in voluntary care arrangements with  
43 their gran, their aunt or their uncle, whatever, may not be  
44 in that situation. If we are involved with a family, then  
45 I think we can be fairly confident that the level of  
46 oversight would be quite high.

1 THE COMMISSIONER: There is a provision of the Act which  
2 is not proclaimed about voluntary care?  
3  
4 MS BOLAND: That is correct. In our submission we say we  
5 think that those provisions should be proclaimed. The  
6 department, I understand, has done considerable work on  
7 this and is in charge of the process, if you like, of  
8 making that happen, so I can only defer to them about where  
9 that process is up to.  
10  
11 MS FURNESS: Making what happen?  
12  
13 MS BOLAND: The proclamation of the voluntary care  
14 provisions in the legislation.  
15  
16 MS MASON: If that is it the case I will take that on  
17 notice. I am sure there is a file somewhere.  
18  
19 MS FURNESS: How many children are we talking about in  
20 voluntary out-of-home care?  
21  
22 MS RYGATE: I don't think we would necessarily know of all  
23 of the children who are in voluntary care arrangements. It  
24 is very hard to know what is happening in every family.  
25  
26 MS FURNESS: So is there any basis for understanding the  
27 resources that might be involved in there being some  
28 oversight of children in voluntary out-of-home care?  
29  
30 MS BOLAND: In the process of discussions with DoCS we  
31 have suggested that we require additional resources. Those  
32 resources are minimal. They are the equivalent of two or  
33 three staff.  
34  
35 MS FURNESS: How can you know what resources you need if  
36 you don't know the population?  
37  
38 MS BOLAND: I think there has been some estimates. Sorry,  
39 my recollection of them is not clear, but I am perfectly  
40 willing - it is DoCS's document, but I am sure they would  
41 be happy to share what the estimates are and how we the  
42 proposed regime would operate.  
43  
44 MS MASON: It goes back to the threshold issue --  
45  
46 THE COMMISSIONER: There may be many circumstances in  
47 which children get into voluntary out-of-home care. It

1 might just be a purely informal arrangement within the  
2 family that no regulatory or other body knows about, it  
3 might result from the fact that child care and protection  
4 proceedings are commenced, and that they effectively are  
5 settled and just continue on the basis that DoCS is happy  
6 for the child to be settled with some relative or friend  
7 without any formal order or support or anything else being  
8 achieved. At least some of those children would be known  
9 to the system, to use the expression - and I don't like the  
10 expression "known to DoCS - but the reality is that those  
11 children would have somehow come into contact with DoCS, so  
12 you would have some indication through the process that  
13 they had been placed outside the statutory care situation  
14 with family or friends or someone. Does the Ombudsman or  
15 anybody else have a view about whether there should be some  
16 greater supervision in relation to those children who  
17 are at this stage or in the future in voluntary out-of-home  
18 care?  
19

20 MR KINMOND: With the changes to the allowance system a  
21 little over 12 months ago, we have an emerging issue of the  
22 recognition of kin care arrangements because there's many  
23 kin carers who in the past simply wanted to claim the  
24 allowance who now want to become formalised carers, and  
25 that is reflected in the department's data in terms of the  
26 expansion of numbers in this area.  
27

28 My understanding is that the department has done some  
29 work around this emerging issue, and is looking at some  
30 pilots in terms of what sorts of arrangements should be in  
31 place, for example, in terms of those authorised kin care  
32 placements.  
33

34 When the whole thing was costed, I understand there  
35 tends to be an emphasis on what would be the cost of the  
36 allowance side of things. The flip side is what would be  
37 the cost of providing case management support in these  
38 cases if it needs to be provided. So it certainly is an  
39 emerging area and my understanding is that the department  
40 is looking at it.  
41

42 The other area we would emphasise is in relation to  
43 children with a disability, for example, who are in  
44 out-of-home care circumstances. They are often voluntary  
45 care placements, but currently they don't fall under the  
46 protections that are available to other children in  
47 out-of-home care. We have particular concerns about that

1 issue.

2

3 THE COMMISSIONER: There does seem to be a bit of a  
4 problem or a gap between a DADHC situation and DoCS. Some  
5 children are bounced between the two agencies partly for  
6 the reason that DADHC is not capable of providing  
7 residential care, at least for young people. I'm not sure  
8 again to what extent the Commission and the Guardian have  
9 looked at this in an oversight fashion.

10

11 MS CALVERT: My understanding is that the definition of  
12 what constitutes voluntary out-of-home care captures some  
13 of those children. Certainly the work that DoCS has done  
14 captures that definition and captures that issue, so that  
15 at a certain point there would be a report activated to the  
16 Department of Community Services that would then require  
17 the department to respond and to sort out the care  
18 arrangements for that child.

19

20 THE COMMISSIONER: Yes, but sometimes the actual process  
21 for that is traumatic in that we have come across cases of  
22 families with a severely disabled child who they really  
23 can't keep at home and they want to have placed into care  
24 with someone who is better able to do it. They don't want  
25 to surrender parental responsibility, and some of them have  
26 got to the stage of actually walking into a DoCS office and  
27 leaving the child and walking out in order to ensure that  
28 something does something for the child. It is a terrible  
29 situation when a parent with a disabled child has to go to  
30 the Helpline and say, "I have got a child who is at risk  
31 because I can't look after the child", and then the child  
32 goes into statutory care, parental responsibility may be  
33 reassigned, and so on, but it is partly due to the fact  
34 that DADHC does not seem to have the resources nor the  
35 facility nor the people to take those children and to allow  
36 the parents to maintain parental responsibility and  
37 contact, and so on. That to me seems to be an absolute  
38 failing of a civilised community. The question is what can  
39 be done and what is being done by way of oversight.

40

41 MS CALVERT: Having sat on the ministerial advisory  
42 committee they were issues that were addressed and provided  
43 to the minister. That then resulted in the department  
44 doing further work. So a starting point, as you would have  
45 indicated, is to get that information from the department.

46

47 MS MASON: As you are aware, there is a separate session

1 that we are doing on disability, and we will be giving you  
2 a submission - it will be publicly available - that it is  
3 in a lot more detail dealing with those issues. I don't  
4 think we have turned our minds to the question of oversight  
5 which is a matter for others.

6  
7 THE COMMISSIONER: We can address that down the track, but  
8 the Premier and Cabinet may look at this as to what needs  
9 to be done to bring DADHC also the party or perhaps even to  
10 give better powers to other agencies to respond to those  
11 cases.

12  
13 We can probably move on to 4 - the question of  
14 allegations against employees, service providers and  
15 authorised carers. We have had meetings with DoCS on this,  
16 and we have heard around the country a large amount of  
17 concern by carers in particular, but I know there are  
18 similar concerns by employees, of the time taken in  
19 relation to having allegations made against them dealt  
20 with, and the consequences where those allegations are  
21 processed in a time which can be up to 12 months. It can  
22 leave carers in limbo and, to use the expression which is  
23 used, they become inactive, which means they can't take any  
24 other children in care and indeed may have the child  
25 removed, depending on how serious the allegation is, and  
26 the assessment of risk that is made. It has further  
27 spin-offs in that it does affect their future employment  
28 because of the need to report to the Commission For  
29 Children and Young People and it affects their  
30 accreditation, and so on.

31  
32 In some ways the problems might be said to relate to  
33 the definition of reportable conduct and as to whether they  
34 are, in effect, too strict, but in some ways they might  
35 also report to the very strict code of conduct which  
36 applies to authorised carers. For example, any degree of  
37 physical correction of a child, even a minor slap, can lead  
38 to a report and all the consequences of investigation  
39 through the department's branch which deals with this, with  
40 a reporting to the Ombudsman, and so on. It might even be,  
41 so it seems, the kind of necessary response to a child's  
42 behaviour of making the child sit on a naughty stool or go  
43 to their room for a little while, et cetera, is going to  
44 report a reportable allegation and set in train a  
45 juggernaut of response and inquiries, et cetera.

46  
47 The DOCS system at the moment does, with the agreement

1 of the Ombudsman, have some types of arrangements and DoCS  
2 at the moment has a choice between having the minor  
3 allegations in particular against carers and employees  
4 dealt with at a regional level with more serious ones being  
5 dealt with at a central level.

6  
7 Questions have been raised, particularly by DoCS, as  
8 to whether there should be some relaxation or  
9 rationalisation of this whole system for dealing with these  
10 allegations, and in particular a reallocation of  
11 investigation into a central agency rather than being dealt  
12 with on a regional basis.

13  
14 The second one is quite important, it seems to me, for  
15 the rural DoCS officers and regions because they are so  
16 pressed for staff that it is really a waste of their time  
17 to have to spend a great deal of time running a complaint  
18 allegation type situation, whereas they should be better  
19 off out in the field. Again I may not have totally  
20 identified the problems with this, but does DoCS want to  
21 amplify its concerns in relation to this process?

22  
23 MS MASON: It is an area of great concern to us, as you  
24 would be aware. I think in the vicinity of 90-odd per cent  
25 of the investigations are of carers, and 8 or 10 per cent  
26 are of our own employees. The situation is that the number  
27 of investigations that DoCS has done has been escalating.  
28 I am not at all happy with the amount of time that it is  
29 taking. As you rightly say, the system at present is that  
30 certain number of these investigations are done by, in  
31 effect, my staff out in the regions and (a) I would doubt  
32 whether they really have the specialised skills to do those  
33 investigations; and (b) it is a distraction from their  
34 frontline work which is what they should be doing.

35  
36 It is not my natural inclination to further increase  
37 central bureaucracy, but that is one case where I think we  
38 may have to. If the system stays as it is, we will have no  
39 alternative but to create a larger pool of specialised  
40 investigators in the central bureaucracy, which again, as I  
41 say, I am reluctant to do.

42  
43 The problems are that in these kinds of investigations  
44 and allegations, especially against carers, in my  
45 experience in another context, it is quite difficult ever  
46 to conclusively establish falsity. The most common outcome  
47 is that you spend months and months and months possibly

1 investigating something. You then come up with a finding  
2 of not sustained or insufficient evidence. The  
3 investigation report gets sent off to Anne's people to  
4 scrutinise. Then the person gets notified to Gillian's  
5 people as a category 2 and receives a letter saying that  
6 they are a category 2 on her system, with various caveats  
7 in the letter saying, "Don't worry, it won't be used  
8 unless...", et cetera." I personally would not find that  
9 very comforting and I don't think many carers find it very  
10 comforting. In a nutshell, that is the dilemma.

11  
12 The further problem, as you rightly identify, is the  
13 stringency of the code, which means, in effect, a carer who  
14 has used any kind of coercion will be investigated, almost  
15 by the force of process, as I understand it, but I have to  
16 talk to Anne in more detail. That is investigable on its  
17 face straight away because it is a breach of the absolute  
18 way in which that code phrased. Then you are on the road  
19 to a concluded investigation and reportable conduct. I  
20 think it is quite a dilemma and something that we have to  
21 work through. More class or kind agreements are a good way  
22 to start, and Gillian and I have had discussions in  
23 another context in the past. It still requires  
24 investigative work even if it doesn't end up with a person  
25 getting reported as a cat 2 - or a cat 1.

26  
27 I would be very keen to explore this with the relevant  
28 agencies. It is a delicate matter because we have to have  
29 child protection. Given the difficulties in the domestic  
30 setting, how we ensure that children are adequately  
31 protected while still not exposing carers to quite an  
32 onerous regime is not something that could be done simply.  
33 If you don't do it really carefully, it could have  
34 unintended consequences in all sorts of directions.

35  
36 Could I also say if any legislative change is done in  
37 this direction, it also has immediate consequences for  
38 other agencies dealing with juveniles too. Obviously  
39 Juvenile Justice has serious problems with the system as do  
40 DET and anyone else who is dealing with kids and juveniles.  
41 It is quite a delicate situation and has all kinds of  
42 difficult effects on them.

43  
44 THE COMMISSIONER: As you say, it is not just DoCS that  
45 has to investigate. If it is a schoolteacher, then the  
46 Department of Education has to go through a similar  
47 process.

1  
2 MS MASON: And Juvenile Justice.  
3  
4 MR LEAN: If I can add to that, this is not a new issue.  
5 It has been around for quite a while. I think in about  
6 2004, the government did try to redress the balance in  
7 terms of the definition of "reportable conduct". That  
8 required extensive consultation with the Ombudsman, and I  
9 think also CCYP. It is a very difficult issue which has  
10 been looked at in the past and there are probably issues  
11 that still need to be considered to work out whether we  
12 have the balance right between whether we are reporting too  
13 much.  
14  
15 THE COMMISSIONER: Thank you for that, but what is  
16 happening is somewhat significant in that there has been a  
17 significant increase in reports concerning DoCS employees  
18 or the carers, and as has been pointed out, it is mainly  
19 carers. The primary concern at the moment is with the  
20 impact on DoCS carers and employees. I have some figures  
21 somewhere, but there has been a very significant increase  
22 over the last few years in the numbers of reports made  
23 which is taking up a lot of time of the agencies. As we  
24 all know, some of these children in care are streetwise.  
25 If they don't get their way, if they are not allowed to go  
26 to the movies or something, they very quickly make an  
27 allegation against a carer. Being difficult children, some  
28 of them very difficult children, carers do have to do  
29 something to keep them in line. If it be the case that  
30 some minor disciplinary action leads to a report and a  
31 juggernaut setting off, it very much affects their ability  
32 to maintain the kind of discipline that is permissible for  
33 parents, which is essential unless you are going to have a  
34 disaster.  
35  
36 DoCS has expressed its concerns. What does the  
37 Commissioner have to say about this regime?  
38  
39 MS CALVERT: Under our legislation, our primary  
40 consideration has to be the impact on the child and our  
41 concern for the child and the consequence for the child.  
42 While I appreciate what you are saying about the  
43 challenging behaviour of some of the children, they have  
44 generally been removed because they have been abused and  
45 neglected and there are good reasons why there must be  
46 strict codes of conduct for foster carers when you are  
47 dealing with children who have been abused and neglected.

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Because the legislation's primary concern is the consequence for the child, the decision was made by the parliament to capture both substantiated REPs or relevant employment proceedings, and those where it is unclear. The legislation does make it quite clear, and that was the reform that was made in 2004, that if the behaviour is reasonable, given the age and maturity of the child and it is reasonable for the discipline, management or care of the child, then it is not reportable conduct.

It also provides that where it is a vexatious, false or malicious allegation, it also is not reported to the Commission. We capture unclear outcomes, unclear allegations - it is unclear findings actually, because we are not interested in the allegation; what we are interested in is the finding at the Commission. The reason why we capture unclear outcomes is that there may be a range of reasons why a conclusive decision was unable to be released: for example, the person resigned before the investigation was completed.

I think there are benefits in having a centralised list in that it allows us to build up a picture over time and across employment settings, which means that if there are patterns of behaviour appearing, then we can identify that. If you are sitting out there in the region as an employer, you won't necessarily know that. I think having a centralised list also means that you can secure it, which is very important from the point of view of the person who might be on the list.

I also think that some people think if you are on the list, you are a risk to children, and that is not the case. The risk determination is made at the point of us conducting the risk estimate which is done using our aware tool. It is a very robust tool that we have developed in conjunction with nationality and international experts. That is what estimates the risk and the relevant employment proceeding is one source of information that helps us estimate the risk.

So the consequence to the employee and carer is actually with the risk estimate tool not with necessarily being placed on the relevant employment list. That is why the Commission has given priority and effort into trying to get the most robust risk estimate tool that we can possibly

1 develop because that is the one that really has the  
2 consequence, and we have now done that.

3  
4 Having said that, I do appreciate the impact on the  
5 employee, and we have tried to be very responsive to the  
6 concerns of our unions and employees about the process. We  
7 have worked with agencies to try to put in place class and  
8 kind agreements so that we refine it as much as we can.

9  
10 We are currently now moving on to looking at what else  
11 we can do to try and strengthen, if you like, the relevant  
12 employment proceeding database and to see how we can  
13 improve that having got the primary issue out of the way,  
14 which is the risk estimate tool.

15  
16 THE COMMISSIONER: Just going back to the percentage  
17 increase I was looking for, there has been a 500 per cent  
18 increase since 2003 in the number of reports against all  
19 categories, that's both employees and carers. When you say  
20 that obviously the focus is on the child, that is true, but  
21 there is a spin-off in that if a carer is made inactive or  
22 some other course is taken in relation to that person and  
23 the child is removed, that is a further potentially  
24 traumatic situation for a child as a result of what may  
25 have been a totally trivial incident which the child  
26 regrets, because if it takes 300 days for the thing to be  
27 resolved and the child has been removed, there is no point  
28 in returning the child.

29  
30 MS CALVERT: I appreciate that. That is probably not, in  
31 a sense, my role. I wait for the outcome before I am  
32 involved.

33  
34 THE COMMISSIONER: Indeed.

35  
36 MS FURNESS: There is just one related issue that I think  
37 has arisen recently between the Ombudsman and the  
38 department and that is whether the definition of  
39 "reportable conduct" would capture an employee of DoCS who,  
40 in the exercise of his or her professional judgment as to a  
41 child, makes a decision on whether or not that child was in  
42 need of care or should or should not be removed. If it  
43 subsequently occurs that that professional judgment was not  
44 exercised well, then does that becomes reportable conduct?

45  
46 MS BARWICK: We wouldn't see that as reportable conduct.  
47 I think the debate is around whether there is a deliberate

1 act to take action. It is an act of commission rather than  
2 omission and we are having discussions around that.

3  
4 MS FURNESS: Let me understand the nature of the  
5 discussions. If an employee of DoCS is making a decision  
6 in the course of their employment as to whether or not  
7 action should be taken to remove a child, presumably on an  
8 emergency basis, and subsequently information is received  
9 that suggested that that child should have been removed and  
10 was not removed, would you consider that to constitute  
11 reportable conduct?  
12

13 MS BARWICK: That has not been the thrust of our debate,  
14 and I would have to give more thought to that, but we have  
15 not been taking allegations of that kind. What we are  
16 looking at is a different situation. The first is a case  
17 where a caseworker, in good faith with the information in  
18 front of them, is making a professional judgment. We may  
19 disagree with that, but it would not be seen as a  
20 reportable allegation. On the other hand, you may have  
21 someone who has all the information in front of them and,  
22 for some other reason, that person has made a decision not  
23 to take risk action and there has been a serious  
24 consequence for the child, we would certainly be discussing  
25 with the department as to whether it is reportable. That  
26 is totally different from a judgment made in good faith  
27 with information as opposed to trying to cover something up  
28 or it could well be corrupt conduct.  
29

30 MS MASON: Corruption is one thing. There are mechanisms  
31 to investigate that separately. In fairness, Anne and I  
32 have yet to have a discussion, which I think we are listed  
33 to have on Monday. We would see it as very much a grey  
34 area and a slippery slope. I have not traced all the  
35 history of it but my strong view from other experience is  
36 that the likely reason for the increase in the number of  
37 investigations is because of various interpretations, I  
38 would guess, by the child protection team, who are the  
39 middle people between the agency and Gillian, in terms of  
40 what constitutes, for example, some evidence so that a  
41 matter is considered not to be false but to be not  
42 sustained, insufficient evidence.  
43

44 On questions such as the one we are now discussing as  
45 to what is neglect, second-hand conduct in terms of the  
46 officer looking at the carer, there is a potential, over  
47 time - no doubt for intellectually sound reasons - for the

1 categories of matter that are subject to investigation and  
2 that are covered by these sorts of controversies to  
3 continue to expand.  
4

5 In regard to this instant question about whether the  
6 conduct of a staff member in oversighting the work of a  
7 carer could potentially be neglect, the purpose of  
8 reportable conduct could end up with a person being  
9 notified to Gillian's system as a category 2, I would say I  
10 would be very concerned about that.  
11

12 MS BARWICK: Could I add that in almost 10 years of our  
13 jurisdiction, this has only just come up. There is one  
14 case and we are having discussions with the department. It  
15 is a very difficult issue and we need to put a lot more  
16 thought into it.  
17

18 MS FURNESS: We would very much like you to keep us  
19 informed as to your discussions.  
20

21 MS BARWICK: Certainly.  
22

23 MS FURNESS: I suppose the conclusion would have to be  
24 that by acting in a way that the employee did in making a  
25 decision in relation to the child and if that decision had  
26 the effect of causing psychological harm to the child, that  
27 would be the only basis upon which it would be reportable;  
28 is that right?  
29

30 MS BARWICK: Psychological harm only?  
31

32 MS FURNESS: If you look at the requirements to the four  
33 categories of conduct, sexual matters, which obviously we  
34 are not discussing, any assault or ill-treatment or  
35 neglect --  
36

37 MS MASON: I think you will find the argument would be  
38 that it is caught under neglect.  
39

40 MS BARWICK: It is neglect, lack of supervision or --  
41

42 MS MASON: Trust me.  
43

44 MS BARWICK: I think we need to have further discussions  
45 with DoCS about this one. The jury is not in on it.  
46

47 MS FURNESS: I have seen correspondence which suggested

1 very strongly that the jury was in on it; however, I am  
2 pleased that the jury is not in on it and we would like to  
3 be involved in the discussions.

4  
5 MS BARWICK: Certainly.

6  
7 THE COMMISSIONER: Ms Boland, do you have any views about  
8 this, because, to some extent, it does affect obviously the  
9 carers or the agencies whose employees have allegations  
10 made against them? To the extent that there can be, I  
11 guess, a dual investigative function in that, say,  
12 Barnardos or Burnside, or any one of the agencies whose  
13 foster carer is involved, have to make some assessment of  
14 the situation. Similarly, of course, DoCS has an interest  
15 in that. How do you see that working so far as your role  
16 is concerned overseeing the agency's response to  
17 allegations?

18  
19 MS BOLAND: Our role in relation to that is obviously to  
20 accredit against systems, and agencies provide us with  
21 certain advice. There has been only one occasion where an  
22 agency's systems were in question. They were being looked  
23 at by the Ombudsman. In that process, we would defer,  
24 obviously, to them overseeing that process - that's their  
25 jurisdiction. That's their strength - and we would await  
26 the outcome of such a review. As I said, it has only  
27 happened on one occasion.

28  
29 THE COMMISSIONER: Mr Kinmond, what's your view on how the  
30 system works or does not work?

31  
32 MR KINMOND: I support my colleague's comment that it is  
33 just one case. Looking at the system generally, as at  
34 26 March 2008, about 40 per cent of the open files from  
35 DoCS were over six months old. I think that illustrates  
36 the opening point you made, Commissioner, about the impact  
37 that has on foster carers, who are by far and away the  
38 majority of people the subject of these complaints.

39  
40 THE COMMISSIONER: And, I should add, they are in short  
41 supply. If foster carers end up either rendered inactive  
42 or unaccredited or they lose faith in the system because  
43 they just get so irritated by what they regard as spurious  
44 complaints not being resolved and they drop out and do not  
45 return, that is a real loss to the system.

46  
47 MR KINMOND: Can I also put some comparative figures on

1 the table. If you look at the Department of Employment and  
2 Training, the child protection team is well advanced in  
3 terms of its class or kind agreements with the Department  
4 of Employment and Training. They are hoping to move to a  
5 situation where only the most serious claims will be the  
6 subject of reportable matters to the Ombudsman.  
7

8 If we look at the Department of Employment and  
9 Training, for example, 34 per cent of all of their matters  
10 are dealt with within 30 days. If we look at DoCS,  
11 however, 8.5 of all matters are dealt with within 30 days.  
12 We have MOUs with a number of NGO agencies. For example,  
13 with Centacare, it would be rare for them not to turn their  
14 matters around quickly.  
15

16 To be fair to the department, it has acknowledged that  
17 this area of delays is a problem. To be fair to us, we  
18 have said that we want this issue of delays fixed so that  
19 we can raise the bar in terms of the matters that class or  
20 kind permits. There is a way forward in relation to this.  
21 It is about ensuring that there is a turnaround in relation  
22 to these matters because the assumption that, because it is  
23 reportable to the Ombudsman's Office, it delays the  
24 handling of the matter and has a deleterious effect on  
25 carers doesn't fit the facts. The reality is a lot of our  
26 work - indeed the department has reported in terms of the  
27 additional amount of action it has needed to take - is  
28 actually spent trying to get the matter finalised. I think  
29 that would be acknowledged by the department.  
30

31 We are keen for an extended class or kind agreement,  
32 but what we have to be able to see is, consistent with  
33 other agencies, the department having the ability to turn  
34 these matters around quickly because justice delayed is  
35 justice denied in these cases.  
36

37 MS FURNESS: Do you have a view on whether the  
38 investigation being centralised or kept in the region would  
39 make a difference to delay or your attitude to the class or  
40 kind agreement?  
41

42 MR KINMOND: If centralisation improves things, that would  
43 be a good thing. It is interesting, though, if you look at  
44 the nature of the matters that we are talking about about  
45 which we have concern, the relatively minor matters or the  
46 lower end of matters, one would hope that the capacity is  
47 there at the regional or local level to quickly deal with

1 these matters.

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My experience is also in the policing area, and let me say there have been a major successes where local commands take responsibility for dealing with their own matters. There would be certainly cases where it would not be appropriate for that to happen. We would like to see in the longer terms that, at local CSCs and at the regions, these matters can be dealt with expeditiously. Perhaps in the short term there may be advantages in a move towards centralisation.

THE COMMISSIONER: One of the problems for the local CSCs, of course, and maybe not with a carer, but certainly if there is an allegation against staff, is that it is somewhat different from the police situation, particularly if the result of this is that a child is potentially at risk. There is a conflict of interest because of the closeness of the way they work. I guess there would be a tendency to take the safe course and to avoid any possibility of discipline or having a harsh outcome for that particular employee. The same with carers, because the carers are such a scarce resource for each CSC and they are desperate to hang on to them, again you may have a conflict; whereas the centralised situation may be better. Clearly the centralised agency would have to refer back to the CSC to get information about the background and what they know about the situation. As you point out, the delays are substantial.

We would appreciate hearing of are any other solutions you may have. It is one thing to say get them dealt with more quickly. One answer to that, of course, is to provide more resources. There is a fairly small number of people in the regions and in the central unit to actually deal with this. So it is a resource issue in getting the right people, the right training, the right approach. If you are going to work on a class or kind agreement which will facilitate removing the less serious ones and have some alternative way of dealing with and or working on that, we would like to hear about that as well.

MS MASON: I think that's right; if there is a genuine willingness to reduce the number of matters that have to be reported and investigated, then obviously that is more desirable to us than proliferating central investigative units. We would approach such discussions with keen

1 interest.  
2  
3 MS BARWICK: Could I also add that this has not been the  
4 case throughout the nine years. We have had interesting  
5 bumps along the way with DoCS. Initially, we, as a result  
6 of our investigations, found that there was significant  
7 under-reporting, which may reflect some of the differences.  
8 We have undertaken substantial work with DoCS over time,  
9 such that two years ago we were quite confident in making a  
10 class or kind determination. Certainly notifications were  
11 coming in on time, the quality of the investigations for  
12 those low-level matters was satisfactory, and matters were  
13 being completed in a reasonable time. Of course, that is a  
14 major concern for us in terms of procedural fairness for  
15 employees.

16  
17 I would have to say, and DoCS will acknowledge this,  
18 that over the last 12 or 18 months or so, there has been a  
19 change and these delays are just blowing out.

20  
21 THE COMMISSIONER: Well, part of the answer is this: the  
22 bare figures are these: in 2003, there were 170 reports,  
23 and in 2007 there were 848 reports. What would be very  
24 interesting would be to actually do a breakdown of those  
25 reports and see what is the profile of the complaints.

26  
27 MR KINMOND: There is a bit of a difficulty in that our  
28 figures are significantly different from those of DoCS in  
29 that regard, and perhaps we would benefit from seeing the  
30 DoCS submission. For example, for the period from 1 July  
31 2006 to 30 June 2007 in terms of DoCS-received matters, the  
32 number is sitting at 482. We know there has been a slight  
33 increase, but it certainly does not match the figures that  
34 DoCS has presented. I think both organisations need to get  
35 together to make sure that you are given complete and  
36 accurate advice on this issue.

37  
38 THE COMMISSIONER: I think it is absolutely critical that  
39 we get clarity on what are the numbers and what is the  
40 profile. If it turns out that some of these reports are  
41 absolutely trivial things which don't require lengthy  
42 investigation and all the ongoing consequences for both  
43 employees and carers, I think that would be worthwhile  
44 finding out.

45  
46 MS FURNESS: The issue may be of triage, if you had an  
47 appropriate triage mechanism, so that those --

1  
2 MS MASON: It may well be, but also in my past experience  
3 there is the issue of getting agreements between the  
4 agencies about what's trivial. That can be a serious  
5 problem with class or kind agreements because what we may  
6 want to write-off off as trivial, the Ombudsman may take a  
7 view, for intellectually defensible reasons, is not  
8 trivial. Then you are locked into a cycle of spiralling  
9 investigations. That is speculation on my part because I  
10 have not looked into it.

11  
12 MS RYGATE: I think the issue around the numbers is about  
13 the difference between the things that initially come to us  
14 as potential matters of reportable conduct and they all the  
15 have to be looked at to assess whether they are or are not  
16 reportable conduct. That's the 848 number that you are  
17 talking about. Once you have done that, some of those  
18 don't fall within the definition of "reportable conduct"  
19 and they don't have to be investigated. But it is true  
20 that the number of matters that have had to be investigated  
21 has also grown substantially and that is the other set of  
22 figures that you have.

23  
24 THE COMMISSIONER: Can you just remind me, please, how  
25 many people actually are in the central unit dealing with  
26 these allegations?

27  
28 MS RYGATE: I think it is 9.6, which includes a part-time  
29 person.

30  
31 THE COMMISSIONER: By nature of the investigation, which  
32 involves not just reading a file but also speaking to  
33 people, that could be a huge work load for 9.6 people.

34  
35 MS RYGATE: And, Commissioner, those people aren't just  
36 doing the investigation into the most serious and most  
37 concerning allegations. They are also responsible for:  
38 managing the interface with the Ombudsman's Office,  
39 managing the process with regional investigations,  
40 reviewing those investigation reports, making sure that  
41 they are okay, responding to all of the report  
42 requirements, dealing with the Commission for Children and  
43 Young People as well. There is a substantial volume of  
44 work involved in this process.

45  
46 MS FURNESS: But we also understand that about 80 per cent  
47 of those investigations are investigated regionally --

1  
2 MS RYGATE: That's right, about 85.  
3  
4 MS FURNESS: So your 9.6 people do something like I think  
5 you said 12 per cent?  
6  
7 MS RYGATE: It varies over the years, and the 9.6 per  
8 cent of people do those 12 per cent, which are the most  
9 serious investigations of the most serious matters. By  
10 necessity, they are likely to take a fair bit more work and  
11 require a higher level of expertise. They are also running  
12 the entire allegations system in terms of all of the  
13 requirements to make sure that the regions do what they  
14 need to do and respond to all of the oversighting agencies.  
15  
16 THE COMMISSIONER: Mr McCallum, do you have any interest  
17 or views on behalf of your agencies in relation to these  
18 matters?  
19  
20 MR McCALLUM: Timing is of the essence. One of the  
21 problems is that there are usually no witnesses to the  
22 incident and it is between the two parties. That actually  
23 then creates difficulties. We have found that one of the  
24 issues identified is that most kids are removed during that  
25 time and that also creates difficulties. So the triage  
26 effect is something which is very important in that regard,  
27 to make sure they are not removed for not good reasons  
28 bearing in mind that the interests of the child prevails.  
29  
30 If it is a serious allegation, the likelihood of the  
31 person actually ever working in that particular area again  
32 is highly unlikely, so it is very important that some of  
33 the orientation to the employment situation of the carer  
34 situation is also very important, to ensure that people are  
35 aware of those pitfalls and the preventative mechanisms  
36 that need to take place before people get involved in the  
37 sector in the first place.  
38  
39 MS FURNESS: In relation to the question of the percentage  
40 of cases in which the children are removed, is there any  
41 data on that?  
42  
43 MS RYGATE: I can get you specific figures. It is  
44 probably more than 50 per cent.  
45  
46 MS FURNESS: More than 50 per cent?  
47

1 MS RYGATE: Yes, I would be happy to get you the precise  
2 numbers on that.

3  
4 MS FURNESS: Is it also the case that there is a quite  
5 small percentage, less than 5 per cent, of cases where  
6 there is a de-authorisation of the carer as a result of the  
7 allegation?

8  
9 MS RYGATE: The issue of de-authorisation, as you know, is  
10 something that is a bit of a work in progress for us. We  
11 think that it is only right and fair that where an  
12 allegation is made about a carer and the process has been  
13 gone through that we give them some level of certainty  
14 about whether they are or are not going to be considered to  
15 care for children in the future. It is a pretty small  
16 number at the moment where de-authorisation proceeds, but I  
17 think that is because we have not necessarily drawn those  
18 processes to a conclusion as well as we might, and we  
19 actually have a project under way within the department as  
20 we speak to try to tidy up that situation, because we  
21 understand that it is an incredible frustration for carers.

22  
23 THE COMMISSIONER: What we hear in practice from many  
24 people is that they are not de-authorised but they become  
25 inactive and they are told, "I'm sorry, we have this  
26 allegation against you. You are not de-authorised but we  
27 are not going to give you any more children", and they are  
28 stuck in limbo, and they have no appeal process.

29  
30 What is de-authorisation? What is DoCS'  
31 legislative authority for de-authorising someone? If it is  
32 reported to the Children's Commission, obviously something  
33 can be done there in relation to working with children,  
34 authority, et cetera, and there is an appeal process there  
35 to the ADT, but at the moment it seems to be an area of  
36 potential limbo which you sail into and never get out.

37  
38 MS MASON: That is right. It is much fairer to people if,  
39 for whatever reason - for example, if there is insufficient  
40 evidence, but you still take the view that they should  
41 be de-authorised, you should put your money where your  
42 mouth is and let them test it at the ADT and see what  
43 happens.

44  
45 MS FURNESS: As part of this project are you looking at  
46 the number of children who are removed from the carers at  
47 the beginning of the investigation or shortly after the

1 allegation has been made and comparing that in some way to  
2 the numbers of carers who are ultimately removed from being  
3 carers as a result of the allegation?  
4

5 MS RYGATE: I'm not aware that that specific question is  
6 being looked at as part of the project, but if you would  
7 like more information I would be happy to provide it.  
8

9 MS FURNESS: There seems to be a slight disconnect between  
10 the two at the moment.  
11

12 THE COMMISSIONER: We can move on to what I suspect might  
13 be a controversial issue, and that is whether the Office of  
14 Children, which is now one body, should be one body with  
15 the two offices of the Commission for Children and Young  
16 People and the Children's Guardian being merged into one.  
17 I don't know if DoCS has a view about that, but no doubt  
18 the two representatives do have a view. Does DoCS have any  
19 view about that?  
20

21 MS MASON: I don't have a strong view, so I will let them  
22 fight it out.  
23

24 MS CALVERT: I don't know that we are going to fight it  
25 out. I think we have already achieved a fair degree of  
26 reduction in administrative duplication by establishing the  
27 Office for Children.  
28

29 It accrued from the functions being performed rather  
30 than necessarily having one, two, three or four agencies  
31 perform them. Although having said that, the functions are  
32 probably better performed if the agencies are separate. I  
33 will talk a little bit about why I think that. Commissions  
34 in other jurisdictions who have combined the functions  
35 have, in reality, limited their focus then almost  
36 exclusively to the child protection system, even though the  
37 legislation does allow them to be broader than that. The  
38 practical effect of it has been to limit their activity and  
39 focus to the child protection or juvenile justice system.  
40

41 My concern is, when I look at where that has happened,  
42 that we run the risk in NSW of reducing the commission's  
43 advocacy for all children, advocacy for children only in  
44 the child protection system. Certainly this is a shift  
45 from what children and young people want the commission to  
46 do, and I think we do need to listen to them.  
47

1 I also think that the reasons why parliament  
2 established a separate Children's Commission in the late  
3 1990s and reaffirmed by the independent review in 2004  
4 haven't changed. So I think those reasons remain for  
5 keeping a separate commission.  
6

7 Perhaps the other reason I think they better perform  
8 if the agencies are separate is that the Guardian's  
9 regulatory function means it is part of the child  
10 protection system, and combining the two functions would  
11 mean that the commission would become part of the child  
12 protection system as well, and I think that may limit our  
13 capacity for being a commentator on the overall system. So  
14 for me the outcome is probably as a result of the functions  
15 being performed, but I think there are good reasons to keep  
16 the functions in separate agencies, and I think we have  
17 already achieved what can be achieved in reducing  
18 administrative duplications with the establishment of the  
19 Office of Children.  
20

21 THE COMMISSIONER: It occurs to me that you each at the  
22 moment have an accrediting function, yours being the  
23 working with children situation, and the Guardian  
24 accrediting out-of-home care. In a sense they are both -  
25 and I don't like using the expression - in broad terms  
26 licensing functions.  
27

28 MS CALVERT: Vetting.  
29

30 THE COMMISSIONER: Vetting functions. If yours is an  
31 advocacy role, that is to advance the interests of children  
32 generally, it doesn't really sit all that happily with a  
33 licensing or vetting role. Would there be any advantage in  
34 transferring that part of the function to the Guardian.  
35

36 MS CALVERT: There are a couple of things I would say.  
37 One is I don't see the working with children check as a  
38 vetting or licensing system. In fact, it is a service to  
39 employers to help them make good decisions about children  
40 and young people, and that is about promoting the welfare  
41 of children and young people which is the role of the  
42 Children's Commission.  
43

44 I also think that our focus on children's  
45 participation and awareness around risk, and so on, has  
46 enabled us to expand our approach to the wellbeing of  
47 children in the work place by looking and developing the

1 child safe child friendly program. So I think I would  
2 perhaps question whether we are in fact a licensing system.  
3 I actually think we are a service to employers to help them  
4 create safe work places which is going to benefit the  
5 wellbeing and promote the wellbeing of children.  
6

7 The other thing I would say is that it is an  
8 individual thing as in it is individuals that we are  
9 providing advice on, not a systemic review or accreditation  
10 in the same way the Guardian is. So I think the functions  
11 of the working with children program sits more comfortably  
12 with the role and purpose of the Children's Commission.  
13

14 THE COMMISSIONER: When we talk about working with  
15 children checks, there is also the parallel situation of  
16 probity checks. I think you have an idea - either you or  
17 the Guardian - and have raised the possibility of there  
18 being some rationalisation of that and the possible  
19 extension of working with children checks to pick up adult  
20 members of households.  
21

22 MS CALVERT: We have raised that as a possibility.  
23

24 THE COMMISSIONER: Do you see a case for expanding either  
25 probity checks or the working with children checks to a  
26 wider category of people, or the alternative of narrowing  
27 the extent to which you make checks.  
28

29 MS CALVERT: I think there are some arguments for  
30 extending it to certain very high risk groups, for example  
31 adult household members of foster carers, but also adult  
32 household members of the family day carers as well, so more  
33 than just foster care, so where there is that parental type  
34 relationship I would see there would be arguments.  
35 Similarly probably with mentors, there would be arguments  
36 for extending the working with children checks to them.  
37

38 MS FURNESS: Can I go back to your earlier comment that  
39 you understand that in other jurisdictions where there has  
40 been a merger of similar functions the combined body has  
41 limited its activities to child protection services, or  
42 issues. What jurisdictions are you referring to?  
43

44 MS CALVERT: Queensland, I think, has narrowed its focus  
45 as it has taken on its expanded role in the child  
46 protection arena.  
47

1 MS FURNESS: What activities are you referring to so that  
2 it has narrowed its role that we could have a look at?  
3  
4 MS CALVERT: Certainly in my conversations with the  
5 various commissioners who fulfilled the role over time, and  
6 from what I understand, they engage in the sorts of issues  
7 they engage with as well.  
8  
9 MS FURNESS: Is there any evidence that would be available  
10 to us of such a narrowing by virtue of publications or the  
11 like?  
12  
13 MS CALVERT: Probably the annual reports would give some  
14 evidence of that.  
15  
16 MS FURNESS: Would you look at annual reports and tell us  
17 what sections we should be looking at to get evidence of  
18 that?  
19  
20 MS CALVERT: Yes.  
21  
22 MS FURNESS: So Queensland is the only jurisdiction you  
23 are referring to?  
24  
25 MS CALVERT: The Victorian jurisdiction is a child safety  
26 commissioner. He is not a children's commissioner, he is a  
27 child safety commissioner. The Northern Territory  
28 jurisdiction is effectively a complaints handling and  
29 monitoring of the child protection system jurisdiction.  
30 They are yet to be appointed. The Tasmanian jurisdiction  
31 is a broader jurisdiction. The Western Australian  
32 jurisdiction is a broad jurisdiction, but again the Western  
33 Australian jurisdiction is only just getting established.  
34  
35 THE COMMISSIONER: Can I go back to DoCS for a moment.  
36 Ms Mason, you nodded your head about extending the working  
37 with children checks to adult household members.  
38  
39 MS MASON: We definitely think that is important, but we  
40 realise that has significant resourcing complications.  
41  
42 MS CALVERT: We would not be in a position to fund it  
43 without additional funding either from the department or  
44 from government.  
45  
46 THE COMMISSIONER: Are there other areas which each of you  
47 think would be appropriate to extend the working with

1 children checks?

2

3 MS MASON: I think those were the major ones.

4

5 MS FURNESS: What about volunteers? I just thought I'd  
6 raise it.

7

8 THE COMMISSIONER: Or a class of volunteers. It is  
9 obvious that for particular activities, someone is going to  
10 be a volunteer, brought into the actions for that day at  
11 very short notice, and you clearly can't check them, but if  
12 people are regularly involved in a volunteer capacity, in a  
13 sense they may be the typical paedophile who is going to  
14 take advantage of a situation where they are going to get  
15 close and continuing access to children on a purely  
16 voluntary basis.

17

18 MS CALVERT: Our submission, as you are aware, does  
19 outline some of the complexities around bringing volunteers  
20 into a working with children check scheme. There are a  
21 number of difficulties to do with the capacity of the  
22 agency to do the checking, whether or not checking is in  
23 fact going to provide the level of safety that people think  
24 it is going to provide, and so on.

25

26 Our final position is that we think that we should be  
27 seeking additional funding to be able to audit prohibited  
28 employment declarations so that they act as a much stronger  
29 deterrent and, secondly, that we be funded to expand our  
30 child safe child friendly program so that agencies who use  
31 volunteers are able to put in place the sort of risk  
32 reduction strategies that the research is suggesting will  
33 be more effective in preventing harm to children, because  
34 most people who harm children don't have prior records, so  
35 there is a limit as to what can be achieved by background  
36 checking, and you probably going to do more harm by doing  
37 broad risk reduction strategies. There are a small group  
38 of volunteers who think should be background checked, and  
39 we have talked about those, such as the adult household  
40 members of family day care.

41

42 THE COMMISSIONER: Is that the extent of it? Would you  
43 want to go beyond that to any other category of volunteers?

44

45 MS CALVERT: Mentors, family day carers and authorised  
46 carers are the three groups that we have certainly  
47 identified. The other group probably would be, if they are

1 providing respite, a personal carer if they are  
2 volunteering for personal care of children with  
3 disabilities. That would be another group we are  
4 interested in.

5  
6 THE COMMISSIONER: Ms Boland?

7  
8 MS BOLAND: By way of introduction I think probably of all  
9 the oversight agencies the Children's Guardian has been the  
10 most debated about what its roles and functions should be.  
11 As you can see by our submission we have done our best to  
12 try to outline the various discussions in relation to the  
13 roles and functions of the Children's Guardian. The  
14 approach taken has been to argue the function, to say that  
15 function should exist, and that is adding value to the  
16 system and better improving the outcome for children in  
17 care.

18  
19 Having said that, we are part of a group - the  
20 guardian and commissioners meet on a regular basis. As  
21 part of that process, internally we have done a comparison  
22 between the various jurisdictions so that we can see what  
23 common ground there was for discussion. So we are more  
24 than happy to provide that to you. It is comprehensive.  
25 It makes a comparison between us and other jurisdictions.  
26 It refers to the legislation and annual reports, and so  
27 forth. So I am happy to provide that if that is of some  
28 assistance.

29  
30 As we are currently structured, obviously I would  
31 concur with the Commissioner's view. Under our current  
32 functions we have already made significant efficiencies by  
33 the amalgamation of our functions. Our functions sit quite  
34 separately. We report to the Minister for Community  
35 Services and as Gillian has pointed out we are part of the  
36 system. There is tension there in relation to being part  
37 of the system, being reportable to a minister on particular  
38 standards, and then the capacity to advocate outside that  
39 system. So we have raised that tension in our paper. I  
40 suppose what we are saying is, in essence, that the current  
41 system functions, and I don't think there is much more to  
42 be gained by a further amalgamation.

43  
44 We have raised, by way of contrast, the Queensland  
45 commission's arrangements. In fact they don't do  
46 accreditation in Queensland, but it is a combination of  
47 functions that are not currently undertaken by the

1 Ombudsman and functions not undertaken by the Commission.  
2 They have a wider role. As I said, I am happy to provide  
3 the contrast document to you. You might find it reasonably  
4 helpful.

5  
6 MS FURNESS: Given the sections which have not yet been  
7 proclaimed in relation to your role, do you consider the  
8 title of Children's Guardian remains an appropriate one?  
9

10 MS BOLAND: There's two views on that. Regarding the  
11 system, I think it probably makes sense to change the  
12 title.

13  
14 MS FURNESS: To what?  
15

16 MS BOLAND: Well, it is an accreditation agency in the  
17 end, so it would be Out-of-Home Care Accreditation, or  
18 something.  
19

20 MS FURNESS: Not very snappy, is it?  
21

22 MS BOLAND: No. Give me some time and I will come up with  
23 something snappier.  
24

25 THE COMMISSIONER: If those provisions were proclaimed you  
26 would have a totally different role. You would be almost  
27 standing in the shoes of the minister so far as parental  
28 responsibility and everything else is concerned. Obviously  
29 you don't want that. You don't think it appropriate.  
30

31 MS BOLAND: No, I think in our submission we have made it  
32 very clear that we think any such additional powers to the  
33 Guardian should be only as a safety net in very specific  
34 circumstances.  
35

36 THE COMMISSIONER: That is interesting, because in your  
37 submission you have dealt with, I guess, a partial  
38 implementation, picking up some of those potential powers  
39 of exercising parental responsibility or intervening in  
40 Children's Court proceedings, and so on, which, if they  
41 were to be adopted, would have to be very carefully, I  
42 guess, specified.  
43

44 I don't think this is the time or place to debate it,  
45 but I would be very grateful for the other key agencies who  
46 are present today to have a look at the Guardian's  
47 submissions and possible either part proclamation of

1 provisions and repeal of other provisions which would  
2 actually give the Guardian a role which might be said to be  
3 a Guardian's role as the final - I don't know what you call  
4 it, but the final something.

5  
6 MS BOLAND: Safety net.

7  
8 THE COMMISSIONER: Safety net where there were things  
9 which weren't going right. So I would welcome submissions  
10 across the table on that. Apart from that, your view is  
11 that the two functions should remain under separate hats,  
12 but within the one office, which I take it means you share  
13 some administrative staff and accounting, and anything else  
14 you have to have.

15  
16 MS CALVERT: Yes, we do.

17  
18 THE COMMISSIONER: Does the Ombudsman have any views about  
19 the continued existence of the two agencies or their  
20 combination in some way or another.

21  
22 MR KINMOND: We think the current arrangement works, and  
23 we think to go any further than that by way of comment  
24 would be far too dangerous.

25  
26 MR MERRICK: I would agree with those views.

27  
28 THE COMMISSIONER: Premier and Cabinet?

29  
30 MR LEAN: The partial merger, for want of a better word,  
31 came out of an audit of expenditure about two or three  
32 years ago, and that was primarily designed to try to  
33 generate efficiencies rather than actually integrate the  
34 functions, hence the two separate statutory roles remain.

35  
36 THE COMMISSIONER: Going back to one thing. You did raise  
37 in your submissions, Ms Boland, the fact that you, unlike  
38 everybody else, is not answerable to a parliamentary joint  
39 committee. Most people don't want to be answerable to  
40 parliamentary committees. Do I get from your submission  
41 that you would be happy to do so?

42  
43 MS BOLAND: Clearly I made a recommendation in that  
44 regard, so, yes. I think it is an accountability mechanism  
45 for other oversight agencies, so it is about lining those  
46 up. It is also about obviously getting a focus on out of  
47 home care issues within that framework.

1  
2 THE COMMISSIONER: So it might be an occasion for you to  
3 be an advocate?  
4  
5 MS BOLAND: I think I do have an advocacy role.  
6  
7 THE COMMISSIONER: No, in the hearings of the committee,  
8 you would have your day in the sunlight.  
9  
10 MS BOLAND: No, I haven't had enough days in the sunlight.  
11  
12 THE COMMISSIONER: Does the Premier and Cabinet have a  
13 view on that? Is it an oversight that the Office has not  
14 been tracked in?  
15  
16 MR LEAN: No, I'm not familiar with the reasons that is  
17 the case.  
18  
19 MS FURNESS: Perhaps it reflects the fact that it is an  
20 accreditation body.  
21  
22 MR LEAN: In fact, the point was made previously, that it  
23 is part of the system as well and subject to other  
24 oversight arrangements.  
25  
26 MR McCALLUM: We'd see the separation as something to be  
27 encouraged. I think there are other roles to be pursued in  
28 both areas. I think the broader think-tank approach of the  
29 commission is actually helpful, it's visionary, and it  
30 gives a view of being proactive about what should be  
31 addressed, and the accreditation functions are very  
32 specific.  
33  
34 There will be a greater role for DoCS in that regard.  
35 They are separate functions. The one which has the highest  
36 profile in terms of public interest does tend to dominate  
37 when you bring those things together. You do lose the  
38 think-tank capacity when you get down to fundamentals, of  
39 accreditation and those sorts of things which become the  
40 drivers.  
41  
42 THE COMMISSIONER: The last thing I want to raise today,  
43 unless anybody has any other views you want to bring to  
44 attention, is this: as I understand it, following the  
45 2002 legislative council standing committee report, an  
46 oversight agency working party was established which was to  
47 deal with both policy and legal issues. It lasted for a

1 while but then it died. I don't know why it died or  
2 whether it achieved anything. There has been a suggestion  
3 put forward that it would be worthwhile reinvigorating it.  
4  
5 MS MASON: It is news to me.  
6  
7 MS FURNESS: I think it was put forward by the Guardian,  
8 wasn't it?  
9  
10 MS BOLAND: We have discussed the recommendation that the  
11 agencies get together and discuss issues.  
12  
13 THE COMMISSIONER: There a view that it would be  
14 worthwhile having as a standing body of some kind, I mean  
15 of an formal or informal nature forum where the outside  
16 agencies can get together and consider policy issues, legal  
17 issues and so on.  
18  
19 MR KINMOND: Yes.  
20  
21 MS BOLAND: Yes.  
22  
23 THE COMMISSIONER: Do we have consensus for that?  
24  
25 MS BOLAND: Yes.  
26  
27 MS CALVERT: I don't know. I'd want some time to reflect  
28 on it, judge.  
29  
30 MS FURNESS: The original recommendation of the  
31 Legislative Council Standing Committee on Social Issues  
32 was:  
33  
34 To ensure that an effective system of  
35 external oversight is established, the  
36 Department of Community Services should:  
37  
38 . Work in partnership with oversight bodies  
39 in the identification of problems and in  
40 finding appropriate solutions.  
41 . Ensure a timely and comprehensive formal  
42 response is provided to all recommendations  
43 made by oversight agencies.  
44  
45 That was the basis upon which it was proposed, if that  
46 helps.  
47

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MS CALVERT: It does and I'll look at it and consider it and provide advice.

THE COMMISSIONER: I think the Ombudsman would be happy with that. DoCS would be happy with it, and the Children's Guardian.

Are there any other views to the contrary or otherwise? Does anybody else want to say anything in relation to this particular forum?

Thank you again for your assistance. Again it has been helpful for us to hear the evidence on the matters we are looking at. Thank you very much.

AT 12.45, THE COMMISSION ADJOURNED ACCORDINGLY