THE ROLE OF OVERSIGHT AGENCIES

NSW DEPARTMENT OF COMMUNITY SERVICES SUBMISSION TO THE SPECIAL COMMISSION OF INQUIRY INTO CHILD PROTECTION SERVICES IN NSW

MARCH 2008

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EXECUTIVE SUMMARY

External oversight of critical child protection functions is vital to ensuring that agencies involved in child protection, including the Department of Community Services (DoCS), are open and accountable for their actions.

This submission examines four core areas of independent oversight:

- the investigation and review of child deaths, undertaken variously by the Coroner, the Ombudsman, the Child Death Review Team (CDRT) and DoCS;
- the investigation of allegations of reportable conduct against employees (including authorised carers) involving DoCS, the NSW Commission for Children and Young People (CCYP) and the Ombudsman;
- the oversight of employees involved with children and young people through the Working With Children Check process undertaken by CCYP; and
- the accreditation and quality improvement of Out-Of-Home-Care (OOHC) services by the Children's Guardian.

Child deaths

It is vital that service providers and child protection system learn from the circumstances which led, tragically, to a child's death. The reviewable deaths framework should enable a close examination of the particular circumstances leading to the child death as well as a constructive examination of systemic issues.

To achieve these goals more effectively, reform is desirable. This would involve refining the definition of reviewable deaths to ensure the deaths reviewed under the reviewable deaths framework have a close nexus to child protection concerns. Working towards a reporting framework more consistent with those in other Australian jurisdictions would be of great value. There is also merit in simplifying review arrangements by having one key external body rather than many being responsible for the review of child deaths.

Allegations of reportable conduct

Changes are needed to the way in which allegations of reportable conduct are managed and investigated to minimise risk to children, reduce delays in finalising investigations, and help ensure that authorised carers are fairly treated. Two areas of reform should be pursued. Firstly, the threshold of reportable conduct could be refined in consultation with oversight agencies to ensure that low level matters are not subject to a full investigation. Secondly, DoCS should centralise and improve the way it deals with the investigation and management of allegations of reportable conduct.

Working with Children Check

The Working With Children Check screens prospective employees that will be working with children, to help determine the suitability of that person for

employment. At the moment, there is some doubt about whether certain classes of people, such as adult household members of family day care centres and licenced home based carers should be screened. DoCS believes that screening of these people is an important risk management tool.

Children's Guardian: OOHC Accreditation

The Children's Guardian's role in oversighting and auditing Out-of-Home-Care (OOHC) services is critical, although some reform is desirable to the regulatory framework governing OOHC services and the audit processes undertaken by the Children's Guardian, to make them more efficient and effective

1. INTRODUCTION

> " Oversight, *n,* supervision, watchful care."[1]

> " The aim of external oversight is to maintain the integrity of government agencies and public officials by holding them accountable for actions and decisions they will make while carrying out their duties. Accountability is a keystone of representative government, as it enhances public confidence in the government sector and, conversely, helps ensure that government is responsive to the interests of the public." [2]

External oversight is a critical element of the legislative, policy and operational framework for the care and protection of children and young people and is essential to building a service system and organisational culture that is open, accountable and self improving.

The activities and decisions of the Department of Community Services (DoCS) affect the most vulnerable in our community directly, many of whom may feel unable to contest or question decisions or actions taken by DoCS. At the same time the wider community has a strong and legitimate interest in ensuring that DoCS is being effective in providing care and protection to those most at risk of harm. It is vital that critical decisions and Department systems and processes are open to productive scrutiny and review.

This submission looks at whether the current oversight arrangements are working, and in areas where they are not, what might be done to strengthen them. As such, it focuses on the following key activities of oversight agencies:

- the investigation and review of child deaths, undertaken variously by the Coroner, the Ombudsman, the Child Death Review Team (CDRT) and DoCS;
- the investigation of allegations of reportable conduct against employees (including authorised carers) involving DoCS, the NSW Commission for Children and Young People (CCYP) and the Ombudsman;
- the oversight of employees involved with children and young people through the Working With Children Check process undertaken by CCYP; and
- the accreditation and quality improvement of Out-Of-Home-Care (OOHC) services by the Children's Guardian.

[1] Macquarie Dictionary, 1981
[2] NSW Ombudsman, *Oversight of public administration*, Public Sector Agencies Fact Sheet No 15, December 2005

2. ARE OVERSIGHT ARRANGEMENTS WORKING?

Oversight arrangements need to deliver results for individual clients and complainants and to the community generally. To achieve this, the powers and functions of each oversight body need to be clear and its responsibilities well matched with its expertise. The benefits of the oversight arrangements need to justify the costs of the system.

DoCS is subject to oversight by the Office of the Children's Guardian, the Children's Court, the NSW Coroner, the NSW Ombudsman, the NSW Commission for Children and Young People and the NSW Parliament. In addition, DoCS may also provide information, reports and/or be called to answer by various other agencies or bodies, including the Privacy Commissioner, the Public Guardian, the Administrative Decisions Tribunal, the NSW Auditor-General, the Independent Commission Against Corruption and NSW Treasury. Of all these bodies, DoCS has the most intensive interface with the Ombudsman.

Clarity in functions and role

Effective oversight arrangements require clarity in functions and roles. Responsibilities are blurred in current oversight arrangements and the proper role delineation between the executive and oversight agencies is not always clear.

As the Ombudsman notes, "It is important to understand that the role … is not to replace or oppose decision-making by government or relevant agencies. Rather, [it] exists to assist agencies and persons within jurisdiction to be aware of their responsibilities to the public, to act reasonably, and to ensure that they comply with the law and best practice in administration."[3]

Despite this, agencies are often faced with detailed recommendations from oversight agencies that effectively direct policy, operational practice and resource allocation.

There needs to be a wide range of other inputs to service and policy development. As the evidence base in child protection improves, this will provide the primary basis for reform directions. In addition, stakeholders such as other government and non government partners, clients, and professional bodies all have particular insights on critical reform matters and should be considered in shaping policy and service reform.

It is inappropriate for any one oversight agency to determine the preferred policy direction on the broader areas for which DoCS is responsible. Decisions about how to best allocate resources for child protection and achieve service improvements are matters for the Minister and Parliament. In any event all the research indicates

[3] NSW Ombudsman, *What is the role of the Ombudsman?,* www.ombo.nsw.gov.au

that child deaths are unpredictable events and it is particularly inappropriate to direct major policy and resource allocations on that basis.

This potential tension between oversighting body and agency has been explicitly recognised and resolved in other areas such as the complaint framework established under the Health Care Complaints Act. Section 91 of that Act provides:

"A recommendation made by the Commission in relation to a matter investigated under this Act must be made in such a way that to give effect to it:

(a) would not be beyond the resources appropriated by Parliament for the delivery of health services; or

(b) would not be inconsistent with the way in which those resources have been allocated by the Minister and the Director-General in accordance with government policy."

Improved outcomes for clients and the community

Clearly there is a need for an avenue for redress for individual complainants and anecdotally it appears that in general they are well satisfied with the outcome following an oversight body's intervention with DoCS on their behalf.

Resources

The cost of responding to oversight agencies needs to be considered in assessing the effectiveness of the current framework.

The requirement to satisfy enquiries to a number of different oversight bodies about the same issues or events is resource intensive. In relation to child deaths, for example, the Coroner, the Ombudsman and the CDRT will all look at the same matters. The Coroner will look at an agency's involvement with a family to determine culpability. The Ombudsman will be looking for maladministration, although it is the case that the Ombudsman has a much broader range of functions under s11(1)(d) of *CS-CRAMA*. The CDRT will be looking at the death in terms of patterns and trends. An agency that was involved with the child or young person will be required to respond to the demands of all three.

In addition to the impact of responding to request from different oversight bodies, DoCS responds to matters from three separate parts of the Ombudsman's Office: the community services division which deals with issues like reviewable deaths; the child protection team which deals with reportable conduct issues; and the general team.

A reactive approach by an oversight agency to high profile cases can also be resource hungry.

More generally, the steady increase in Ombudsman related oversight matters is placing increasing pressure on available resources to meet these requests. This is demonstrated by the following trends:

- Since the beginning of 2006, the average number of matters about which the Ombudsman made contact with DoCS in relation to general oversight has increased from approximately 70 per quarter to about 120 per quarter.

- In the period January 2006 to December 2007 there have been 319 preliminary inquiries under s13AA of the *Ombudsman Act* and 250 matters referred to DoCS for local resolution under *CS-CRAMA*. Only three of these inquiries proceeded to finalised investigations by the Ombudsman.

- The number of allegations has increased steadily (from 170 in 2003 to 848 in 2007) with cases of reportable conduct increasing over the same period from 145 to 434. These allegations are principally against authorised carers. This increase is likely to be due to a number of factors including the wider knowledge of these provisions in the community as well as the low threshold for “reportable conduct”.

3. REVIEW OF CHILD DEATHS

> “ It is unrealistic to expect that it will ever be possible to eliminate the deliberate harm or death of a child – indeed no system can achieve this. However there is great scope for services to be operated more effectively and efficiently.”
>
> Lord Laming
> Victoria Climbie Inquiry
> United Kingdom, 2003

Among numerous child protection cases that can be virtually identical, it is impossible to predict which will be the ones that end in tragedy. Risk factors present in cases of fatal child abuse are generally similar to those present in many thousands of other child protection cases.[4]

How it works

There are four key players in the current system of child death review - the Ombudsman, the Coroner, the CDRT and DoCS.

The appropriate structure and scope of responsibilities in relation to the review of child deaths has been the subject of significant debate and review over the last decade.

In early 2001 The Cabinet Office chaired a review of the system for oversight of providers of community services in NSW with a view to clarifying jurisdictional issues, resolving issues with the complex regulatory and oversight framework and dealing with concerns about the quality of oversight. This review was part of the work done which resulted in the amalgamation of the Community Services Commission with the Ombudsman and the revised *CS-CRAMA* which gave the Ombudsman jurisdiction to review the deaths of certain children and people with disabilities in care.

Under *CS-CRAMA* the death of a child or young person is reviewable by the Ombudsman if:

- the child resided in out of home care

[4] Wilczynski (1997) (as cited in Reder et al 1999) reported that: ‘identifying a potential child-killer from a caseload of at-risk parents is a very difficult task. Indeed, there is general agreement that the only effective way to prevent child fatalities is to improve service provision to the entire at-risk population’ (p. 197). In a similar vein, Levine *et al.* (1994) (as cited in Reder et al 1999) believed that: ‘the difference between a fatal and nonfatal injury may be a matter of chance. The conditions triggering severe injury or fatality are probably highly similar’ (p. 456) and: ‘No risk measure is so closely predictive of actual harm that it could be used to justify drastic legal intervention into families’ (p.465).

Reder, P. & Duncan, S. (1999) Lost Innocents: A follow-up study of fatal child abuse. Routledge, London.

- a report had been made about the child in the three year period preceding their death
- a report had been made about the child's sibling in the three year period preceding their death
- the child's death was, or may have been due to abuse or neglect or occurred in suspicious circumstances
- the child was an inmate of a children's detention centre, correctional centre or lock up (or was temporarily absent from such a place)
- the child was in residential care authorised or funded under the *Disability Services Act 1993* or a residential centre for handicapped persons

As part of the legislative reform it was intended that the Coroner would be responsible for the investigation of individual deaths, including assessing mandatory reports of those deaths and deciding on the appropriate level of investigation and/or referral to other agencies. The Ombudsman was to be responsible for the systemic review of deaths in care and the publication of an annual report on this matter as well as exercising monitoring, review and complaint-handling functions previously vested in the Community Services Commission.[5]

However, following advice from the Coroner the additional powers referred to it were repealed (in November 2002), returning discretion to the most senior coroners to dispense with inquests into reviewable deaths. The Coroner has conducted inquests into the reviewable deaths of 28 children since December 2002 and has made recommendations arising from a number of these inquests.

The CDRT[6] undertakes specialised research to prevent or reduce child deaths. It is made up of 12 independent experts and six representatives from government departments and it is administered by the CCYP. The CDRT publishes an annual report on child deaths and other special reports[7] as research findings become available.

A further overlay to the framework of review of child deaths in NSW has been the establishment within DoCS of significant internal capacity in relation to the review of children's deaths. In August 2003, as a key part of the Government's $1.2 billion five full year reform package, DoCS established a Complaints, Assessment and Review (CAAR) Branch. The Child Deaths and Critical Reports Unit (CDCR) is a

[5] Under s 43, *CS-CRAMA* the Ombudsman is required to report annually on

- data collected and information relating to reviewable deaths that occurred in the period covered by the report
- any recommendations made as to policies and procedures to be implemented by government and service providers for the prevention or reduction of reviewable deaths
- information about the implementation of previous recommendations.

[6] The CDRT is responsible for the systemic review of all deaths of children in NSW from birth to 17 years. Its functions are to

- a register of <u>all</u> child deaths in NSW;
- classify these according to cause, demographic criteria and other relevant factors;
- identify patterns and trends; and
- make recommendations to government and non-government agencies for the prevention of further child deaths.

[7] See for example Fatal Assault and Neglect of Children Report published in 2003

unit in this branch and has an increasing capacity to provide a timely centralised, systematic and consistent response to deaths of children known to DoCS.

Because it is an internal function it can accurately reflect the organisational context in which events occur, staff are more willing to talk about issues, recommendations are practical, and most importantly it has the capacity to deliver on organisational learning and improvement. DoCS recognises that the model needs constant improvement and refinement, particularly in the context of the ability of the CDCR to deliver systemic reform.

Appendix 1 provides information on child death review frameworks in other jurisdictions.

Key Issues

The objective of a reviewable deaths framework is to ensure that where a child who had some close connection with the child protection system dies, there is a timely and effective review of the circumstances of that death. It must operate on two levels. Firstly it must investigate the individual death in a way to determine whether the cause of death was related to child protection concerns for the child and make recommendations aimed at the prevention or reduction of such deaths. Secondly it must identify general casework or overall system reform matters that warrant attention or remediation, if they exist.

The reviewable deaths framework is not designed to address the question of culpability for a death. That issue is a matter for the Coroner and the Police. Additionally it is not designed to determine specifically whether there has been maladministration, as that function sits as one of the Ombudsman's more general responsibilities.

At its best, a child death review can lead to a public debate about opportunities for systemic reform both of child protection practices and policies generally that will minimise the number of child deaths in the future. However a review can also lead to destructive and destabilising consequences for individual workers and the child protection system.

Experts such as Eileen Munro have argued that a punitive system of oversight, can have very detrimental effect on worker morale and system performance.[8] The consequences can include over-reliance on procedures, diversion of resources, and difficulty in attracting and retaining staff. It also prompts further investment in "crisis" intervention rather than early intervention and prevention. The end result is loss of focus on clients and consequently poor outcomes.

Academic literature supports the contention that the way to build an effective child protection environment is to examine child deaths in a manner that does not destabilise the child protection system. To determine ways to improve the child protection system, casework decisions must be reviewed in the context of the multiple systems impacting upon actions and decisions.

[8] Eileen Munro, *Can you design a safe child welfare system,* Paper for Wood Commission 2008

An advantage of accessing and understanding the environment in which deaths occur is that recommendations for change can take into account features of day to day child protection work and systems. This helps in devising practical, achievable, context specific recommendations. A collaborative approach reduces defensiveness, and ensures more relevant and helpful solutions and a sense of ownership.

DoCS believes that the structural arrangements for the investigation, review and reporting of child deaths and the manner in which these reviews are currently undertaken do not promote effective reform of child protection practices. The framework is in need of reform to make it more focused and efficient.

Recommendations

Nexus between review and child protection concerns

The definition of reviewable child deaths in NSW is wider than Victoria, but broadly in line with other jurisdictions such as Queensland and South Australia. The Victorian Child Death Review Committee reviews the deaths of children and young people who were clients of the Victorian Child Protection service at the time of their death or within three months prior to their death.

The NSW definition of “reviewable death” should be made more meaningful in two ways: a child’s death should be reviewable if the cause of death was, or may have been due to abuse or neglect or occurred in suspicious circumstances AND the child was ‘known to DoCS’ based on reports about the child or a sibling in the same household in the 12 months prior to the death (rather than three years, as is currently the case).

Limiting the definition to circumstances of abuse, neglect or suspicious circumstances would ensure the focus of the reviewable deaths framework was on identifying causal links between the deaths and the child protection response, if they exist.

The 12 month timeframe would also help ensure there is a real possibility of identifying causal links between child protection concerns and the death of a child – or at least relevant circumstances – and would ensure that the investigation is focused as much as possible on contemporary practices and procedures.

Of the 114 child deaths known to DoCS in 2006, 81 (71%) of children and/or their siblings were reported in the last twelve months. Only one of these cases subject to a detailed DoCS review would fall outside the 12 months reporting parameter, so the identification of issues for organisational learning is likely to remain consistent.

Stronger, clearer institutional arrangements for the review of child deaths

Institutional arrangements for the review of child deaths should be modernised in light of contemporary evidence about how best to ensure that child death reviews are productive in achieving improvements to the child protection system. Independent oversight of the review of child death should remain as a central

element of this system, but there is merit in considering whether structural arrangements could be changed to make this function more rigorous and effective.

Having one key external review body, rather than several, is recommended.

One possible model would be a framework similar to that operating in Queensland for the review of child deaths.

Under this option a panel would be responsible for the independent oversight of child death reviews. Tapping into superior levels of expertise available via the panel will help ensure that the response to a child death is driven by best evidence in child protection practice. It also provides much clearer lines of accountability.

Under these new arrangements the membership of panel would need to be reviewed to ensure that it comprises senior officials of relevant service agencies that are able to commit to reform, the Ombudsman and Coroner, as well as child protection experts (academics).

DoCS would be obligated to review its involvement in every case in which a child or sibling was “known to DoCS” in the previous 12 months. Child death reviews would be required to be completed within a strict time frame (6 months). The extent and nature of the review would reflect the nature of the death - where there is a preliminary finding that the death was related to child protection issues, a detailed review would be necessary.

Findings of the child death review and recommendations for reform or remedial action would be considered by the DoCS senior executive.

Every child death review report would be referred to the panel. Where the death related to matters of abuse and neglect, or suspected abuse or neglect the report would be referred to the Coroner as well.

The panel would review the DoCS report, any subsequent advice from the Coroner as well as input from other agencies if relevant, and make recommendations in relation to systemic reform, if warranted. The panel would also be empowered to independently report directly to the Minister on the child death if it considered it necessary and desirable to promote improvements to child protection practices. The panel would also carry out a broader function in relation to all child deaths. Its report would include a report on reviewable deaths and only one deaths register (as opposed to the current two) would have to be maintained.

This is of course only one possible model. It needs to be acknowledged that the institutional arrangements of accountability agencies in each state are extremely intricate. The jurisdiction in Queensland of the Ombudsman, for example, is very different from that of NSW.

The essential point of any reform to the system is that it is simplified, that it is adequately resourced and that it results in clear and practical recommendations that are capable of implementation. Preferably such recommendations should be crafted through a process of consultation with DoCS. At present it is too common to be confronted with recommendations made in a public report which are either nebulous or unlikely to address the problem.

Child death reporting

As the joint submission to the Special Commission made by Dr Cashmore and Professor Scott and the Commissioner for Children and Young People[9] noted, an annual reporting cycle on child deaths matters, that does not lead to new information, or which does not allow for enough time for change to be implemented or measured, can demoralise and inadvertently destabilise the service system. Because of this, the joint submission recommended extending the reporting time for the report into reviewable deaths to every three years, with a focus on deaths from child abuse and neglect and children who die in suspicious circumstances. This reform should be considered.

[9] Joint Submission to the Special Commission of Inquiry into Chuld protection Services in NSW, Dr Judy Cashmore, Professor Dorothy Scott , Commissioner Gillian Calvert, pages 11 and 15

4. ALLEGATIONS OF 'REPORTABLE CONDUCT'

From time to time allegations of abuse may be made against DoCS staff, authorised carers and others who work on behalf of DoCS.

An allegation of reportable conduct is significant for both the child or young person, and the authorised carer against whom it is made. The legislative arrangements are intended to ensure that allegations are properly investigated, that the rights of person against whom the allegation is made are recognised, and that recognition is given to difficulties in determining appropriate behaviour.

One of the major challenges for DoCS in this area is in investigating the allegations in a timely manner. DoCS recognises that its failure to investigate allegations efficiently and effectively means that:

- children may be at risk as a result of delays in finalising investigations;
- authorised carers are unfairly treated due to delays (carers represent 92% of employees investigated). The delays in investigation and the deficiencies in investigative practice impact severely on authorised carers' confidence in the system. There are instances where carers have become disillusioned with the process and have decided to withdraw from care giving; and
- there is an increased scrutiny by the Ombudsman, which adds to DoCS costs and system complexity.

How it works

DoCS Allegations Against Employees Unit (AAE) manages the allegation process and investigates for the whole of DoCS allegations relating to salary staff and serious allegations in relation to carers. The regions are responsible for all other investigations. Regional investigations divert staff from child protection work.

Section 25A of the Ombudsman Act 1974 provides that the use of force that is trivial or negligible need not be notified to the NSW Ombudsman provided "the matter is to be investigated and the result of the investigation recorded under workplace employment procedures". The *Code of Conduct for Authorised Carers, Schedule 2, Children and Young Persons (Care and Protection) Regulation 2000,* prohibits the use of physical punishment of a child in care. This means that any physical punishment, no matter how trivial needs to be investigated.

The class or kind agreement with the Ombudsman in September 2006 has not had an appreciable impact on the workload of investigating low level allegations. While DoCS is not required to report on the investigation of these allegations to the Ombudsman, it is required to investigate them. The class or kind agreement also only applies to about 5% of reported allegations. Both agencies have expressed a willingness in the past to revisit the agreement, and this will be progressed.

DoCS is required to notify CCYP of all completed proceedings related to reportable conduct and acts of violence in the workplace and in the presence of a child.

Matters are notified in two categories. Category 1 matters are where the investigation found reportable conduct or an act of violence took place, or some evidence that reportable conduct or an act of violence occurred, however the finding is inconclusive and DoCS considers that the conduct *should* be considered in an estimate of risk when the person next seeks child related employment. Category 2 matters are where investigation has found some evidence that reportable conduct or an act of violence occurred, however the finding is inconclusive. The Ombudsman's Office takes a clear view that where there is 'some evidence' of reportable conduct present, the matter requires a Category 2 notification.

CCYP always considers Category 1 notifications in its risk assessment as part of a Working With Children Check. Category 2 notifications are only considered if there has been more than one notification or other relevant records are found as it relates to low level inconclusive findings.

The CCYP's risk assessment level is provided to the prospective employer who has the right to determine whether that person is employed or not. The impact of these arrangements is that the employment prospects of authorised carers can be affected by a series of low level cases of reportable conduct which are not proven. In any event, carers are very worried and disconcerted by being notified even if advised that Category 2 notices will not be taken into account.

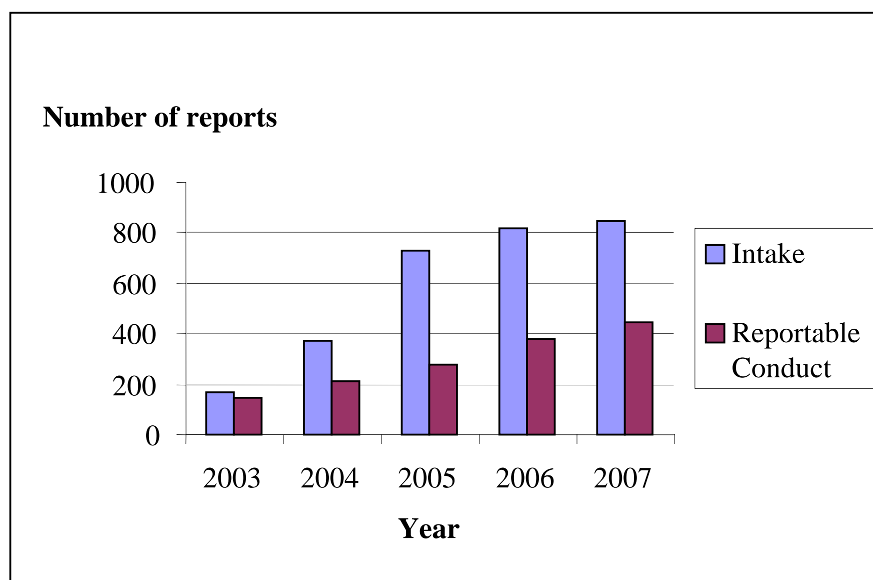
The breakdown of notifications by category is set out below.

Year	Category 1	Category 2	Total Notifications
2000	1	2	3
2001	20	28	48
2002	68	33	101
2003	71	19	90
2004	112	33	145
2005	94	50	144
2006	153	68	221
2007	169	67	236

Delays in completing investigations are increasing. The Department acknowledges that this is unsatisfactory.

A large and increasing amount of work is being generated by the system established to respond to allegations against employees. This is likely to be a consequence of an increased awareness of reporting obligations. In 2007 intake reports to AAE totalled 848 (729 for the full year in 2006). Not all of these reports met the threshold of reportable conduct under the *Ombudsman Act 1974.* Of the total cases reported 434 were accepted as reportable conduct (378 in 2006). See Table 1 below.

Table 1: Reports to AAE



Recommendations

Investigation, reporting and oversight commensurate with risk

Further refinement is needed in defining what physical abuse is regarded as "reportable conduct". This will assist in ensuring attention is not diverted to trivial or negligible matters.

Clarification is also required that the abuse covered by the reportable conduct relates to the activities of the person with daily care of the child, and not the actions of anyone whose actions might have prevented abuse.

The conduct of professional staff working with a child should be considered from a negligence or professional performance perspective. To characterise individual decisions made in this context as neglect (and so reportable conduct) inappropriately blurs the distinction between the respective roles of the carer with other people, and unnecessarily broadens the number of matters subject to investigation.

Interpretations by oversight agencies of the "neglect" provision have the capacity to drastically increase the number of DoCS staff subject to allegations of reportable conduct. DoCS staff could find themselves liable for notification to the CCYP for errors in professional judgement, or indeed for legitimate exercises of professional judgement, which provide in hindsight to be erroneous.

Notwithstanding the approach to reportable conduct thresholds, DoCS needs to ensure that the level of investigation that is undertaken matches the level of risk disclosed by the allegation. DoCS proposal is to enhance resources dedicated to the investigation function, discussed below.

While DoCS recognises that the CCYP reporting arrangements are intended to identify patterns of behaviour, in the case of authorised carers the provisions are can be unnecessarily stringent. It is recommended that many matters falling within Category 2 should not be required to be notified to CCYP. This could in all likelihood be achieved through a class or kind agreement.

More efficient investigation of allegations

Substantial improvements could be made to the management of reportable allegations by centralising the investigation of these allegations within DoCS. This will mean a fairer system with allegations being reviewed faster and in a more consistent manner.

Conducting disciplinary investigations into allegations of reportable conduct is a specialist task which is best undertaken by trained staff By centralising this function DoCS would be able to develop and implement a uniform investigation strategy that matches the type and level of investigation with the level of the risk disclosed by the allegation.

Where an allegation of reportable conduct relates to low level conduct, the level of investigation should not be extensive and the matter should be resolved within a short time frame. Differential investigation will also ensure that available resources are focused on the investigation of serious allegations.

By centralising the investigation of allegations and removing unnecessary work from the field, resources will be freed up at the local level to focus on crucial child protection matters. Risk assessment of children in the care of persons subject to allegations would still have to be conducted at the local level.

This reform cannot be achieved at current resourcing levels which are simply failing to keep pace with the numbers of reportable conduct allegations being made. Substantial new investment will be required. It is also not tenable to recover investigative resources from frontline staff who are presently undertaking investigations in addition to direct client work.

5. WORKING WITH CHILDREN CHECKS

How it works

An important element of the child protection framework is the Working With Children Checks (WWCC) which investigates the background of people who are engaged in child related employment. Under the provisions of the *Commission for Children and Young People Act (CCYP Act) 1998*, there is a responsibility to conduct a WWCC Check (WWCC) on these people.

A WWCC is usually referred to as ‘screening’. It is a national background check of relevant criminal records, relevant apprehended violence orders (AVOs) and relevant employment proceedings. It covers all recommended applicants for child related employment, where child related employment involves ‘direct unsupervised contact with children’. DoCS also includes foster carers in this definition.

In addition, under the *Children’s Services Regulation 2004* DoCS is required to conduct ‘probity checks’ of each applicant for a children’s service licence and of each proposed authorised supervisor of a service. The Regulation also requires the licensee to conduct a ‘probity check’ of any individual who is, or is proposed to be, engaged (including as a volunteer) in the operation or management of the service. The Regulation requires these checks to be conducted, as far as practicable, in accordance with CCYP’s guidelines for employment screening and says they may be carried out by CCYP on behalf of DoCS or a licensee. Probity checks, unlike WWCC, do not include charges and spent convictions or AVOs**.**

CCYP has conducted WWCCs for children’s services licensees. However, the Children’s Services Regulation only requires probity screening – and therefore CCYP is only **required** to conduct probity screening (lesser form than WWCC).

Recommendations

Scope of screening requests to CCYP

DoCS is concerned there may be a change to screening practices in relation to:

- Children’s services licensees and authorised supervisors
- Adult household members of foster carers, adult household members of family day carers, and adult household members of licensed home based carers
- Businesslink contractors
- Students working with DoCS officers
- Adoption applicants.

DoCS has undertaken a detailed examination of its screening requirements and is putting changes in place to reduce demand in some areas.

However, DoCS believes the wider class of people described above should continue to be screened and that a legislative amendment should be made to clarify their obligation in this regard.

Working With Children Checks should be required for the following positions

- all new DoCS staff positions (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff);
- any contractors engaged by the Department to undertake work which involves direct unsupervised access to children, or access to the KiDS system or file records on DoCS clients (eg. IT contractors);
- students working with DoCS officers;
- children's services licensees;
- authorised supervisors of children's services;
- adoptive parents;
- adult household members of foster carers, family day carers and licensed home based carers.

This will have resource implications.

6. OUT-OF- HOME CARE SERVICE ACCREDITATION

How it works

The functions of the Children's Guardian, established under the *Children and Young Persons (Care and Protection Act) 1998* are to:

- promote the best interest of all children and young persons in out of home care;
- ensure that the rights of all children and young persons in out of home care are safeguarded and promoted
- accredit designated agencies and to monitor their responsibilities under the Act and regulations.

The *NSW Out-of-Home Care Standards* are used by the Children's Guardian for the accreditation and quality improvement of out-of-home care services in NSW. The Office for Children-Children's Guardian (OCCG) has prepared benchmark policies for each of these standards. The OCCG also conducts a case file audit program for designated agencies (that is non government providers, DoCS, and the Department of Ageing, Disability and Home Care.

As discussed in the DoCS OOHC submission, the Children's Guardian has recently noted from a review of systems in place in other Australian and overseas jurisdictions that the requirement that all OOHC agencies be accredited is atypical of most accreditation schemes. Accreditation is generally not a pre-requisite to enter a particular market, with OOHC accreditation in NSW effectively operating as a form of licence.

Recommendations

Reduce complexity of regulatory framework

The accreditation framework should be substantially reformed so that the objective of ensuring high quality OOHC services is achieved in a way the maximises the opportunity for service innovation, is cost effective, and reduces the level of unnecessary red tape experienced by OOHC providers.

The NSW Government's principles on best practice regulation should underpin a review of the accreditation framework, including its standards. It is anticipated that this would result in the:

- articulation of quantitative outcomes to be achieved by the regulation
- rationalisation of the number of standards
- substantial simplification of standards
- clearer link of the level of regulation imposed and risks associated with the provision of OOHC services.

It is important that the regulatory framework is sufficiently flexible to accommodate changing models of care. For example, currently relative and kinship care is increasing, however the *NSW OOHC Standards* do not take account of relative and kinship care effectively.

The Children's Guardian is examining this issue and DoCS has made a submission to its Review of Accreditation Standards.

It will be challenging for DOCS to meet the current accreditation standards by 2013 as required due to the demand for OOHC services and because it is the provider of last resort. The Children's Guardian and DoCS need to develop proper accountability arrangements for DoCS OOHC services that recognise this.

Impact of compliance program on DoCS

DoCS supports the work of the Children's Guardian in conducting compliance auditing through its Case File Audit program and sees this as vital to improving the quality of OOHC services.

The 2006/07 Case File Audit was a significant logistical exercise within DoCS. It was much larger than the first and second case file audits with over 1500 case files called in.

The Case File Audit also highlighted significant differences between the OOHC case files maintained by DoCS and the case files maintained by other designated agencies with both allocated and unallocated OOHC case files within DoCS being examined. The difference in performance was, as discussed in the OOHC submission to the Special Commission, largely due to resource and workforce issues.

Notwithstanding concerns about methodology and analysis, DoCS has accepted the findings of the 2006/07 Case File Audit and implemented remedial action to improve performance.

DoCS has recommended to the Children's Guardian that future audits be conducted using a two staged approach to minimise resource impact of the process while maintaining the integrity of the audit.

The Children's Guardian's role generally

As discussed in the OOHC submission, DoCS does not support the proclamationl of the unproclaimed provisions[10] of the Act that provide for the Children's Guardian to exercise the parental responsibility of the Minister for children and young people in out-of-home care and in relation to undertaking review of an out of home care placement at any time.

DoCS considers it would distort the Children's Guardian's functions in oversighting the OOHC sector. It would also lead to a duplication of costs and inefficiencies as designated agencies referred matters to the Children's Guardian for decision.

There remains a gap in the regulatory arrangements in relation to oversight of voluntary care arrangements. Currently the *Children and Young Persons (Care and Protection) Act* (s135(1)(c)(ii), 155 and 156) envisages a scheme of intensive regulation of children and young persons who are placed voluntarily by their

[10] These include sections 150(6), 155(2)(b)(i), 181(1)(a), 181(d), 182 and 184

parents in care. However, these sections remain unproclaimed due to concerns about the workability of the provisions, in particular, the breadth of arrangements that would be captured, including those where there is no suggestion that the Children Guardian's intervention is necessary. DoCS has consulted with the Children's Guardian and other key stakeholders about the introduction of a revised scheme for protecting children and young people from abandonment and harm when placed by their parents in voluntary care.

APPENDIX 1: Child Deaths Oversight Arrangements

Victoria

The Victorian Child Death Review Committee (VCDRC) was established in 1996. It is a multidisciplinary ministerial advisory body.

The functions of the VCDRC are:

- To review the deaths of all children and young people who are current or recent clients of the Victorian child protection service.
- To identify any themes, trends or patterns, which emerge from the review process and advise the Minister for Children and Minister for Community Services of their implications for policy and practice in Child Protection and related services.
- To identify particular groups of child deaths that may benefit from further investigation and oversee a group analysis process to gain a more comprehensive understanding of the issues involved and best practice responses.
- To prepare an annual report for the Minister for Children and Minister for Community Services that is tabled in Parliament as part of a transparent and accountable approach to the deaths of children known to Victoria's Child Protection service[11].

The deaths of children in Victoria which are reviewable are deaths of children who had been notified to the Department of Human Services within three months prior to their deaths.

The VCDRC does not conduct individual inquiries itself. This is done by the Office of the Child Safety Commissioner which then provides these reports to the VCDRC. The Office of the Child Safety Commissioner also provides a range of administrative support services to the VCDRC

The VCDRC describes its annual report as serving two related but distinct functions:

- it provides quantitative and demographic data about the deaths of children known to child protection services who died in the reporting period
- it provides qualitative analysis of child death inquiries reviewed by the VCDRC in the reporting period.

In its 2007 annual report, the VCDRC reported on the deaths of 18 children, nine of whom died from acquired or congenital illness, four from accidents, one from SiDS and four for reasons unknown or undetermined at the time of reporting.

The Victorian Department of Human Services only conducts investigations in relation to individual child deaths if significant or urgent issues have arisen. The

[11] www.ocsc.vic.gov.au/vcdrc [accessed online 27/02/08]

department copies its incident report to the Office of the Child Safety Commissioner to facilitate the commission's monitoring role.

The Victorian Ombudsman does not have a specific statutory child protection oversight role although its jurisdiction includes the Department of Human Services, and its child protection jurisdiction extends to funded external agencies providing child protection services in the community. It is rare for the Ombudsman to use its own motion power to investigate a matter in the child protection jurisdiction. There have been fewer than six such own motion investigations in the last eight years, none of which led to a major public report.

Queensland

The current oversight regime for child deaths in Queensland was established in August 2004.

The Child Death Case Review Committee (CDCRC) is an independent multi-disciplinary committee chaired by the Commissioner for Children and Young People and Child Guardian, supported administratively by the Commission for Children and Young People and Child Guardian.

The review functions of the Commission are:

- Maintaining a register of all child deaths in Queensland based on notifications from the Registrar of Births, Deaths and Marriages and details of all child deaths reported to the State Coroner
- Conducting research into the risk factors associated with child deaths and making recommendations to prevent such deaths occurring
- Preparing an annual report on child deaths, and providing secretariat support to the Child Death Case Review Committee.

The Queensland Department of Child Safety is required to conduct a review of its involvement in each case where a child dies, when that child was known to the department in the three years before they died. This must be done within six months from the time the department learns about the death and the department then provides its report to the Child Death Case Review Committee (CDCRC).

The CDCRC reviews the report and must in turn report back to the Director-General of the Department of Child Safety within three months of receiving it.

The CDCRC makes recommendations about improving policies, relationships and the need for any disciplinary action against departmental staff.

The CDCRC can request advice on the implementation of its recommendations, report to the responsible minister and the Premier if it is not satisfied with the department's action, and report on this monitoring and implementation in its annual report.

The Queensland Ombudsman does not have a specific statutory child protection oversight role but it has conducted at least two significant investigations into the adequacy of actions taken in relation to the safety, well-being and care following of two children who died, focusing on the quality of decision-making and serious

maladministration[12]. These investigations were both initiated by complaints to the Ombudsman.

Western Australia

The Advisory Council for the Prevention of Deaths of Children and Young People (ACPDCYP) was established in Western Australia in 2003 for a two year term. This term was continued for a further three years until April 2008.

The Council is independent and reports to the Cabinet Standing Committee on Social Policy through the Minister for Community Development who chairs the Cabinet Committee.

The terms of reference of the Council are to:

- Review and analyse data, information and research relating to the causes of deaths of children and young people, identify patterns and trends relating to those deaths and consider pathways to prevention
- Identify areas that would benefit from further research and consider linkages of data to better inform pathways to prevention
- Evaluate the effectiveness of interventions designed to reduce or prevent deaths of children and young people
- Identify policies, programs and practices that are successful in reducing or preventing deaths of children
- Formulate recommendations to be implemented by government, private organisations and the community for the prevention or reduction of deaths of children and young people
- Undertake other functions as the minister may direct.

Current work of the ACPDCYP includes:

- examining child death review processes in other states in order to make recommendations to the WA Government on what would be ‘effective, sustainable and relevant to the Western Australian context’
- conducting an Indigenous Qualitative Research Project to gain understanding of the circumstances of deaths of infants, children and young people to inform recommendations for change in policy and practice
- developing an Indigenous Community Education and Information Dissemination Project to inform the community about findings from *The First Research Report: Patterns and Trends in Mortality of WA Infants, Children and Young People 1980-2002*[13].

There is currently no child death register or statute requiring review of child deaths and annual reporting in Western Australia.

The Ombudsman for Western Australia has general jurisdiction over the Department for Child Protection. In 2007 the Ombudsman tabled in Parliament his ‘Report on Allegations Concerning the Treatment of Children and Young People in Residential Care’. The Ombudsman does not have any specific child death review functions.

[12] Reports on the deaths of Brooke Brennan (May 2002) and Baby Kate (October 2003)
[13] http://www.community.wa.gov.au/DCP/Resources/Council [accessed online 28/02/08]

South Australia

The Child Death and Serious Injury Review Committee (CDSIRC) was established in February 2006 to review the circumstances and causes of deaths and serious injuries to all children. Its role is to 'help prevent death and serious injury to children now and in the future'[14].

The Committee's functions include:

- maintaining a database of the circumstances and causes of child death or serious injury
- review of child deaths and serious injury 'with the aim of identifying legislative or administrative means of preventing such deaths or injuries in the future'
- making recommendations and monitoring the implementation of those recommendations
- maintaining links with similar bodies, interstate and overseas.

The Committee is not required to review all individual deaths and may not undertake a review if this would compromise any ongoing criminal or coronial inquiry. The Committee should, however, review cases:

- where there are indications of abuse or neglect
- where the child or a member of the child's family has been the subject of a child protection notification in the past three years
- where the child was under the guardianship of the Minister or was in the care of a government agency
- where a case is referred by the Coroner.

The Committee reports to the Minister for Families and Communities at the conclusion of each individual review and on its annual report. The Minister must table the Committee's annual report in Parliament.

In its annual report for 2006-2007, the Committee reports that only four of the 13 reviews identified for 2005-2006 deaths had been completed. For the 2006-2007 period, 16 cases had been identified by the time of the report with 19 yet to be considered. Reviews are not conducted until coronial processes are finalised.

The South Australian Ombudsman has no specific child death review function but the Department of Families and Communities is within its jurisdiction.

Tasmania

In Tasmania, the Paediatric Committee of the Obstetric and Paediatric Mortality and Morbidity Committee maintains a register of paediatric deaths.

A specific review into the deaths of ten children believed to have been known to the child protection system in Tasmania was commenced in December 2006.The review was conducted by a Consultant Paediatrician and Director of Women's and Children's Services at the Royal Hobart Hospital, the former Acting Commissioner for Children, a child protection consultant and a Deputy Secretary of the Department of Heath and Human Services.

[14] http://www.cdsirc.sa.gov.au [accessed online 28/02/08]

Summarised findings, but not the full report of the review, were publicly released by the Minister for Health and Human Services in November 2007.

In his annual report for 2006-2007, the incoming Commissioner for Children in Tasmania noted that he wished to expand the role of the child death review process 'beyond the examination of children and young people known to child protection services, to the examination of preventable deaths of all Tasmanian children'[15]. The June 2007 newsletter of the Council of Obstetric and Paediatric Mortality and Morbidity reported on the Commissioner's activity in the following way:

> The new Commissioner has particular interest in centralising the process of review and drawing upon the current support and resources of the Office for Commissioner for Children, Coroner's Office and the Paediatric Mortality & Morbidity Committee of the *Council of the Obstetric & Paediatric Mortality and Morbidity* to assist the process of review. This Committee will primarily serve as a "check-point" for highlighting the effectiveness and current working status of the Child Protection system. This is particularly important in view of the consistent number of cases associated with Child Protection Services reported each year (note: approximately 5 paediatric death cases reported annually in Tasmania).

[15] Commissioner for Children Annual Report 2006-07 [online: www.childcomm.tas.gov.au accessed 05/03/08]