

QCPCI

Date: 23.10.2012

Exhibit number: 95

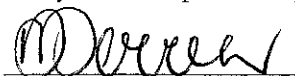
Statement of Witness

<i>Name of Witness</i>	Katina Perren
<i>Date of Birth</i>	[REDACTED]
<i>Address and contact details</i>	Madden Solicitors 54 James Street Yeppoon QLD 4703 Phone 07 4939 8955 [REDACTED]
<i>Occupation</i>	Solicitor
<i>Officer taking statement</i>	Karen Charles
<i>Date taken</i>	16 /10 /2012

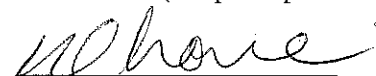
I, Katina Perren state;

1. I am a solicitor entitled to practice in Queensland.
2. I was admitted to practice in November 1998 and have been Independent Children's Lawyer and Separate Representative for the past 5 years (approximately). I was appointed as a member of QCAT on 1 December, 2011.
3. Since admission, my primary areas of practice have been in the Family and Federal Magistrates Court, in the Magistrates, District and Supreme Courts in the areas of Criminal Law, Child Protection, Youth Justice and Domestic Violence.
4. I have been appearing regularly as duty lawyer in the Magistrates Court at both Yeppoon and Rockhampton for the last 9 years including acting as Duty Lawyer for respondents in the trial Domestic and Family Violence program through the Rockhampton Magistrates Court.
5. For most of this time (and since my inclusion on the Legal Aid Panels as an Independent Children's Lawyer and Separate Representative) myself and Ms Madden (the principal of

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the firm) have been the only qualified Separate Representatives in the Central Queensland area and have (until approximately 12 months ago) conducted the bulk of these files for this area including Rockhampton, Emerald, Longreach and Gladstone. There has also been only a limited number of firms practicing in the area of Child Protection during this time and our firm has also carried out significant amounts of party work in the Child Protection jurisdiction.

6. Due to my locality my evidence is given on the basis that I work in a regional centre which covers a large geographical area and that some of the difficulties that are faced here may not necessarily be issues in the more centralised areas of Queensland.
7. My statement is based on my long experience working in the child protection area including what I have witnessed occurring and also discussions which I have had with staff who work for the Department of Communities (Child Safety).
8. I have read the *Commissions of Inquiry Order (No.1) 2012* and intend to address those areas of the inquiry which I believe I have the relevant knowledge and experience to address.

3(c)i – whether the current use of available resources across the child protection system is adequate and whether resources could be used more efficiently;

9. There is clearly insufficient resources across the child protection system, however, equally the resources currently available could be used more efficiently.

Inefficiencies

10. The child protection system has become so mired in paperwork and procedures that the time and work which is involved in the simplest of tasks is so cumbersome as to prevent those tasks being achieved in an appropriate time frame.
11. The Department of Communities (Child Safety) (hereinafter referred to as “Child Safety”), is also so over-managed that very little positive work is achieved in reasonable time frames.

Size of files and paperwork

12. As a separate representative I have, on innumerable occasions, inspected the files of the Child Safety. The files are individual to each child, as opposed to a family/sibship. Both within the individual children’s files and between the other sibling’s files the same document will have been produced, printed and placed on the files numerous times.

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13. For example, in a family of six children the same set of six forms are filled out for each child separately and, whilst it is accepted that some children may have needs that other children do not, the overall concerns and reasons for the children being removed from their parents' care would be the same in respect to all children and any differences could be allowed for in the one form rather than dealing with each child separately.
14. The amount of large, cumbersome and repetitive forms is staggering and it seems that more time goes into accumulating these files than the time that it spent actually working with the families.

Procedures

Family Group Meetings

15. Goals are often set at Family Group Meetings (FGM's) which require Child Safety to organise certain things for the child or family (such as, doctors' appointments, assessments, counselling or courses for parents etc). FGM's are held once every 6 months (on short term orders) and it is not at all unusual to find that Child Safety has not met its goals within the timeframes set out in the FGM (or, in fact, within the six month period between FGM's).
16. Whilst I do not work at Child Safety, my experience is that there are so many steps that need to be taken before these things can be attended to that it simply can't occur in the time frames provided particularly if there is a cost to be incurred.
17. Most adjournments sought in child protection matters are sought by Child Safety as they have not attended to the tasks for which an adjournment is sought in the time frame set between adjournments.
18. The running of FGM's is a prime example of the inefficiencies in the Child Safety. Prior to the FGM a meeting is held with all Child Safety staff that are involved in the file and Child Safety will then come to the FGM with "bottom lines". This is completely contrary to the principles set out in the *Child Protection Act 1999* ("the Act") as to the purpose of FGM's. At the FGM Child Safety will usually have a Child Safety Officer and a team leader present, however, neither of these people have authority to make decisions outside the "bottom lines" set at the Child Safety meeting held prior to the FGM. This means that FGM's become somewhat useless in achieving the purposes set out in the Act.
19. Family Group Meetings have become so over-stylized that they rarely achieve a purpose. Child Safety's "agenda" is the only thing discussed unless the legal representatives are strong enough to hold their ground. The mediators are never impartial but usually Child Safety employees or ex-Child Safety employees. Consequently when issues are raised the mediator will make comments like "Child Safety won't agree to that so there is no

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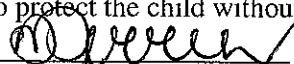
point in raising it". The mediators steer the meeting away from any agenda item which is not on Child Safety's agenda.

20. Once again this needs to frustration from families which only leads to an increase in the level of animosity between families and Child Safety and decreases the chances that parents will work collaboratively with Child Safety.

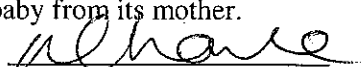
Staff Management

21. The involvement of so many people in decision making on files adds to the difficulties that Child Safety face in respect to any particular child in care.
22. Child Safety has a system whereby certain Child Safety Officers are placed on teams. There is usually a team for Long-Term Guardianship Orders, a team for Short-Term Orders and a team for the initial Temporary Assessment Orders and Court Assessment Orders.
23. Families are shifted from one Child Support Officer to another during this process and also Child Safety often changes the roles of Child Support Officers. Consequently, there is rarely any continuity of care for a particular family.
24. It is common for the Child Support Workers conducting the files at the initial point of contact (being the Court Assessment Order (CAO) or Temporary Assessment Order (TAO)) to be relatively junior and inexperienced.
25. This is not at all efficient.
26. The best Child Support Workers to be carrying out these initial assessments are the experienced Child Support Workers. Unfortunately, many of the junior Child Support Workers simply do not have the experience in applying the legislation and carrying out their responsibilities in order to make professional decisions in respect to children. This means often children who have been taken into care should not have been and children who do need to be taken into care, are not. There are frequently striking discrepancies between the decisions made at this point.
27. It is my opinion, based on my years of experience in this area, that only highly skilled and experienced Child Support Officers should be making those initial decisions.
28. This is particularly important because the taking of children into care, particularly for the first time, should be a decision that is made carefully with much common sense and experience being applied.
29. I have had newborn children taken from their parents because the parent has a past history with Child Safety that may be five to ten years previous. These decisions are being made, in my view, without keeping the best interests of the child as a paramount consideration.
30. Certainly there are less intrusive Orders that could be applied for and made in these situations to protect the child without separating a newborn baby from its mother.

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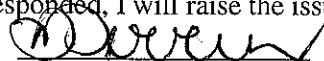


31. The less experienced staff should commence their time with Child Safety working with children on long-term Orders and work their way up to shorter-term Orders and then to making decisions about the urgent temporary Orders such as CAOs and TAOs. Alternatively, more inexperienced workers should be partnered with experienced workers to guide and mentor them.
32. Furthermore, the Child Support Workers who are given the responsibility for the shorter-term and urgent Orders should be given the autonomy to make decisions without needing to constantly reference back to their superiors.
33. It is my view that the superiors within Child Safety should be responsible for monitoring and reviewing files within the Child Safety as opposed to being the ultimate decision makers for every decision. I frequently had experiences of Child Safety workers (particularly in Emerald) telling me that their manager had said that they take a certain position. When questioned as to the rationale for these decisions, the Child Safety worker was unable to answer the question and I was referred to the Manager (who was, inevitably, unavailable).
34. The requirement that decisions have to be run past numerous levels before they can be made means that the efficiency levels within Child Safety are greatly reduced and that, with some of this bureaucracy removed and more autonomy given, particularly to experienced Child Support Workers, the efficiency within Child Safety would be greatly increased.

Effect of inefficiencies

35. The inefficiencies outlined above lead to numerous difficulties, not only for children and parents, but also for other stakeholders involved in the process.
36. There is no accountability in relation to the Child Safety files. For example, when discussing a file with the current child care worker, we will be told that they "don't know anything about that" because it was done when they didn't have the file. This can be in answer to queries about assessments for children, previous goals set for parents, previous outcomes promised to families etc. It is acknowledged that the fact that the files are so large may be one of the reasons that when they change hands between Child Safety workers, the incoming worker cannot discern what has happened on the file previously.
37. I also find it nigh on impossible to get a response out of Child Safety unless there is a Court date within 24 hours of my request.
38. Frequently, phone messages, emails and correspondence go un-responded to by Child Safety and responses are usually only received by our office on the day of a Court event. I believe that the fact that I get a response at all is because Child Safety know that if they haven't responded, I will raise the issue with the Court.

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39. The fact that Child Safety files change hands regularly means there is no continuity in the files and frequently it is impossible to get any useful response from the officer who has the conduct of the matter at any particular point in time.
40. I am an educated legal professional and I cannot get timely responses to my enquiries. Often we will get a message from "Jane" at Child Safety and when we return the call we are told that there are three "Janes" in the office and no-one can tell us which "Jane we are to be speaking to". The most frequent complaint from clients is that they can't get responses for queries they have. Often they say they have tried to ring Child Safety numerous times and no-one has returned their call. This would seem to go a long way to explaining why Child Safety files rarely proceed in an expeditious manner.
41. Even as a legal professional I find dealing with Child Safety a frustrating task, for many families the frustrations arising out of these inefficiencies mean that some families "give up" on ever being able to jump through Child Safety's "hoops" and walk away. This is not an acceptable outcome for the children of these families.

Benefits of removing inefficiencies

42. A reduction in the amount of paperwork and the consequent streamlining of the files would mean that children would receive better continuity of care even if files were moved between Child Safety workers.
43. The staff at Child Safety would be able to better use their time in assisting children and families which would increase the efficiency of the system.
44. Removing the high levels of bureaucracy within Child Safety and using staff according to their level of experience would create extremely positive outcomes for children for the following reasons:
 - a. Families in need of care could be identified earlier, reducing the level of resources which are ultimately required;
 - b. Decisions to place children in care would be made by more experienced staff. This would lead to earlier interventions in families who require assistance and prevent children who should not be taken into care suffering the trauma of being removed unnecessarily.
 - c. The organisation of supports and assistance for children and families would occur in a timely fashion which would foster positive attitudes within families requiring assistance.
 - d. Decisions as to whether children will need on-going care could be made more quickly and prevent long periods where the children are left in "limbo" in respect to their future.

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45. Greater efficiencies would also mean that staff could manage more files and decrease the amount of staff required to properly resource the system.


Resources

46. Notwithstanding what I see as significant levels of inefficiency within the child protection system, I believe that even if these inefficiencies were removed there may still be a need for higher staffing levels, particularly in qualified frontline staffing.
47. There are other areas in which further resources could be addressed some of which will be dealt with further on in my statement.
48. However, there is a significant shortage of external agency support within the child protection system which also contributes to difficulties in having matters finalised in a reasonable time frame.
49. There are many agencies and NGO's who provide services to families in the child protection system but the ability to access these services is extremely limited due to the number of families needing assistance and the inability of families to access assistance due to distance.
50. While an increase in efficiency of the system may lead to a decrease in the amount of families requiring high level intervention and make these supports more available to families who desperately need assistance, I still do not know that there would be sufficient assistance from these NGO's to meet the needs of families.
51. Certainly the distance issue is one which is prohibitive no matter what assistance is available as it is rare that families in the system have the finances or resources to enable them to travel regularly for assistance.
52. One of the clearest shortages of resources is a shortage of people willing to act as carers for children and, whilst I am aware that significant campaigns are run to attempt to engage more appropriate people to become carers, the lack of support and assistance to them often discourages interested parties to become carers or causes current carers to leave the system.
53. On numerous files the siblings in families are often separated and / or moved from placement to placement due to a lack of carers willing to have the care of children on a long term basis.
54. I know of many carers who will not care for children over a certain age as they are aware that these children are often very aware of how the system works and the carers do not wish to be put in a position where they have to defend themselves.
55. I acted for one couple who had the care of a child (whose parents were both intellectually impaired) since the child was only a few months old. The child was approximately 2 or 3

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years old when the carers were asked to take a sibship of 6 children into their care for emergency accommodation. The carers reluctantly agreed.

56. During the short time the sibship of six were in the care of my clients, the oldest child (a sixteen year old girl) made an allegation that the male carer had behaved in a sexually explicit manner towards her.
57. This family of children were known to our office and had a significant history with the child protection system. The child who made the allegation had a history of making such allegations. The allegation was also made when the child was expressing a desire to leave the care of Child Safety and move in with her boyfriend.
58. Whilst my client's took no issue with the removal of the sibship from their home, Child Safety also removed the youngest child from their care immediately.
59. Whilst this was extremely distressing for my clients, the Child Safety officers who made this decision, seemed to have no regard for the best interests of the infant child who had been in my clients care (without incident) since, effectively, birth.
60. My clients then paid for a criminal solicitor in Brisbane to defend the allegation made by the 16 year old and, to fund same, mortgaged (and ultimately had to sell) their home in order to pay for the defence. Just prior to the criminal trial commencing the child who had made the allegations recanted and the proceedings were dropped.
61. This lack of support for carers (both personally and financially) makes choosing to be a foster carer quite a minefield, particularly given that the children who come into care may and do already know how to manipulate the system to their advantage.
62. In regional areas children are often sent to live in a different town to their parents or siblings as a result of the lack of available carers in a given area.
63. The other significant area where children are adversely affected by a lack of resources is in the lack of sufficient numbers of people who are capable of carrying out supervised contact between the children in care and their parents or siblings.
64. How much contact occurs in any given matter is decided by availability of supervisors and not on what is in the best interest of the children keeping in mind the importance of these primary attachments.
65. Even in matters where the goal is re-unification of the family unit, supervised contact may only be able to occur once a fortnight for a short period of time. If the children are very young, studies show that this is not enough contact for the child to maintain a bond with their natural parents and often it is the case that the younger children, when moved back to their parents care, are moved back suddenly and the bond that they have with their carers is not able to be broken in an appropriate way,

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66. This sudden break in a bond between a young child and their primary carer has been shown in studies to cause damage to a child. In these matters the child can be removed suddenly from their natural parent and placed in care for a significant period of time and then, just a suddenly, be removed from the carer to another carer and/or back to their parent, so the child suffers several significant breaks in primary attachments at a very young age.

67. These difficulties occur as a direct result of their not being enough resources available for a child to be re-introduced to their family of origin in a staggered and child focussed way.

Lack of Funding

68. Our office, as at approximately the middle of 2011, stopped accepting Child Protection files due to the lack of Legal Aid funding for these files.

69. When I advised that we would no longer be practicing in this area, a senior Child Safety Officer from Child Safety commented to me words to the effect of "but what will happen when you're not there to act for the parents". She told me that she was concerned that the "Child Safety would just walk all over the parents with nobody there to protect them".

70. In the UK, child protection is considered one of the penultimate areas of practice and those who practice in the area are held in high regard and are much in demand.

71. In Queensland, practitioners who work in this field are not esteemed in this manner and certainly are often seen as second class practitioners.

72. This is indicative of the level of importance placed on child protection in Queensland. I have always felt proud to practice in this area and take my responsibility very seriously. Our office never worked on these file within the funding levels provided to our office.

73. It was common for me to do thousands of dollars of work on these files which our firm was never paid for due to the low level of Legal Aid funding.

74. With the high level of child protection files and separate representative files our firm had it actually meant the office was losing significant money on this area of practice.

75. Whilst we met with officials from Legal Aid and explained our predicament, nothing was done to rectify the situation and there was no choice but to cease practicing in this area.

76. When we would initially receive a file from Legal Aid the Court would often send us their file. These files could be 2 to 3 feet of paper and we would be giving 2 hours at Legal Aid rates to read the file. If we asked for the matter to be deemed complex we would have to write and respond to numerous pieces of correspondence from Legal Aid, often to no avail.

77. I work from an office situated in Yeppoon and we would be given funding for 3 mentions on a matter at \$360.00. We were not aided to negotiate or correspond with anyone

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between mentions and that \$360.00 included my time for travel, waiting, discussions with parties at Court and any correspondence or negotiations in between.

78. I was also given funding for one FGM (2 hours to include the mention date after the FGM) and 2 hours for a Court Ordered Conference (also including the mention date after the Conference was held).
79. I have never attended a Family Group Meeting that went for less than two hours and would be hard pressed to recall one that went for less than three hours. Court Ordered Conferences were more time efficient but two hours was usually allowed for the Conference alone.
80. When acting in child protection you are dealing with Child Safety which is (as outlined) inefficient at best. You have parent's that are generally uneducated and often have many social, psychological and, at times, medical problems which means that both communicating with them and managing their expectations is time consuming and can require considerable skill.
81. There are usually many people involved in a matter including school representatives, representatives from cultural support organisations and recognised entities, support people, carers, child safety workers, party solicitors and separate representatives.
82. It is impossible to negotiate and communicate with a multitude of stakeholders and assist parents in understanding the processes involved for the funding granted under the current funding guidelines.

Effect of Lack of Funding

83. Whilst it is easy to dismiss the lack of Legal Aid funding as greedy lawyers wanting more money I don't believe this is the case. Under previous Legal Aid funding guidelines our office was probably breaking even on these files, the new funding levels mean that our office was losing significant money by attempting to continue to practice in this area. This leads to a significant reduction in experienced practitioners working in the area of child protection.
84. The involvement of Lawyers actually acts to reduce the amount of funding required in the child protection system. Parties in child protection matters view Child Safety as "the enemy" and often it is the legal practitioners who can assist parties to participate effectively in the process.
85. This not only means better outcomes for children and families who can be reunified but reduces the level of Court intervention reunification is not realistic as a good practitioner will advise and encourage a client to consent to orders where their prospects of success are non-existent.

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86. This reduces the burden on Child Safety, the Courts, government and non-government agencies increasing the efficiency of the system.
87. Even the staff at Child Safety see the benefit of a lawyer's involvement in child protection matters either as a separate representative or party representative.
88. Essentially, the whole culture surrounding the role of legal practitioners in the child protection system and the system itself needs to change. The serious and complex nature of these matters should be treated with the resources and respect that the system requires. From a (completely altruistic) perspective, this area of law should be one which is given the highest priority in society as improvements in these areas will ultimately effect the level of resources required for many issues in society down the track. The areas where I would expect to see significant reduction in demand would be the child protection area itself, criminal law, provision of medical services (particularly mental health), reduction in incidences of domestic violence and possibly a decrease in the burden on the Family Law system.
89. Whilst I am aware I have conducted no research myself in these areas my statement above is made from my experience in these areas of practice over a long period of time, studies that have been conducted by reputable people on the effect separation from a primary care giver on children, the effect of children being raised in high-conflict relationships and the effects of abuse and neglect on children. All of these issues have serious outcomes for children, particularly in the long term and unfortunately our child protection system as it currently stands is, more often than not, increasing these problems, rather than decreasing them.
90. I am unable to comment on funding needs for Child Safety or other agencies as I am not aware of what the levels of funding are or how the funding is utilised.

3(c)(ii) – The current Queensland Government response to children and families in the Child Protection system including the appropriateness of the level of, and support for, frontline staffing

Experience and Training

91. The biggest difficulty that I face when dealing with Child Safety is the lack of training given to Child Safety Workers in respect to both the law and the requirements of the Act.
92. Frontline staff at Child Safety often, as will be noted in many of the examples I will give in this Statement, lose sight of the primary objectives of the Act being that their primary focus should be the best interests of the children.

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93. Frontline staff who are inexperienced require significant training in maintaining an objective role and supporting families so as to produce the best possible outcomes for children.
94. It is often the case that the Child Safety Workers become so entrenched in the matter that it feels that they are taking an adversarial role with the parents rather than a collaborative role.
95. Parents of children who have been taken into care will often feel animosity and anger towards Child Safety staff. This is not an extreme reaction but one which is to be expected when children are removed.
96. In my experience, however, if handled appropriately by a mature and experienced Child Safety Officer these perceptions held by parents (who are often lacking in education) can be overcome and parents can be assisted in understanding that the primary goal is to support and assist their family (whilst protecting the children).
97. If the Child Safety Officer can act in an objective and supportive way towards the parents the outcome for the children who are in care is often better.
98. For example, I acted for a client who was the mother five children one of which had ADHD. The mother had a very nervous disposition and often had heightened volume speech and certainly could speak very quickly. Her method of speaking also included a large amount of profanity, however, this was simply her normal speech pattern.
99. The mother freely admitted to both me and the Child Safety staff that she wanted to be a good parent but that she had no-one to teach her as she had been alone since she was 15.
100. The mother did not drink alcohol, smoke cigarettes or use illicit drugs.
101. She maintained a residence for the children and when she received Government payments for her children would often spend them by buying reasonable items for the family including washing machines, computer games for her children and the like. She was certainly a child focused mother who wanted very much how to learn to parent her children properly and was struggling greatly with the number of children she had and particularly with the child who had ADHD.
102. Whilst a number of Child Safety staff were placed in roles to assist this family only the most experienced managed to move the matter forward.
103. Inexperienced staff members found the mother's style of speaking difficult to handle and took offence. The staff acted as if they were "fighting" the mother for the care of the children rather than focussing on reuniting the family which was the goal of the Case Plan at the time.
104. A good example of this is, after a senior Child Safety officer had increased the mother's time with the children to such a point where the children were living all back under one

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roof with the mother, the child with ADHD made a complaint that his mother had threatened to "go down to the shop and buy a wooden spoon and smack him with it if he did not do what he was told". The newer (and more inexperienced Child Safety worker) immediately, and without notice to me as my client's legal representative or to my client, removed all five children from her care again.

105. The decision to move the five children was made on the morning prior to a Court mention however the children were not removed from my client's care until after the mention had occurred.
106. This action only led to anger and bewilderment from my client, the children were taken out of their home again, and ultimately all the good progress which had occurred with the family was undone within 24 hours.
107. When discussing my client with Child Safety workers about this matter they frequently cited the mother's aggression towards them as a reason the children should not be returned. All my attempts to explain that the fact that they did not like the way my client spoke to them was not a reason for them taking such a position fell on deaf ears.
108. Furthermore, the Child Safety workers could not see how their removal of the children (for what I believed to be no valid reason) would upset my client. The workers simply had no capacity to empathise with the position of the mother and adjust their judgement of her accordingly.
109. This adversarial approach taken by Child Safety in this instance is common particularly throughout less experienced staff members within Child Safety.
110. Much of the time Child Safety officers set unrealistic goals for a particular family. There focus seems to be on achieving a utopian household rather than focussing on ensuring there is simply an adequate level of safety within a household.
111. These families come from backgrounds of multi-generational abuse and neglect and are, for the most part, from the lower socio-economic levels of society. Notwithstanding, Child Safety officers frequently seem to require parents maintain "perfect" behaviour all of the time which is something that is impossible for any family to maintain.
112. Rather than supporting the mother's authority and assisting her by providing education on other available options, Child Safety simply removed all five children from the mother.
113. The goals set for families are, therefore, often unrealistic in the circumstances and parents rarely receive any encouragement or acknowledgement for changes they have successfully achieved. Responses to slip ups by the parents, on the other hand, are often swift and disproportionate to the set back.

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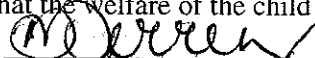
Effect of Training

114. I believe that ensuring the Child Safety staff are appropriately trained in what the Act requires of them and what their role is would improve the way situations like this were handled so that Child Safety worked in a more collaborative approach with the parents and their legal representatives (if they have any).
115. Whilst I accept the role of a Child Safety worker is difficult and much of the time thankless, like other frontline service providers (police, ambulance officers, nurses) they need to have a thick skin, and ability to be objective and to act in a way which is consistent with the objects of their governing legislation.
116. Whilst I am not saying that staff should have to tolerate overly abusive or aggressive and threatening behaviour and there should be no tolerance for same, staff need to be realistic and objective in their reactions to these behaviours and apply a level of tolerance and empathy in respect to same.
117. As an ex-registered nurse who has worked in the public system both in towns and at remote areas including aboriginal townships, I believe I can comment on this issue with some level of credibility. The ability to objectively assess peoples poor behaviour and consider whether this is normal behaviour for the person or out of character and whether it is appropriate to take the behaviour personally is a learned skill and staff need training and support in dealing with these issues if this ability is not one the possess naturally.

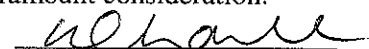
3(c)(iii) – Tertiary Child Protection interventions, case management, service standards, decision making frameworks and Child Protection Court and Tribunal processes

118. I have already covered a lot of points in respect to service standards the decision making framework with Child Safety itself.
119. Whilst the *Child Protection Act* sets out what the considerations are for the Court in these matters these primary considerations do not appear to be in the front of the mind of Child Safety staff.
120. Whilst there are some Magistrates who case manage Child Protections matters well in order to keep both Child Safety and the parents on track in moving towards finalisation of these matters, it is a particularly busy system and given the lack of funding now and the significant decrease in Legal Practitioners acting for parties in these matters, the Courts are very busy with these sorts of matters and have less capacity to case manage.
121. In respect to the legislation I believe it would be highly beneficial to use the Family Law framework in regards to primary and secondary considerations and with a strong emphasis that the welfare of the child must always be the paramount consideration.

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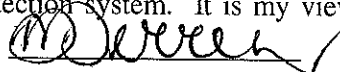


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122. I also believe that it needs to be more specifically set out within the legislation that psychological harm is a form of harm which would allow Child Safety to remove a child from care.
123. I was appointed an Independent Children's Lawyer in a very complex Family Law matter.
124. The parties were the child's mother (who was intellectually disabled suffering from hypothyroidism – or cretinism as it is more colloquially called). The child had been taken by the maternal grandmother who suffered from significant psychological problems which were difficult to diagnose due to her non-compliance with the Family Court proceedings.
125. Notwithstanding numerous requests by the Family Court for the Child Safety to intervene, they refused to do so.
126. Notwithstanding numerous requests by the Independent Children's Lawyer for the child to be removed from the care of the maternal grandmother, I was repeatedly told that Child Safety did not feel that the child was at any risk of harm.
127. This was despite my office providing to Child Safety all of the specialist reports setting out that the child was at risk of long term harm in the care of the maternal grandmother. I also supplied Affidavits and letters from me setting out that there were no other people within the family unit with whom the Family Court could place the child.
128. For the child's own legal representative to be, effectively, begging Child Safety to take a child into care due to concerns that the Independent Children's Lawyer could prove in respect to long-term psychological harm to the child and to not have Child Safety respond positively to these requests was extremely frustrating.
129. In my view, there are a number of issues that this particular case raised.
130. Firstly, the weight Child Safety places on the psychological safety of the child as opposed to the physical safety of a child. More clarification and weight being given to this consideration may be of assistance in this regard.
131. Secondly, the fact that Child Safety refused to intervene on Family Law proceedings where the child's own Lawyer and the Court was strongly requesting that Child Safety do so. It is my opinion that the Federal Magistrates Court or Family Court should have the capacity to Order the Child Safety in Queensland to intervene in proceedings where there is a child at risk and the Court has no other option in respect to where to place the child. At the very least, the Court should have the power to place the child in the care of the Child Safety and specify under which type of Order that the child should be placed.
132. I have significant experience in both the Family Court, Federal Magistrates Court and the Child Protection system. It is my view that children in care would be better served in

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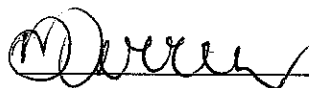
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Queensland if the Child Protection Court system was run more in line with the Federal Magistrates Court proceedings in children's matters.

133. In the Federal Magistrates Court there is a high level of case management and the welfare of the child is always a paramount consideration and this is reinforced as the case progresses through the Court system.
134. The Court forms in the Federal Magistrates Court are simpler and often Court proceedings are complicated in the Child Protection system as Child Safety does not understand the legalities and procedural norms of appearing in Court.
135. For example, Child Safety will file voluminous Affidavits in respect to each child (rather than one affidavit in respect of the matter). As the matter progresses, rather than filing simple updating affidavits they will redraft the initial affidavit and simply add updating material to the end of it and re-file.
136. It would also be beneficial for Child Support Workers to have ready access to a Solicitor (either in-house or otherwise) who is experienced in Child Protection law. This Solicitor could oversee and assist staff in preparing the documents for Court and to ensure that the documents were drafted correctly and in manner which reduces the amount of reading and documentation for the Court to consider and for parents to understand.
137. Often Affidavits prepared by Child Safety Staff contain hearsay evidence, opinion evidence and are repetitive and cumbersome to read.
138. They are not chronological and this only makes the proceedings more cumbersome in that they are difficult to read and respond to and the responses to their Affidavits often become cumbersome by necessity.
139. A competent and experienced Legal Practitioner would be able to guide Child Safety workers to ensure that they were maintaining a correct focus on the child's best interests while assisting families with these matters.
140. Court files in Child Protection matters are extremely large, particularly where there is a large sibship involved.
141. The Federal Magistrates Court process and procedures are more suited to dealing with the conflicts and issues that are involved in families including families where there are allegations of abuse.
142. The involvement of Family Consultants in the Court is also another service which could exist when Child Protection matters come before the Court particularly on an interim or urgent basis.
143. This would make interim decision making easier for Magistrates and hopefully lead to better outcomes for the children involved.

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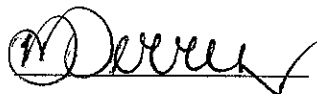
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Section 3(c)iv. – the transition of child through and exiting the Child Protection system

144. In my view, the most telling evidence of what the likely outcomes are for children who proceed through the Child Protection system is the fact that Child Safety considers that it is a risk factor if a parent of a child who has been brought into care was, in fact, a child in care themselves.
145. Whilst it has to be accepted that in dealing with complex family matters issues are often multigenerational, outcomes for these children will rarely (if ever) be perfect. The outcomes that are achieved for the children are often less than what could be achieved if the system was running effectively with proper resourcing and sufficient services, which could be sourced from non-government agencies.
146. In my experience often children in care end up entering the Youth Justice system at a fairly early age and, whilst it cannot categorically be said that a better Child Protection system would prevent this totally, I believe that a more efficient and effective system may reduce the incidence of this occurring.
147. As previously stated a lot of the outcomes come back to the lack of training and experience of the Child Safety staff dealing with matters.
148. There was one matter where I acted on behalf of the father in Child Protection proceedings. Similarly to one of the previous matters outlined, the father did not drink, he held a full-time job and had the care of his child who was a young boy.
149. Whilst the father most definitely needed assistance in appropriate parenting the adversarial approach taken by Child Safety led to a situation where, ultimately, it was the child who was making decisions on his own behalf.
150. Child Safety workers tend to take the child's word as the absolute truth and often don't give much, if any, credence to the position of the parent.
151. The father was told that if the child was to be returned to his care he could not physically discipline the child. He complied with this request and would then verbally discipline the child. Whilst, in my opinion, there were probably times when the father inappropriately verbally disciplined the child he did not receive any support or training in this area.
152. Once again, the child was taken from him and placed into care after a complaint of inappropriate discipline and shortly thereafter entered the Youth Justice system for petty crimes. I often acted for the child as duty lawyer on these occasions.
153. When the child began absconding from his carers, as they were also unable to control him, Child Safety, effectively, washed their hands of the child saying there was nothing they could do as the child was non-compliant with their attempts to keep him in care.

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154. The intervention of Child Safety did not assist the father in understanding appropriate discipline of the child from a very young age and therefore once the child realised that, effectively, he could control his father by simply complaining to the Child Safety if his father did something he did not like, the child could effectively undermine the father's authority completely.
155. Unfortunately, this knowledge led to the child also undermining his carers to the point where my last contact with the child, who I have acted for numerous times in the Youth Justice system, was that he lived at no fixed address and he comes before the Court on a not frequent but regular basis for petty crimes such as unauthorised dealing with shop goods, trespassing, stealing and the like.
156. It is highly likely, in my view, that this child will eventually graduate to more significant crimes and this is not an appropriate outcome.
157. If the Child Safety officers in this matter had acted more appropriately and if they had the resources to be able to have some longer-term in-home assistance for the father then perhaps the father's authority over the child would not have been undermined to the point where the child does not take any responsibility for his actions.
158. My experience in the Youth Justice system, however, is that the Youth Justice system is a fairly effective system particularly when it comes to young offenders who do have familiar support and parents who are willing to take responsibility for their children's actions.
159. Unfortunately for the children who do not have family supports (such as children who have been in care) or children whose parents do not take responsibility for their children's behaviour or discipline the children in any way, whilst the Youth Justice system does all it can to assist these children it is not as likely to be an effective system for children who don't have the reinforcement of their family unit.


Section 3(d) – reviewing the effectiveness of monitoring, investigation, oversight and complaint mechanisms for the child protection system and identification of ways to improve oversight and public confidence in the Child Protection system.

160. In my experience I have had cause to participate in Children Services Tribunal Hearings in respect to decisions made by Child Safety. This review process has now been taken over by the QCAT jurisdiction and, whilst I have had no cause to appear before QCAT on a Child Protection decision in my view this system worked well when it was under the auspices of the CST. I can only assume it continues to do so under the auspices of QCAT.

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161. The only difficulties with review proceedings in respect to child protection proceedings is, once again, the cumbersome nature of the documents which are filed by Child Safety in respect to these matters. Training and better documentation would assist in these matters being dealt with in a more expeditious fashion. Also, the lack of funding for legal representation also means the proceedings are not conducted as expeditiously as they should and often, due to the lack of representation the outcomes tend to be one sided as parents, mostly, do not have the intelligence, to appropriately understand and participate in the process.
162. In respect to public confidence issues unfortunately members of the general public who have no cause to have contact with the Child Protection system I believe are relatively apathetic about the system.
163. However, for parties who appear in this jurisdiction as parents it is my view that public confidence in these people could be increased by having the focus of Child Safety being on support and assistance to families, particularly for intervention measures, so that they are seen as a helpful entity as opposed to an adversarial one.
164. Also, improving efficiencies so that matters are dealt with and final decisions or Consent Orders reached as quickly as possible would also assist in increasing confidence in this system.
165. Due to the high level of bureaucracy outlined above and cumbersome record keeping requirements of Child Safety these processes are often significantly longer than they should, in fact, be.
166. As previously stated, this could be improved by a more case managed approach such as that taken by the Federal Magistrates Court.

Declaration

This written statement by me dated 16-10-12 and contained in the pages numbered 1 to 19 is true and correct to the best of my knowledge and belief.

 Signature
Signed at ROCKHAMPTON this 16th day of October 20 12

Witnessed:

 Signature
Name Karen Charles Rank CDec Reg. No. 98536