QUEENSLAND COMMISSION OF INQUIRY INTO CHILD PROTECTION

COMMISSION FOR CHILDREN AND YOUNG PEOPLE AND CHILD GUARDIAN

AFFIDAVIT

I, **ELIZABETH FRASER** of Level 17, 53 Albert Street, Brisbane in the State of Queensland, being the Commissioner for Children and Young People and Child Guardian, affirm:

1. The purpose of this statement is to inform the Queensland Child Protection Commission of Inquiry (the QCPCOI) about:

   1.1. How the Terms of Reference outlined in section 3 of the *Commissions of Inquiry Order (No. 1) 2012* relate to the Commission for Children and Young People and Child Guardian (the CCYPCG);

   1.2. How the recommendations of the *Commission of Inquiry into Abuse of Children in Queensland Institutions* (the Forde Inquiry) and *Protecting Children: An Inquiry into the Abuse of Children in Foster Care* (the CMC Inquiry) have been implemented from my perspective as the Commissioner for Children and Young People and Child Guardian; and

   1.3. The relative strengths and/or weaknesses of the current child protection framework from my oversight perspective, to assist the QCPCOI in charting a new road map for Queensland's child protection system over the next decade.

2. I advise that the CCYPCG will be lodging a submission with the Commission of Inquiry in regard to the specific activities undertaken to implement the recommendations of the Forde and CMC inquiries and to demonstrate the ongoing need and value of the oversight model established by these inquiries.

3. I also propose to provide a separate submission on behalf of the Child Death Case Review Committee (CDCRC) in my capacity as chair of this Committee.

AFFIDAVIT
Filed on behalf of the
Commissioner for Children and Young People and Child Guardian
Level 17, 53 Albert Street
BRISBANE QLD 4000
Ph: 07 3211 6700
Fax: 07 3035 5900

Background

4. I was appointed to the role of Commissioner for Children and Young People and Child Guardian on 17 January 2005 as established by section 14 (1) of the *Commission for Children and Young People and Child Guardian Act 2000* (the CCYPCG Act).

5. Section 15 of the CCYPCG Act specifically provides that as Commissioner, I am to control the CCYPCG with my functions and powers set out in Chapter 2, Part 2 of the CCYPCG Act. Further, the Assistant Commissioner is responsible to me under section 19 for the proper performance of my Child Guardian functions.

6. Section 22 (1) of the CCYPCG Act outlines that as Commissioner I must act independently and in a way that promotes the rights, interests and wellbeing of children and that I am not under the control or direction of the Minister with portfolio responsibility for the CCYPCG Act, who, in accordance with *Administrative Arrangements Order (No. 4) 2012*, currently is the Minister for Communities, Child Safety and Disability Services.

The Queensland child protection system

7. The rate of child protection intakes can be viewed as a barometer of the health of our community. It reflects the quality and success of our broad functioning as a society and, to an extent, the role state and national governments play in supporting this functioning.

8. Most of Queensland's 1.1 million children and young people live in a family environment where little or no external services are required, beyond those that are universally available from state and federal agencies, to keep them safe and well and see that they achieve their potential in life. A fact supported by the rate of entry of Queensland children and young people into out-of-home care, which as at 30 June 2011 was 7.0 per 1,000 children (below the national average of 7.3 per 1,000).

9. Other children and young people live in circumstances where parental functioning is diminished, sometimes due to multiple co-existing factors, to the extent that it places children at risk of harm and of requiring statutory child protection services. For these families, targeted and effective prevention and early intervention services are essential to support parenting, if it is to meet a minimum standard that is acceptable to the community and will enable the children to safely remain in their home environment.

10. Families needing these services may find that the combination of state, national and funded non-government responses deliver a fragmented mix of services, across a patchy infrastructure. The result being an inability to access the required services, leading to an escalation of risk factors and, ultimately, increased risk to children.

11. Children's rights have long been recognised and entrenched within Australia, and by ratifying the United Nations Convention on the Rights of the Child (in 1990), Australia committed to ensuring that an obligation was placed on those in power to take special account of children's needs, well-being and vulnerabilities. The principles of the Convention are reflected in the *Child Protection Act 1999* and the CCYPCG Act.

12. The drive for change and improvement in child protection over the past decade has arguably been reflective of increasing community expectations and public discussion as to the critical task of raising children in safe and supportive care environments. Heightened community awareness of what constitutes harm and its effects, combined with increased capacity to recognise and report concerns about the treatment of children, including mandatory reporting by specified service providers, has significantly increased the flow of child protection referrals for assessment.

13. While ongoing work is clearly required to maintain current service delivery outcomes and improve critical areas of wellbeing, the next challenge must be to meet, and preferably exceed, the legislative and community expectations about the delivery of support to families where their treatment of children places them at risk, including escalating risk, of harm.

14. Currently Queensland's child protection system is required to cater to the needs of some of the State's most vulnerable and disadvantaged children and young people. It requires the Government, through its Child Safety Officers, to act as a substitute parent in response to complex, and often confounding, problems that have origins in the privacy of people's homes. As a result, children who enter the child protection system are vulnerable and disadvantaged for a variety of reasons that may have been in existence since birth, including intergenerational abuse, drug and alcohol misuse, mental health issues and/or poverty.

15. Consequently, the suite of services that the child protection system must deliver spans from referral to early intervention and prevention services to assist family functioning, through to long term statutory interventions to help keep children safe and restore their well-being. All statutory interventions incorporate a minimum range of mandated services essential in helping children and young people cope with the abuse that triggered their entry to care and in re-establishing their wellbeing and expected life outcomes.

16. As a result of the many and often complex needs of the children and young people known to the child protection system, a myriad of service providers may be involved, including the Department of Communities, Disability Services and Child Safety (as the lead agency responsible for administering the *Child Protection Act 1999*), other Queensland Government agencies (such as, the Department of Education, Training and Employment, Queensland Health and the Queensland Police Service), carers, non-government service providers and their peak bodies. The roles and services of these agencies and organisations have evolved over time in response to the changing needs of children, differing policy approaches, machinery of government changes and prior commissions of inquiry. It is widely recognised and accepted that although the Department of Communities, Disability Services and Child Safety

is the lead agency, it requires significant support and collaboration to successfully administer its responsibilities under the *Child Protection Act 1999*.

17. Once children are placed in the statutory child protection system, the State is required by law to not only ensure that children are kept safe, but also that they are provided with the necessary supports and services to allow them to enjoy a standard of wellbeing, education and health comparable to their peers outside of the system. The service delivery needs of children in the statutory child protection system vary widely (depending on the reasons they were placed in the statutory system in the first place as well as their own individual resilience) and will change over time. For this reason, individual case assessment and planning as to service needs is essential and required by the *Child Protection Act 1999*.

18. A critical responsibility of the child protection system is to ensure children do not inappropriately enter the system and transition out of the system at the earliest opportunity. High quality assessments are needed to ensure that there exists sufficient support for the safety and well-being of children either to remain with their family, or after they are reunified, or have grown into adulthood.

19. The statutory child protection system can therefore be viewed across three key service domains:

    19.1. Firstly, high quality assessment and intervention decisions are required up-front;

    19.2. Secondly, for those children in out-of-home care, high quality coordinated services that meet their individual needs must be provided; and

    19.3. Finally, evidence based decisions to support reunification and timely and inclusive planning for transitions to independence are essential.

20. In addition to helping keep children safe and restoring their wellbeing, a properly administered statutory child protection system can interrupt intergenerational cycles of abuse and neglect, meaning it has potential to not only serve the immediate needs of the child, but also serve as a major prevention and early intervention initiative for generations to follow.

Role of CCYPCG in child protection system

Overview

21. The CCYPCG sits distinct and apart from the service providers within the Queensland child protection system. The CCYPCG provides the key independent external oversight mechanism for the Queensland child protection system and also researches, reports on and advocates in relation to how children in the broader community are fairing, including the factors affecting their vulnerability.

22. The Department of Communities, Child Safety and Disability Services has responsibility for the delivery of services to children and young people under the *Child Protection Act 1999,* whereas the CCYPCG has a legislative mandate to provide independent oversight of the child safety and youth justice systems in Queensland. The legislative basis for the CCYPCG's role and functions are set out further in paragraphs 46 to 52 below.

23. The role the CCYPCG plays for children and young people in the child protection system helps ensure, for government and the community, that circumstances of abuse such as those that gave rise to the Forde and CMC Inquiries will be identified and addressed should they arise.

24. The need to maintain the dignity and privacy of children and young people who have been subjected to significant abuse and neglect is critical and this is achieved, in part, through broad and encompassing legislative confidentiality provisions. These provisions, while necessary to protect the confidentiality and privacy of those involved, enable service providers to communicate, but effectively close the service system off from outside scrutiny. In these circumstances, it is essential that child focused oversight be undertaken by content experts, including staff with high-level expertise in a range of areas including, but not limited to, investigations, child protection, child development and child health, consistent with the recommendations of the CMC Inquiry in this regard.

25. The manner in which the CCYPCG discharges its statutory oversight role ensures the confidentiality of highly sensitive information is maintained, and in doing so the dignity and privacy of those children and young people who have been abused and neglected. It also ensures service providers are able to clearly understand and action their statutory functions, but within a framework where they are held accountable for their obligations and any failings, both individual and systemic.

26. The value of and need for external and independent oversight of service delivery in the child protection system cannot be overstated and has been identified historically in Queensland, particularly through the various Inquiries into the child protection system, and most recently supported by the inquiry into the child protection system in Victoria (the *Protecting Victoria's Vulnerable Children Inquiry 2012*). The recent Victorian Inquiry highlighted the importance of appropriate systemic monitoring and evaluation mechanisms and oversight. It also highlighted the need for such external monitoring to have functional independence from the agencies whose services are subject to the oversight jurisdiction.

Community Visitor program

27. A key example of the distinction between oversight and service delivery in the child protection system is the difference between Department of Communities, Child Safety and Disability Services' Child Safety Officers and the CCYPCG's Community Visitors. Child Safety Officers carry out direct service delivery functions under the *Child Protection Act 1999,* while Community Visitors monitor these services in accordance with statutory requirements and specified service standards, provide safety alerts and advocate on behalf of the children when issues arise. Accordingly, Community Visitors provide an

essential check and balance on Child Safety Officers' service delivery.

28. The Community Visitor role requires regular and frequent visits to children and young people in out-of-home care. The objective of these visits is to build trusting relationships with the children and young people and verify their safety and well-being needs are being met. The visits provide a value for money audit role of a critical area of statutory service delivery that attracts significant investment and risk.

29. Where Community Visitors identify serious issues, alerts are raised immediately with either the Department or Queensland Police Service. Resolution and advocacy for children on less urgent issues is attempted locally with service providers in the first instance.

30. Further details on the role and functions performed by CCYPCG Community Visitors are outlined in a summary document (attached hereto and marked Annexure "A") and the position description (attached hereto and marked Annexure "B").

Complaints resolution

31. The CCYPCG receives and responds to complaints about any government or non-government service provided (or not being provided) to young people in the child safety and/or youth justice systems.

32. In responding to complaints, the CCYPCG advocates and negotiates with service providers to improve outcomes for individual young people. In addition, these complaints help the CCYPCG to monitor trends and advocate for changes in policies, practices or legislation to improve outcomes for Queensland children.

33. Last financial year, 4,621 complaint issues were actioned. Of these 2,198 were issues identified and escalated by Community Visitors due to their seriousness or inability to be resolved locally, while the remaining 2,423 issues were raised with the Complaints team by the general public.

34. The CCYPCG complaints function links and interfaces with the Community Visitors to centrally manage the escalation of serious issues and to take complaints from members of the public.

Collection of empirical data to facilitate systemic review

35. A further example of how the CCYPCG fulfils its unique role in the child protection system is by creating and maintaining accountability and transparency of service delivery at the systemic level. This has been achieved through the independent triangulation of data drawn from the CCYPCG's primary engagement (research) with children and young people in out-of-home care, the CCYPCG's own administrative data generated by its Community Visitor and Complaints functions and accessing the administrative data of the multiple agencies providing direct child protection services.

36. The powers for obtaining this data were included in the CCYPCG Act following the CMC Inquiry and have been used effectively through establishing formal Monitoring Plans with each relevant agency (which are attached hereto as Annexure "C").

37. The way in which this data is prioritised and presented is critical. To manage the flow and analysis of data and information collected through the CCYPCG's Child Guardian functions, the CCYPCG has established comprehensive information management systems and processes.

38. In 2005 the CCYPCG conceptualised and agreed with service providers and stakeholders on the Child Guardian Key Outcome Indicators for the child protection system. These 10 Key Outcome Indicators focus on the areas of greatest importance for children and young people in out-of-home care; in doing so they create essential transparency and accountability of service delivery and provide a mechanism for early alert of system failure. Providing this system level view of performance publicly also enables the Government, stakeholders and the community to be kept informed of both developments and failings in the child protection system and to readily contextualise any individual critical incidents within broader system performance.

39. The CCYPCG has actively published as much relevant information as possible about the outcomes experienced by children and young people, much of which is unique. This type of data, and regular reporting, was not available prior to the implementation of the CMC Inquiry's recommendations in 2004. Further, it is not otherwise available from any service provider. The fact that it is prepared by an independent statutory body means that it provides unbiased and credible data to facilitate continuous improvement of services, and also to establish public confidence in an otherwise closed system. Further information about the recent outcomes evident in the data produced by the CCYPCG is outlined in below.

Employment screening (Blue Card system)

40. Although not forming part of the Child Guardian function, the CCYPCG's Blue Card regulatory system complements the statutory oversight model through requiring appropriate management of risks to children and young people in service environments, including by criminal history screening of persons wanting to work with children and young people. The influence of the Blue Card system in contributing to a reduction in the rate of substantiated harm of children in out-of-home care, by preventing unsuitable individual from working as carers or living in care households, is evidenced below in paragraphs 84 to 85.

Child Death Case Review Committee (CDCRC)

41. The CDCRC is a multi-disciplinary committee made up of between five and seven members with expertise in fields including child health, forensic pathology, investigations and child protection.

42. It has a statutory function to oversight departmental reviews of the service delivery provided to children and young people who have died and were known to the child safety service system in the three years prior to their death. Its primary focus is to identify shortcomings in the child safety service system implicated in a child's death. The Committee also provides a valuable contribution to broader policy and practice development and child death prevention strategies.

43. In my role as Commissioner, I chair the CDCRC and the Assistant Commissioner is also a statutory member of the Committee. The remaining members are appointed by the Minister with portfolio responsibility for the CCYPCG Act.

44. The occurrence of child protection system failure as a factor in child deaths was highlighted by the Queensland Ombudsman Office in its 2001 and 2003 investigations into the deaths of Brooke Brennan (aged 3) and baby "Kate" (aged 10 weeks). These investigations highlighted critical failings in both service delivery and the Department's internal child death review processes. The Ombudsman's findings and recommendations were adopted, contextualised and strengthened in the findings of the CMC Inquiry, which established the CDCRC.

45. The CDCRC continues to play an important role in building public confidence that relevant action or inaction will be independently reviewed to facilitate the identification of child protection service system failures as a risk factor in deaths

Legislative basis for CCYPCG's role in the child protection system

46. In relation to children in the child protection system, the CCYPCG is legislatively required to:

    46.1. Monitor, audit and review systems, policies and practices relating to child protection services. Section 23 of the CCYPCG Act describes the way in which I must perform my monitoring functions. Chapter 3 of the CCYPCG Act details my specific monitoring powers and the required processes around the making of recommendations to improve future service delivery to children in the child protection system. Section 18 of the CCYPCG Act outlines the CCYPCG monitoring functions and these include:

        46.1.1. Monitoring, auditing and reviewing the systems, policies and practices of service providers that affect children in the child protection system (as per section 18 (1) (a) of the CCYPCG Act);

        46.1.2. Monitoring, auditing and reviewing the systems, policies and practices of the Department responsible for administering the *Child Protection Act 1999* (currently the Department of Communities, Child Safety and Disability Services) and licensees under that Act (as per section 18 (1) (b) of the CCYPCG Act); and

46.1.3. Monitoring compliance by the Chief Executive of the Department of Communities, Child Safety and Disability Services with the Indigenous Child Placement Principle as it is articulated in section 83 of the *Child Protection Act 1999* (as per section 18 (1) (c) of the CCYPCG Act).

46.2. Resolve and investigate complaints about services to children in the child protection or youth justice systems. Section 17 (1) (a), (b) and (d) of the CCYPCG Act outline these functions with the details about the associated powers and required procedures contained in Chapter 4 of the CCYPCG Act. This Chapter also outlines in Part 4, Division 6 how reports prepared under the CCYPCG Act may be tabled in Parliament;

46.3. Administer a statewide visiting program for children in out-of-home care, residential services (including authorised mental health facilities) and youth detention. My function in relation to this is outlined at section 17 (1) (o) of the CCYPCG Act and the detailed provisions about the appointment of Community Visitors, their functions and reporting requirements when they visit children is contained in Chapter 5 of the CCYPCG Act;

46.4. Participate in and support the Child Death Case Review Committee (CDCRC) (as established under Chapter 6 of the CCYPCG Act - Child deaths, Part 1 Child Death Case Review Committee) in the following ways:

46.4.1. The Assistant Commissioner and I are members of the CDCRC (as required by section 120 (1) (a) and (b) of the CCYPCG Act);

46.4.2. I am the Chairperson of the CDCRC (as required by section 127 (1) of the CCYPCG Act); and

46.4.3. The CCYPCG provides administrative support to the CDCRC to ensure that it can carry out its functions effectively and efficiently (as required by section 142 of the CCYPCG Act).

46.5. Apply to the Queensland Civil and Administrative Tribunal (QCAT) for a review of a decision where I am dissatisfied with a decision made about a child under the *Child Protection Act 1999* and I have been unable to resolve my issues with the Director-General of the Department of Community Services, Child Safety and Disability Services. My function in relation to this is outlined under section 17 (1) (e) of the CCYPCG Act and Chapter 10, Part 1 defines what constitutes a reviewable decision and outlines when I may apply for a review of a reviewable decision.

47. The functions outlined in paragraph 46 above will be referred to in the remainder of this statement as the CCYPCG's 'Child Guardian' functions (as contemplated by section 17 (2) of the CCYPCG Act).
48. Additionally, the CCYPCG has a legislated role to screen and monitor people

who seek to work in organisations regulated by the blue card system and work with those organisations to promote compliance with their regulatory obligations. The relevant functions are outlined in section 17 (1) (q), (r) and (ra) of the CCYPCG Act, with Chapter 8 containing provisions about applying for and receiving a positive notice (a "Blue Card"), the decision making process and relevant review rights. These functions will be referred to in the remainder of my statement as the CCYPCG's 'Blue Card Screening' functions.

49. A subset of the CCYPCG's Blue Card Screening functions includes screening and monitoring of employees, organisations and government agencies who deliver services to children in out-of-home care.

50. The following sections of Schedule 1 of the CCYPCG Act define the categories of persons who are relevant to the provision of services falling within the child protection system:

    50.1. Section 1 – Residential facilities (note that this category also captures other individuals working in or operating residential facilities which do not fall within the scope of the *Child Protection Act 1999*); and

    50.2. Section 14 – Care of children under the *Child Protection Act 1999*;

    50.3. Section 24 – Businesses relating to licensed care service under the *Child Protection Act 1999*.

51. The Blue Card Screening functions that relate to the child protection system are outlined above will be referred to in the remainder of my statement as the 'Child Protection Blue Card Screening functions'.

Legislative role for CCYPCG in relation to all children

52. In relation to all children (including those in the child protection system), the CCYPCG has a legislated role to:

    52.1. Monitor and review laws, policies and practices that relate to the delivery of services to children (or otherwise impact on them) and promote those which uphold the rights, interests and wellbeing of children (under section 17 (1) (i) and (j) of the CCYPCG Act);

    52.2. Assist children to participate in matters that may affect them through:

        52.2.1. Promoting the establishment of accessible participation mechanisms by service providers (section 17 (1) (h) of the CCYPCG Act);

        52.2.2. Encouraging the development and coordination of advocacy and other support services for children (section 17 (1) (k) of the CCYPCG Act);

        52.2.3. Promoting awareness among children about advocacy entities, complaints agencies and other relevant entities (section 17 (1) (l) of the CCYPCG Act);

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52.2.4. Conduct, coordinate, sponsor and participate in research into matters affecting the safety and wellbeing of children and promote an understanding of, and informed public discussion about the rights, interests and wellbeing of children (section 17 (1) (m) and (n) of the CCYPCG Act); and

52.2.5. Record, analyse, research and report on information about the deaths of all children in Queensland (section 17 (1) (p) of the CCYPCG Act).

53. These functions enable the CCYPCG to promote how children and young people are faring in comparative national contexts and highlight factors influencing their vulnerability across a range a well-being measures, including their health, education, mortality, crime and justice. The CCYPCG publishes its findings in two key annual reports: the Snapshot of Queensland children and young people (the latest Snapshot 2011 report is attached hereto and marked annexure "D") and the Child Death Annual Report series (the latest Annual Report: Deaths of Children and Young People in Queensland 2010-11 is attached hereto and marked annexure "E").

Relevance of CCYPCG to the QCPCOI

54. The CCYPCG is relevant to the QCPCOI Terms of Reference in five distinct ways:

54.1. It undertakes independent analysis of the need and demand for child protection services in Queensland, including trends and patterns in the factors influencing the vulnerability of children, and is able to highlight possible links to child protection system capacity issues;

54.2. Evidence gathered and created through its Child Guardian and other functions may inform the QCPCOI about the performance of the child protection system;

54.3. Analysis of the evidence gathered and created has triggered systemic advocacy and change, including formal recommendations under the CCYPCG Act, and the outcomes of these activities may provide the QCPCOI with insights into the functioning and responsiveness of the child protection system to continuous improvement demands and help highlight priorities for reform;

54.4. The CCYPCG contributes to the safety of children in the child protection system through the Child Protection Blue Card Screening functions; and

54.5. The effectiveness of the CCYPCG needs to be considered by the QCPCOI in the context of progress it has made in monitoring services and reporting on outcomes for children and young people, and its contribution to building public confidence in the child protection system. The role and functions of the CCYPCG also need to be considered in terms of the contribution that will be required toward oversight of the status of children, their relative vulnerabilities

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and the performance of the child protection system across the next decade.

55. I will now specifically outline the nature of my interest in each of the Terms of Reference of the QCPCOI. The CCYPCG's recommendations in relation to each Term of Reference will be contained in the CCYPCG submission.

Term of Reference 3 (a): Review the progress of the implementation of the recommendations of the *Commission of Inquiry into Abuse of Children in Queensland Institutions* (the Forde Inquiry) and the Crime and Misconduct Commission Foster Care Inquiry (the CMC Inquiry)

56. This Term of Reference is relevant to the CCYPCG because implementation of ten of the Forde Inquiry recommendations and eight of the CMC Inquiry recommendations substantially altered the CCYPCG's role and functions.

57. These recommendations have all been implemented and, in combination, have established a model of independent oversight for children and young people reliant on the child protection system comprising individual and systemic monitoring and advocacy. This now provides a robust system of safeguards for some of Queensland's most vulnerable children and young people. To date, this has helped to prevent the recurrence of historical failures evidenced through the Forde and CMC Inquiries. This has enabled the current QCPCOI to be focused on system effectiveness and planning for the next decade, rather than responding to crisis, including the likely demand upon the child protection system identified by community and mandatory reporting.

58. The relevant recommendations of these inquiries are attached hereto and marked annexure "F".

Positive outcomes of the implementation of Forde and CMC Inquiry Recommendations

59. The oversight model created following implementation of recommendations and responses to findings of the Forde and CMC Inquiries provides for:

    59.1. Systemic oversight through the provision of information on the comparative needs of prevention and early intervention and statutory services:

        59.1.1. The capture and analysis of ongoing contact with children in out-of-home care through the statewide visiting function. This means that early advice is received and reported about service delivery issues that are impacting on outcomes for children (either broadly or in particular groups);

        59.1.2. Seeking, seriously considering and promoting the views and voices of children and young people in out-of-home care in a way that enables them to be included and valued in the assessment of service delivery; and

59.1.3. In-depth monitoring through the conduct of audits and investigations and the analysis of data and other system level information, which may then be reported publicly and/or be actioned through formal recommendations under the CCYPCG Act.

59.2. Individual oversight of service delivery issues through:

59.2.1. The statewide visiting and complaints resolution functions, which provide cost effective informal (local) advocacy to service providers on behalf of children; and

59.2.2. When required, the escalation of more significant and serious issues with the Chief Executive of the Department of Communities, Child Safety and Disability Services or exercising an appeal right of a 'reviewable decision' to QCAT.

Areas for improvement to the oversight model remaining, following the implementation of Forde and CMC Inquiry Recommendations

Independence

60. Prior to the Forde Inquiry, the former Children's Commission reported to the (then) Minister for Families. As an outcome of the Forde Inquiry, a change to administrative arrangements occurred resulting in the newly created Commission for Children and Young People reporting to the Premier of Queensland and its attachment to the Department of the Premier and Cabinet (as per recommendation 25 of the Forde Inquiry).

61. Subsequently, *Administrative Arrangements Order (No. 4) 2012* outlined that the Minister to be accountable for administering the CCYPCG Act is the Minister for Communities, Child Safety and Disability Services.

62. To ensure independence, to reduce conflicts of interests and to enhance public confidence in the accountability of the child protection system, I consider that it is necessary for the CCYPCG to again be administratively responsible to a central agency, which has no service responsibility related to the CCYPCG's oversight jurisdiction. In addition to managing potential conflicts, restoring the administrative arrangement post-Forde Inquiry would better enable the CCYPCG's broader responsibility for all Queensland children and young people to be linked to core central agency policy objectives related to the provision of quality universal services, such as health and education.

63. An additional measure, to support public confidence in the oversight of the child protection system, would be to mandate the regular review of the CCYPCG (as presently exists within the *Ombudsman Act 2001* and the *Crime and Misconduct Act 2001*). This would ensure the mandate and focus of the CCYPCG is considered, reviewed and set out in a formalised agenda, ensuring its ongoing relevance to current government policy.

Inconsistent jurisdiction over the child protection and youth justice systems

64. The implementation of the Forde and CMC recommendations inadvertently created inconsistent jurisdiction for the CCYPCG in relation to children in the child protection and the youth justice systems. Two examples of this are as follows:

    64.1. The CCYPCG may take a complaint about a child in the youth justice system and is required to visit all children in youth detention, however may not conduct a monitoring activity about service delivery to a group of children in the youth justice system unless the services in question may impact on children in the child protection system. In contrast, the CCYPCG may perform all of these functions for children in the child protection system; and

    64.2. The CCYPCG is required to visit children in youth detention, but is not legislatively mandated to visit 17 year olds who reside in adult correctional centres.

65. To address these inconsistencies, consideration should be given to amendments to the CCYPCG Act to establishing greater consistency in the CCYPCG jurisdiction so that all Child Guardian functions may be used for children in the child protection and youth justice systems.

66. These two categories of children are highly vulnerable and often share similar contexts of abuse, neglect and disadvantage, so should have the same oversight and accountability mechanism available to them.

67. It is more efficient and effective for the CCYPCG to have the full suite of Child Guardian functions available to use for children in youth justice system as it can select the most appropriate to use according to a particular situation.

Term of Reference 3 (b): Review of Queensland Legislation about the protection of children, including the *Child Protection Act 1999* and relevant parts of the *Commission for Children and Young People and Child Guardian Act 2000*

68. The current model of child protection system oversight provides a robust system of safeguards for Queensland children and young people in the child protection system. However, I have identified scope for amendments to the CCYPCG Act to create:

    68.1. Better consistency and clarity around the legislative provisions for providing reports and recommendations about Child Guardian functions to Parliament and Ministers.

        68.1.1. Currently, the CCYPCG has different requirements about the reporting, natural justice processes and the provision of recommendations across its Investigations, Monitoring and Child Death Review functions;

68.1.2. These provisions would be greatly improved if they were made consistent and there was a requirement for the CCYPCG to report annually to Parliament about its Child Guardian functions (similar to the annual reporting requirements for the CDCRC under section 141 or the annual report requirements for the CCYPCG child death review function under section 146 of the CCYPCG Act); and

68.1.3. This would result in an independent annual report on the child protection system being mandated for tabling in the Parliament and this would enhance oversight, transparency and accountability.

68.2. Efficiencies for the Complaints function under Chapter 4 of the CCYPCG Act, with a view to improving access for disadvantaged complainants and removing unnecessary formality by:

68.2.1. Removing the requirement for adults to provide complaints in writing under section 58 of the CCYPCG Act; and

68.2.2. Providing a preliminary information gathering power to allow the CCYPCG to make reasonably necessary inquiries to determine whether a complaint should be investigated and requiring the principal officer of an agency to give the CCYPCG reasonable help in the conduct of the preliminary inquiry (as is the case in section 22 of the *Ombudsman Act 2001*).

69. Consideration should also be given to amendments to the *Child Protection Act 1999* to include a definition of 'best interests of the child', particularly given the significance of this phrase in guiding many major decisions about children and young people under both the Child Protection and CCYPCG Acts.

70. This Term of Reference is also relevant to the CCYPCG as, through its Child Guardian function and interactions with the Department of Communities, Child Safety and Disability Services, proposed amendments to the *Child Protection Act 1999* have been identified that would further strengthen the safeguards related to the Blue Card System which impact on foster and kinship carers and their adult household members:

70.1. I propose that information about persons who have been alleged as being responsible for harm to a child under the *Child Protection Act 1999* are to be considered as part of the Blue Card Screening Process.

Term of Reference 3 (c) (i): Reviewing the effectiveness of Queensland's current child protection system - whether the current use of available resources across the child protection system is adequate and whether resources could be used more efficiently

71. This Term of Reference is relevant to the CCYPCG as it serves to highlight that the investment in the oversight of the child protection system is appropriate in terms of what it delivers to children and young people, service providers, the Government and community.

72. The CCYPCG's forward estimates have, like other government agencies, been reviewed and reduced. However, resources allocated to the CCYPCG are broadly sufficient and I have attached a cost-benefit breakdown (attached hereto and marked annexure "G") in relation to the main investment of resources under my Child Guardian external oversight function, which is the Community Visitor role. This analysis shows that the core Community Visitor activity (visiting a child) costs on average $133 per visit and advocacy (if required) to locally resolve a service delivery issue costs on average $33.

73. The cost of the Community Visitor function is less than 1% of the investment in the child protection and youth justice systems. It delivers a high return on investment for the audit type assurance provided; that is, it represents an essential safeguard for children in out-of-home care and a key mechanism for managing the risks of service failures to the Queensland Government, as the children's' substitute parent.

Term of Reference 3 (c) (ii): Reviewing the effectiveness of Queensland's current child protection system - the current Queensland Government response to children and families in the child protection system including the appropriateness of the level of, and support for front line staffing

74. Of the approximate 1.1 million children in Queensland, a very small percentage will ever enter out-of-home care. However, those children and families who are at-risk will have high support needs and sometimes be clustered geographically and/or remotely. The current secondary supports for at-risk families differ across the State in terms of coverage, accessibility, scope and design. Also, often, little quality data or evaluative outcomes are available about the effectiveness of family support services.

75. On the basis that this Term of Reference relates to all prevention and early intervention services up to when a child is formally taken into out-of-home care, it is relevant as the CCYPCG is in a position to provide key evidence (refer the CCYPCG *Child Guardian Key Outcome Indicator Update 2008-11* which is attached hereto and marked annexure "H") some of which is summarised below:

    75.1. The percentage of families demonstrating an improvement in the primary presenting factors, secondary presenting factors or both decreased by 15% from 2008-09 to 2010-11, suggesting a decline in the effectiveness of the Referral for Active Intervention services.

75.2. Of the 21,403 distinct children and young people subject to a Child Concern Report in 2009-10, 38.9% were subject to a subsequent Child Concern Report or Notification within 12 Months, meaning that risk factors remained, or escalated, for 38.9% of families with known needs and concerns.

75.3. There are well recognised historical reasons for the chronic disadvantage experienced by Aboriginal and Torres Strait Islander people. Providing more integrated supports for at-risk Aboriginal and Torres Strait Islander families is critical, and also provides a major opportunity, to reduce the reliance on the statutory child protection system.

75.4. There is a dire need for tailored interventions for Aboriginal and Torres Strait Islander children and young people and their families, given the comparative rates show Aboriginal and Torres Strait Islander children and young people:

75.4.1. Are subject to a child concern report at approximately three times the rate of non-Indigenous children and young people;

75.4.2. Are subject to a Notification at approximately five times the rate of non-Indigenous children and young people;

75.4.3. Are subject to a substantiation at approximately six times the rate of non-Indigenous children and young people; and

75.4.4. Are living in out-of-home care at approximately nine times the rate of non-Indigenous children and young people.

76. Appropriately planning and implementing quality services for at-risk families is critical to the continuous improvement of the system delivering statutory child protection services. However, the delivery of prevention and early intervention services for at-risk families cannot occur in isolation; it must build upon existing policy platforms that are already established to increase educational participation and attainment and create employment opportunities for communities. In other words, it is critical that the investment in providing services that can address chronic social dysfunction such as drug and alcohol abuse, violence and mental health issues, can lead to something positive to prevent individuals and communities relapsing.

77. Scope also exists to reduce the number and rate of entry of children into the child protection system by investigating ways to better support parents who relinquish children to the child protection system due primarily to their high needs, most notably those stemming from disability. It is a distortion of the intent, and misuse of the resources, of the child protection system to acquire guardianship of children from their parents where no genuine child protection concerns exist and all that is required is greater disability support.

Term of Reference 3 (c) (iii) and (iv): Reviewing the effectiveness of Queensland's current child protection system - the effectiveness of tertiary child protection interventions, case management, service standards, decision making frameworks, and child protection court and tribunal processes and the transition of children through and exiting the child protection system

78. This Term of Reference is relevant to the CCYPCG as it is in a position to provide evidence about the outcomes experienced by children who enter out-of-home care. This evidence is attached to this statement as follows:

    78.1. Child Guardian Key Outcome Indicator Update 2008-11 (see annexure "H");

    78.2. Indigenous Child Placement Principle Audit 2010-11 (attached hereto and marked annexure "I");

    78.3. Views of Children and Young People in Foster Care Queensland 2010 (attached hereto and marked annexure "J");

    78.4. Views of Young People in Residential Care Queensland 2009 (attached hereto and marked annexure "K");

    78.5. Child Death Case Review Committee Annual Report 2010-11 (attached hereto and marked annexure "L").

79. As noted above, the CCYPCG's Child Guardian Key Outcome Indicator Framework was established in 2005. It established, in agreement with service providers, 10 indicators under three broad service delivery domains; namely, Assessment and Interventions; Safety and Well-being in Out-of-Home Care; and Reunifications and Transitions.

80. The Key Outcome Indicator Framework was most recently reported against for the 2008-11 period on 25 May 2012 (see annexure "H"), across the following outcome areas for children:

    Assessments and Interventions

    80.1. Despite significant efforts across the past eight years, which have succeeded in reducing the Investigation and Assessment backlog, the percentage of child protection Investigation and Assessments commenced and finalised within Departmental benchmarks remains low (32% commenced within required timeframes and 59% finalised within required timeframes).

    80.2. There have been relatively minor improvements evident in Investigation and Assessment response and finalisation rates over the past three years, which is a significant concern and should form a major area of focus, action and planning for the QCPCOI.

    80.3. My observations regarding interventions have been dealt with in paragraphs 75-77 above.

Safety and Well-being in Out-of-Home Care

Safety

80.4. Children continue to report feeling safe in out-of-home care when responding to Child Guardian surveys (see annexures "J" and "K").

80.5. Substantiated 'Matters of Concern' and Serious Issue Alerts raised by my Community Visitors remain relatively low.

80.6. However, greater safety concerns exist for children and young people placed in residential care, compared to foster care. This is evidenced by the fact that only 93.0% of respondents to the CCYPCG's 2009 survey of children in residential care advised that they felt safe, which is similar to the 2007 result (whereas 97.9% of children and 98.4% of young people in the 2011 foster care survey indicated that they felt safe);

Health

80.7. CCYPCG Community Visitors and Child Guardian surveys have identified children with unmet health needs.

80.8. There is a lack of Departmental child health passport data, and therefore little available evidence that the required health needs assessments and planning are occurring for children and young people in out-of-home care. This issue has been ongoing and is a cause of concern given it is widely recognized that children entering out-of-home care have much greater health needs (due to their social and family circumstances) than children in the general population.

Education

80.9. While the percentage of children in the child protection system with an Educational Support Plan and having adequate resources is encouraging, their achievement levels according to the most recent NAPLAN data are significantly below their peers who are not in care.

80.10. Suspensions and exclusions continue to be an issue for children in care. They experience relatively high levels of suspension and exclusion, when their engagement and participation in education is critical to re-establishing their well-being and expected life outcomes.

80.11. The percentage of children in care reporting experiences of bullying has risen.

Stability

80.12. While there has been a relatively minor decrease in the number of children experiencing three or less placements since 2008-09, there has been an increase in those children and young people experiencing seven or more placements while in care;

80.13. There is evidence to suggest that the stability of placements can be further enhanced in two key areas:

80.13.1. Continuing to apply greater emphasis and effort to identifying and transitioning children and young people in out-of-home care who are suitable candidates for having their guardianship transferred to a person other than the chief executive (as contemplated by sections 51X (3) (c) (i) and section 59 (7) (b) of the *Child Protection Act 1999*).

80.13.2. In August 2011 a number of legislative and policy reforms came into effect in relation to long term guardianship orders and these included specific provisions to support assessments and decision making for the granting of the orders to 'suitable persons' rather than the Director-General. According to recent operational data (June 2012) received from the Department of Communities, Child Safety and Disability Services, there are 7347 children placed in out-of-home care and 4148 were reported as being on long term guardianship orders. Of these children, 890 (21%) were on a long term guardianship order to someone other than the Director-General). This is an improvement from the 16% in the 2005-06 reporting period. Further effort to effect as many of these transfers as possible could improve stability for eligible children and young people and reduce the service delivery impost.

80.14. Establishing greater placement options, in particular residential care options that better meet the needs of young people with challenging and high-risk behaviours, would assist their stability. Options should include ready access to therapeutic services to assist in managing and de-escalating behaviours.

Aboriginal and Torres Strait Islander children

80.15. Aboriginal and Torres Strait Islander children remain significantly over-represented at every stage of the child protection system.

80.16. Closing the gap on Aboriginal and Torres Strait Islander disadvantage remains a significant challenge, with reliance on national policy initiatives and the need for increased integration of national and state services. Local community leadership, participation and ownership is critical to driving the agenda and shaping and maintaining improved long-term outcomes for children.

80.17. While Queensland has seen some early returns following the Closing the Gap initiatives, available data shows that this vulnerable group of children are nevertheless increasing their contact with the child protection system at rates disproportionate to non-Indigenous children. It is uncertain at this time whether this is the result of increased need, or as a consequence of increased reporting in relation to this group.

80.18. Successive CCYPCG audits of the Department's compliance with the Indigenous Child Placement Audit have shown deficiencies in the implementation of the *Child Protection Act 1999* requirements in both practice and systems. In 2008 no evidence could be found of compliance across all required steps in the process and in 2010 compliance across all steps was evident in 15% of placements. Significant delays have also occurred in the Department's response to formal recommendations made in the inaugural (2008) audit. The CCYPCG assessment is that greater emphasis and leadership on this critical area of service delivery is still required within a departmental setting.

Individual needs

80.19. Slight gains have been made across this indicator; in particular, increases have occurred in relation to the percentage of young people with a current case plan and the percentage of young people reporting involvement in case planning. However, scope for further improvement remains.

Reunifications and Transitions

Reunifications

80.20. While reunification is the ultimate aim, an effective assessment of whether this is possible in the circumstances of individual children is required and it should be ensured that appropriate decision making occurs where reunification is unlikely to occur, so that children and carers are not left with uncertainty or alternatively, children are not placed back in unsafe environments.

80.21. The number of children known to CCYPCG Community Visitors who were reunified with their families has decreased over the past three reporting periods.

80.22. The percentage of young people reporting being adequately involved in the reunification process has increased over the past two years.

80.23. Scope also exists for the Department to improve its data to enable better monitoring of reunification outcomes.

Transitions to independence

80.24. Currently, children in the statutory child protection system are required to transition to independence at the age of 18 years (although consideration could be given to the potential for this to be extended). Regardless of the age of transition, adequate advanced planning is essential to ensure positive outcomes are achieved.

80.25. An increase of 8% since 2009-10 in transition from care planning has occurred. However, as at 30 June 2011 only 64% of young people entitled to a transition plan had one in place. A much greater effort is required by the Department to ensure that all children ready to transition from out-of-care have an adequate plan and supports in place.

Confidentiality and exchange of information

81. Outcomes for children in the child protection system are highly dependent on the exchange of critical information between various parties to promote delivery of effective services. Legislative provisions currently allow information to be shared within the state and across state borders and are not considered to present a barrier in this regard. However, the practical application of the information sharing provisions does not always achieve the policy intent of the legislation and this may be an area for further improvement.

Blue card system

82. This Term of Reference is further relevant to the CCYPCG in the context of its blue card screening function. On 31 May 2006 the blue card system commenced the screening of foster and kinship carers and their adult household members in the child protection system, as well as relevant people associated with licensed care services. This change was intended to build on key recommendations of the CMC Inquiry by strengthening the approval process to more effectively regulate carers.

83. Where the CCYPCG determines a person is eligible to hold a blue card, the Department of Communities, Child Safety and Disability Services makes the ultimate decision about the suitability of the person and is responsible for the final approval and issuing of authorities under the *Child Protection Act 1999*.

84. A review of applications for Child Protection Blue Card Screening readily demonstrates the critical nature of this activity as a safeguard for children and young people reliant on the children protection system:

    84.1. Since 2006-07, over a quarter (26.18%) of child protection applications have returned criminal history information, compared to all applications in that period, for which just over one in ten (10.71%) returned criminal history information;

    84.2. In the 2011-12 financial year, 31.2% of child protection applications returned a criminal history, compared to 14.69% for all applications; and

    84.3. Further, of all negative notices issued since 2006-07, the proportion of child protection applicants being issued with a negative notice (0.44%) is nearly three times higher than that for all applicants (0.17%).

85. The rate of substantiated "matters of concern" (i.e. harm in out-of-home care) has reduced from over 8% of the child protection population in 2004-05 to 2.3% in 2010-11. Foster and kinship carers and adult occupants of care environments have been subject to Blue Card system safeguards, including criminal history screening, since 2006-2007.

86. These statistics clearly highlight the importance and value of the Blue Card System in this sector, as a mechanism for preventing abuse to children and young people in out-of-home care. It is a highly cost effective and efficient means to leverage and utilise existing information held by the Government for the protection of children.

Term of Reference 3 (d): Reviewing the effectiveness of the 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

87. This Term of Reference is relevant to the CCYPCG's performance of its Child Guardian functions. In my view, the CCYPCG has fulfilled all statutory requirements under the CCYPCG Act (including, since the Child Guardian functions commenced in 2004).

88. Key monitoring reports have been completed and published, which have formed the basis for CCYPCG's systemic advocacy efforts. These reports have also added significantly to the publicly available evidence about child protection service outcomes and, in doing so, have contributed to public confidence in the child protection system. These pieces of work include the following:

    88.1. Five reports against the Child Guardian Key Outcome Indicator Framework (see annexure "H" for the most recent report).

    88.2. These reports have met the key objective of establishing agreed frameworks (with service providers) for systemic oversight of their service delivery. This has involved identifying and prioritizing key areas of service delivery, brokering agreements with service providers about the creation and regular provision of outcome (and proxy outcome) data and publicly reporting. Initially reporting occurred annually. It has now moved to an online interactive format, which will soon progress to quarterly.

    88.3. The findings of the most recent Queensland Child Guardian Key Outcome Indicator Update Report have highlighted significant concerns related to:

        - The timeliness of Investigation and Assessments
        - Aboriginal and Torres Strait Islander overrepresentation and management of the statutory compliance with the Indigenous Child Placement Principle, and
        - Insufficient planning for transition to independence for young people 15 years and over.

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88.4. In the past five years more than 75 investigations, audits and reviews have been conducted resulting in over 450 recommendations, mostly for improvements to child protection service delivery. This body of work includes two reports about the Department's compliance with the Indigenous Child Placement Principle (see annexure "I" for the most recent report). After making recommendations, the CCYPCG monitors implementation to ensure that the intended positive outcomes for children and young people are achieved. Types of recommendations can be grouped in the following categories:

- Improvements to policies and procedures to better support frontline child protection practice (for example delivery of services to children who are chroming, working with parents with mental health issues and who care for children);

- Providing training to specific staff to address identified service delivery issues (for example, record keeping deficiencies and supervision practices);

- Interagency collaboration and information sharing, including where multiple service systems connect (for example where the Department and Queensland Health are both providing services to a client, clarifying inter-agency service linkages and dependencies to promote the safety and wellbeing of children of parents with mental health issues); and

- The need for the conduct of individual staff members to be assessed in a disciplinary context (typical circumstances are where an adverse outcome has occurred due to individual failings and this may not have been previously identified by the relevant service provider).

88.5. Five reports about surveys of children in the child protection system (with the most recent reports attached hereto and marked annexures "J" and "K"). These survey reports provide critical insights into the child protection system from the perspective of children and young people, have been widely accepted as credible research within academia and are valued by service providers as providing critical insight into children's experiences in out-of-home care.

88.6. Seven Child Death Case Review Committee (CDCRC) annual reports, which identify that in this time the CDCRC has reviewed 449 cases (relating to the deaths of 456 children known to the child protection system) and made 672 recommendations targeting improvements to the Child Protection System.

88.6.1. The CDCRC has also played a critical role in driving the quality of internal (Departmental) child death review processes. Its focus on building agency capacity to conduct these reviews and establishing the required accountability remains relevant.

88.6.2. The CDCRC is a multi-disciplinary committee made up of between five and seven members with expertise in fields including child health, forensic pathology, investigations and child protection. Section 121 of the CCYPCG Act also provides that the State Coroner or a deputy may be appointed as a member of the CDCRC. The current CDCRC members are profiled in annexure "M".

88.6.3. In the course of conducting these reviews the CDCRC has identified 2 cases where the actions or inactions of the Government have been directly linked to a death.

88.6.4. All child death case reviews are also provided to the State Coroner and provide critical expert insights that assist in determinations about the need for and conduct of inquests.

89. This collective work represents CCYPCG's best endeavours to support a journey into best practice for human service delivery. In combination, these proactive and reactive mechanisms of oversight have greatly assisted agencies that contribute services to child protection, hear children's views, build capacity, capability and accountability. By taking a whole of system view, they have also highlighted critical aspects of multi-agency collaboration required to help meet the needs of very vulnerable children and young people.

90. This Term of Reference is also relevant to the CCYPCG's individual monitoring and advocacy for children in out-of-home care.

90.1. The Community Visitor role requires regular and frequent visits to children and young people in out-of-home care. The objective of these visits is to build trusting relationships with the children and young people and verify their safety and well-being needs are being met. The visits provide a value for money audit role of a critical area of statutory service delivery that attracts significant investment and risk.

90.2. Where Community Visitors identify serious issues, alerts are raised immediately with either the Department or Queensland Police Service. Resolution and advocacy for children on less urgent issues is attempted locally with service providers in the first instance. The role of the Community Visitor is described in annexures "A" and "B".

90.3. Since inception of the broader visiting powers for out-of-home care (2004) Community Visitors have written 324,657 reports about child visits, recorded 7373 serious issue alerts and identified 87,234 issues requiring local resolution.

90.4. In 2010-11, Community Visitors completed 40,952 visit reports in relation to 7511 distinct children. 1.4% of visit reports identified a Serious Issue, and 18.6% of visit reports identified a Locally Resolvable Issue.

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90.5. Since 2010 Community Visitors have taken a risk-based approach to visiting, meaning those children and young people who are confirmed as safe and well in their placements are visited less often.

90.6. Of those children and young people within the Community Visitor jurisdiction, currently 42% receive a monthly visit and 58% are visited every second month, which highlights these children and young people have been assessed as stable and receiving good quality care (and may serve as an indication that they are candidates for review as to alternative guardianship arrangements).

90.7. The latest Views Survey of children and young people in foster care conducted April to July 2011 asked young people to rate the helpfulness of their Community Visitor on a scale from 1 (very unhelpful) to 10 (very helpful). Responses from the 783 young people who responded revealed that 80.8% rated their Community Visitor's helpfulness at 9 or 10 (with a mean score of 9.2).

90.8. The latest Views Survey of young people in residential care conducted August to November, 2011, and responded to by 32% of all young people living in residential care during the period, also asked young people to rate the helpfulness of their Community Visitor on a scale from 1 (very unhelpful) to 10 (very helpful). Responses from these young people revealed that 69% rated their Community Visitor's helpfulness at 9 or 10 (with a mean score of 8.6).

Term of Reference 3 (e): Reviewing the adequacy and appropriateness of any response of, and action taken by, government to allegations, including any allegations of criminal conduct associated with government responses, into historic child sexual abuse in youth detention centres

91. The CCYPCG has conducted a search of its records and determined that it does not hold any information which may be relevant to this particular Term of Reference. However, a significant volume of complaints and information were provided to the Forde Inquiry for consideration. I note the Forde Inquiry did not consider the issue of abuse of 17 year olds who were accommodated in adult jails.

92. Aside from those matters that appear to be specifically contemplated by this Term of Reference, I have consistently advocated for the implementation of a complaints management process for detention centres that complies wholly with Forde Inquiry recommendation 15, and where complaints of a significant nature are raised. For example, it is my opinion that where complaints involve suspected official misconduct these should be investigated by a body external to the detention centre environment.

93. In my opinion, it is essential that complaints management processes in environments such as detention centres be best practice in terms of accessibility, accountability and transparency if they are to contribute meaningfully to the safety and wellbeing of young people in detention and prevent systemic abuse.

Affirmed by ELIZABETH FRASER on 8 August 2012 at Brisbane in the presence of SALLY MARIE HALLIS SMHALLIS

JUSTICE OF THE PEACE (QUAL. ED.)
QUEENSLAND GOVERNMENT
Reg.No.: 103926
DEPARTMENT OF JUSTICE QUEENSLAND

E Fraser
Deponent

8/8/2012

E Fraser