Chapter 9

Chapter 9

Oversight and complaints mechanisms

Recommendations of both the Forde Inquiry (Commission of Inquiry into Abuse of Children in Queensland Institutions 1999) and the 2004 Crime and Misconduct Commission Inquiry into abuse of children in foster care (Crime and Misconduct Commission 2004) emphasised the need for children to be heard, for the public to have confidence in the child protection system, and for it to be accountable and transparent. The recommendations from these inquiries strengthened business and reporting systems within the former responsible departments and expanded the monitoring and review functions of external oversight mechanisms.

As a result, Queensland has the most comprehensive and far-reaching oversight mechanisms for child safety in Australia through:

- broad powers of the Commission for Children, Young People and Child Guardian
- community visitors visiting children in out-of-home care and youth detention monthly or every two months
- complaints systems allowing for various levels of internal and external assessment and resolution of complaints
- a two-tiered review process of deaths of children known to the department within three years of the death
- mandated performance reporting by the Department of Communities, Child Safety and Disability Services and the Commission for Children, Young People and Child Guardian
- inter-departmental governance committees
- employment screening of all volunteers and employees working with children and daily monitoring of blue card holders for changes in their criminal history.

'Accountability' refers to the requirement for departments that regulate child protection and services essential to the wellbeing of children in care to explain or justify their actions to another person or body to legitimise their authority to the public (Bird 2001).

Government agencies with roles as regulators are accountable for the way in which they exercise their powers and discretions, and for the way they expend resources. In addition to such agencies explaining their actions, accountability may include mechanisms that require further actions from agencies not meeting expected performance standards, such as a reversal of decision, removal from office, or a penalty in the form of civil or criminal sanctions.

However, accountability also has to be balanced against efficiency, expertise and independence (Bird 2001, p739). Although strong oversight mechanisms can reduce the risk of harm and increase the safety and wellbeing of those within the system, excessive oversight can be counterproductive in creating inefficiencies by diverting resources unduly from frontline services towards compliance and administrative systems that may not add value. Typically, after serious breaches of public trust, greater external scrutiny is required, but as internal accountability systems mature it is important to consider whether the level of external oversight continues to be fit for purpose, or whether public confidence has increased to a point where external controls can be streamlined and resources redirected.

Term of reference 3(d) requires the Commission to consider 'the effectiveness of monitoring, investigation, oversight and complaint mechanisms and ways to improve the oversight of and public confidence in the child protection system'.[1]

This chapter outlines current oversight and complaint mechanisms, identifies issues and concerns about their impact and effectiveness, and poses questions about how best to balance accountability and openness with practical levels of supervision to achieve the goal of a reliable, efficient child protection system that ensures the safety and wellbeing of children for which it is responsible.

To date, comments to the Commission on term of reference 3(d) have been few. Therefore, the questions in this chapter are inviting perspectives on the efficiency and effectiveness of each existing oversight mechanism, as well as of the broader oversight of the child protection system.

9.1 Current status in Queensland

Oversight includes the functions of audit, evaluation, monitoring, inspection and investigation to help an organisation improve service delivery quality, effectiveness, productivity and integrity.

The Department of Communities, Child Safety and Disability Services has direct responsibility for regulating child protection through administering the *Child Protection Act 1999*. In addition, the following agencies have responsibility for identifying children in need of protection and for providing the necessary services to children within the child protection system for their wellbeing:

- Department of Education, Training and Employment – early childhood, education, training and employment services

- Queensland Health – health services
- Queensland Police Service – safety and law and order functions
- Department of Justice and Attorney-General – administering court services and youth justice services.

State government entities are subject to a number of internal and external oversight processes to meet public accountability and regulatory compliance. These include:

- internal audit and governance requirements under the *Financial Accountability Act 2009*, including the *Financial and Performance Management Standard 2009*
- the Queensland Audit Office, which is legislated to undertake:
  - annual financial audits
  - performance audits to assess how effectively, efficiently and economically public sector entities are meeting their objectives (Queensland Audit Office 2012)
- the Crime and Misconduct Commission, which investigates allegations of misconduct to ensure that Queensland's public institutions are accountable for their conduct (Crime and Misconduct Commission 2012)
- the Queensland Ombudsman, which investigates complaints about Queensland Government departments (Queensland Ombudsman 2008)
- the Queensland Civil and Administrative Tribunal, which reviews administrative decisions and a range of disputes (Queensland Civil and Administrative Tribunal 2012b)
- the State Coroner, who investigates reportable deaths (Queensland Courts 2012a)
- inter-departmental committees and networks such as the Child Safety Directors Network and independent Queensland parliamentary committees who oversee the performance of agencies within their portfolio
- Workplace Health and Safety Queensland, which investigates complaints and enforces legislation related to the welfare of workers at work (Department of Justice and Attorney-General 2012)
- the Office of the Information Commissioner, which promotes access to information held by the government, and protects people's personal information held by the public sector under the *Right to Information Act 2009* and the *Information Privacy Act 2009* (Office of the Information Commissioner 2012).

In addition, specific monitoring arrangements for Queensland's child protection system constitute a multi-tiered network of internal, external and judicial review mechanisms:

- Tier 1 – internal oversight mechanisms used by the Department of Communities, Child Safety and Disability Services to provide a system of performance monitoring, licensing and quality standards, complaints management, review and evaluation

- Tier 2 – external oversight mechanisms: the Commission for Children and Young People and Child Guardian (the Children's Commission) and specific functions of the Queensland Ombudsman
- Tier 3 – judicial oversight mechanisms comprising the Queensland Civil and Administrative Tribunal and the courts. Judicial oversight mechanisms are considered more closely in Chapter 10.

9.2 Tier one: internal oversight of Department of Communities, Child Safety and Disability Services

9.2.1 Performance monitoring and reporting

On its website, the Department of Communities, Child Safety and Disability Services presents quarterly performance data on key performance measures based on the child protection framework (Department of Communities, Child Safety and Disability Services 2012h). This includes services delivered, and safety and wellbeing measures. As well, the department is required to produce a number of public reports annually:

- a departmental service delivery statement and an annual report, which set performance measures and report against them, with explanations for changes from previous years and strategies for improvement
- the *2010–11 Child protection partnerships report*, an annual report on the operations of Queensland Government agencies relevant to child protection[2]
- reporting against six broad outcome areas in response to the *National framework for protecting Australia's children*, a Council of Australian Governments agreement in September 2009 (until 2020).

Comparisons with other Australian jurisdictions are published annually in:

- the Report on Government Services using the performance indicator framework referred to above, which reports on equity, efficiency and effectiveness, and publishes the outputs and outcomes of child protection and out-of-home care services (Steering Committee for the Review of Government Service Provision 2012)
- the Australian Institute of Health and Welfare's *Child protection Australia* reports (Australian Institute of Health and Welfare 2012).

9.2.2 Licensing, quality standards, criminal screening

The Crime and Misconduct Commission Inquiry recommended that a quality assurance strategy be developed and implemented for all services (government and non-government) and a minimum standard be set for the licensing of non-government services (2004, p180). In response, in 2006 the department developed and implemented quality standards for non-government organisations with independent

external assessment. In July 2012, the Human Services Quality Framework replaced six sets of quality standards required for delivering services to different client groups within the Department of Communities, Child Safety and Disability Services. The intent is to create a streamlined and client-focused quality framework for human services that facilitates continuous quality improvement. The framework contains six human service quality standards:

- governance and management
- service access
- responding to individual need
- safety, wellbeing and rights
- feedback, complaints and appeals
- human resources.

The framework will be introduced over three years as organisations renew their quality status, with the first audits to commence in 2013 for disability service providers and services licensed to provide child safety care services. Multiple individual service licences will transition to a single organisational-level licence.

Services providing care to children in the custody or guardianship of the chief executive of the department are licensed to ensure that care provided meets the statement of standards in the Child Protection Act (Department of Communities, Child Safety and Disability Services 2012g). External audits to meet the requirements of licensing will be conducted under the Human Services Quality Framework.

Suitability checks are undertaken through the department's Central Screening Unit for carers, directors and staff of licensed care services. Where blue cards are required, these applications are processed and determined by the Commission for Children and Young People and Child Guardian. The Central Screening Unit undertakes other checks such as checks of traffic offences and child protection history, depending on the context and the role the applicant will undertake. The department can also undertake criminal history checks pending the issue of a blue card where placement of children is required urgently.

The department participated in the development of the National Standards for Out-of-Home Care, a Council of Australian Governments initiative. The 13 standards came into effect on 1 July 2011 and cover areas such as children and young people's education, health and participation in decisions that affect their lives (Department of Communities, Child Safety and Disability Services 2012e).

9.2.3 Complaints management

The department has a dedicated internal complaints management process and operational procedures (Department of Communities, Child Safety and Disability Services 2011b, 2011c) which incorporate the minimum standard required in Australian Standard IS 10002-2006 *Customer satisfaction – guidelines for complaints handling in organisations* and the Queensland Government Public Sector Commission Directive No. 13/06 *Complaints management systems*.

The department's process for complaints relating to a child safety matter involves the following steps:

- The complainant makes initial contact with the complaints officer at the local Child Safety service centre. Where possible, the complaint is managed locally either by the local Child Safety service centre or by regional office.
- If the complaint is not resolved, or it is inappropriate for the complaint to be managed locally, it is escalated to the Child Safety Central Complaints Unit.
- If not satisfied with the way in which concerns have been managed, the complainant may seek an internal review or an external review by the Queensland Ombudsman (Department of Communities, Child Safety and Disability Services 2012d).

The majority of accepted complaints for 2010–11 and 2011–12 were managed by the local Child Safety service centre (59 per cent and 61 per cent respectively). The top five complaint issues were in relation to child protection orders, officer conduct and employment, investigation and assessment, foster and kinship carers, and intake.[3]

Complaints concerning alleged misconduct of a public official may be elevated to the Ethical Standards Unit, where the matter may be referred to the Crime and Misconduct Commission.

As described in section 9.2.2 of this chapter, the Human Service Quality Framework includes a standard in relation to feedback, complaints and appeals. Non-government services are required to have complaint management processes. Complaints referred back to non-government-funded organisations for resolution are monitored by the department to ensure that they comply with the organisation's internal complaints policy.

9.2.4 Child death review

The Queensland child death case review process consists of a two-tier system for reviewing deaths of children in cases where the department received information about alleged harm or risk of harm to the child in the three years prior to the child's death.[4] The department's Child Death Case Review Unit conducts Tier 1 reviews, which do not investigate the cause of death, but consider the services delivered to the child under

the Child Protection Act and explore the decisions and factors that significantly affected service delivery.

The department decides the terms of reference of its review, which can include consideration of any of the following:

- compliance with legislation and policies
- adequacy and appropriateness of the department's involvement with the child and the child's family
- sufficiency of the department's involvement with other entities in the delivery of services to the child and the child's family
- adequacy of legislative requirements and the department's policies relating to the child
- recommendations relating to the above and strategies to put the recommendations into effect.

Trends in child deaths are reported on the department's website (Department of Communities, Child Safety and Disability Services 2012b). Tier 2 reviews are described in section 9.3 below.

Question 32

Are the department's oversight mechanisms – performance reporting, monitoring and complaints handling – sufficient and robust to provide accountability and public confidence? If not, why not?

Question 33

Do the quality standards and legislated licensing requirements, with independent external assessment, provide the right level of external checks on the standard of care provided by non-government organisations?

9.3 Tier 2: External oversight

9.3.1 Functions of the Commissioner for Children and Young People and Child Guardian

The Commissioner for Children and Young People and Child Guardian provides oversight of the child protection system through:

- the community visitor program
- complaints and investigations

- monitoring and reporting activities
- strategic policy and research
- employment screening.

There is significant variation of the role, scope and function of children's commissioners and child guardians across Australian jurisdictions. In other jurisdictions, the functions of the Queensland Commission for Children and Young People and Child Guardian are performed by a number of agencies.

In Queensland, the role of the Commissioner for Children and Young People and Child Guardian includes monitoring the child protection system, managing the community visitor program, responding to complaints and investigations, leading case reviews into child deaths and delivering the 'working with children' checks.

Although the role of most children's commissioners and child guardians includes a monitoring function for the out-of-home care system, not all commissioners respond to complaints about individual children or conduct Child Death Case Reviews. In New South Wales and Western Australia, the Ombudsman performs these functions, and, although the Australian Capital Territory and South Australia have a complaints and review function, child deaths in those jurisdictions are reviewed by the department responsible for child protection.

The community visitor program

The community visitor program commenced in 2001 with visits to children in detention and at residential care sites, and was extended to children in foster homes in 2004 after the Crime and Misconduct Commission Inquiry into abuse of children in foster care. The role of community visitors is to promote and protect the rights, interests and wellbeing of children in care.[5]

Community visitors report to the Child Guardian and the Children's Commissioner and are independent of any other government department or community organisation. They regularly visit children and young people who are in care, record problems or complaints in relation to service delivery and their safety and wellbeing, and follow up centrally or with the local Child Safety service centre to resolve the problems. Service delivery concerns are also followed up with other government and non-government service providers. The most common matters raised by children are contact with family or their child safety officer, placement arrangements (including safe living environments or stability of placement) and therapeutic care needs.

Community visitors also undertake unscheduled visits to 'visitable sites' where children and young people are living in other residential care contexts such as youth shelters or disability respite facilities.

In 2011–12, there were 153 community visitors with 42 children allocated to each (at any one time), supervised by 11 zonal managers and supported by a five-person unit that provides training and IT support. Community visitors visit an average of between 2,000 and 3,000 children on a monthly basis and between 3,500 and 4,000 children every two months. Although the majority of children and young people receive either monthly or two-monthly visits, quarterly visits can be implemented should a child or young person directly request a decreased visiting schedule.

For the 7,911 children and young people visited by community visitors in 2011–12, 44,356 individual child reports and 4,017 site reports were generated. Through a regular survey of young people in care, the Commission for Children and Young People and Child Guardian reports on the views of children and young people, who have rated the helpfulness of community visitors as 9.0 (2010–11) and 9.1 (2011–12) out of 10 (Commission for Children and Young People and Child Guardian 2012a, pp86, 90).

Information gathered by community visitors is aligned with complaints data and departmental performance data to identify systemic and practice issues that are negatively affecting the delivery of quality service.

In a recent submission, the department acknowledged the importance of the community visitor program being maintained to provide an ongoing mechanism for children in out-of-home care to raise issues independently. However, it submits that additional requirements now exist, such as the requirement for all family-based carers to be approved under the Child Protection Act, to have a blue card, and to meet the standards of care. The department suggests that there may be opportunities for improving efficiency within the community visitor program by concentrating on more frequent visits to children who have higher support needs or who are placed in particular types of arrangements.[6]

Different variations of community visitor programs have been adopted by most Australian states and territories. Though each program exists as a mechanism that enables vulnerable children to have their voice heard by an adult who has the capacity to advocate on their behalf, there are differences in the population subgroups that the community visitors connect with. In some jurisdictions, these subgroups include children and young people with disabilities or mental illness, and those in residential care facilities, those in juvenile justice centres or those who meet a ‘most vulnerable’ criterion. Many jurisdictions do not specifically target children and young people in state care under child protection orders, but it is recognised that those who fall within the specific subgroups will receive visits: for example, those also with a disability or in youth detention. Queensland is the only jurisdiction that currently visits all children in out-of-home care. Visiting schedules include both planned and unplanned visits, with Queensland’s program requiring the most regular visits.

Complaints and investigations

The Commission for Children and Young People and Child Guardian receives and responds to complaints about any government or non-government service provided (or not being provided) to young people in the child safety system. Complaints can be accepted from a child or young person, or from any other person (including an anonymous complaint on behalf of a child).

In 2011–12, the Children's Commission resolved 4,561 complaint issues on behalf of children and young people.[7]

The Children's Commission has broad powers to support its investigative functions.[8] This includes a power enabling the Commissioner to initiate an investigation, whether a complaint has been received about the matter or not. This may occur in such circumstances as those where the matter raises issues of public interest or where there is a significant issue about a law, policy or practice underlying a service to a child in the child safety system.[9]

The Commissioner can make recommendations to government on matters affecting the performance of the child protection system.[10] Traditionally the acceptance rate of recommendations by relevant departments and service providers has been exceptionally high, with 100 per cent of recommendations made in the 2010–11 and 2011–12 periods being accepted (Commission for Children and Young People and Child Guardian 2012b, p92). Although the Children's Commissioner does not have the power to compel acceptance and implementation of recommendations made, the Commissioner can give a copy of the report with her comments to the Minister responsible for the service provider if the Commissioner is not satisfied that a recommendation has been accepted by the relevant department or satisfactorily implemented.[11]

Investigation reports are not usually released publicly, but the Commissioner does have the power to ask the Minister to table a report.[12] The most recent investigation tabled in Parliament was in 2008 (Queensland Parliament 2012). The Children's Commission periodically releases versions of its reports on its website that do not provide any identifying details, so as not to breach any privacy or confidentiality provisions or constraints. This provides a further level of transparency for its investigative function.

The Commission for Children and Young People and Child Guardian advised that in the past five years more than 75 investigations, audits and reviews have been considered, resulting in over 450 recommendations, mostly for improvements to child protection service delivery.[13] All recommendations are monitored to ensure effective implementation by relevant service providers.

All jurisdictions across Australia have an external complaints and investigations function, with varying powers. The function is undertaken by different agencies in

different jurisdictions, including the ombudsman or children's commission.

Monitoring and reporting activities

Through its Child Guardian function, the Children's Commission monitors and reviews the systems, policies and practices of the department and other service providers who deliver programs to children and young people in the child protection system. Monitoring activities are carried out under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000*, which provides powers to:

- require information or documents from a service provider
- require periodic reporting from a service provider
- require service providers to review their systems, policies or practices
- make recommendations to a relevant service provider
- monitor the implementation of recommendations made to a service provider.

The Commission for Children and Young People and Child Guardian enters into monitoring agreements with service providers, setting out key data it requires them to report against.[14] These agreements are reviewed regularly to promote information gathering to enable better understanding of outcomes for children.

Further to the recommendations arising from the Crime and Misconduct Commission Inquiry, the Children's Commission publicly releases information about the outcomes experienced by children and young people in the child protection system. This includes the annual Child Guardian report and other reports (such as the Indigenous Child Placement Principle Audit) as a result of its targeted monitoring activities.

Since 2006, the Children's Commission has reported annually on the 10 Child Guardian key outcome indicators agreed to by service providers. This annual report is intended to be an objective system-level and evidence-based assessment of the safety and wellbeing of children and young people in out-of-home care. Reporting under this framework is intended to:

- highlight trends and issues (both positive and negative) in child protection service delivery
- create transparency and accountability of service delivery
- provide an additional 'early alert' of system failure
- enable government, stakeholders and the community to be kept informed of both developments and failings in the child protection system
- promptly contextualise any individual critical incidents within broader system performance.

Through the 'Views surveys' series, the Commission for Children and Young People and

Child Guardian regularly collects information about children and young people's perspectives on and experiences of the child safety and youth justice systems, and their needs and circumstances. Community visitors help those children and young people whom they visit to complete these surveys, which ask a range of questions about such matters as their sense of safety and happiness, current living situation, placement history, educational, health and disability needs, experiences of the child protection system (including the availability, responsiveness and quality of services and programs), and having a say in decisions.

These surveys are the largest cross-sectional longitudinal study of their kind involving the direct participation of children and young people in state care. The information is then used to inform child protection policy and practice decisions to shape departmental performance indicators. The surveys provide critical insight into children's needs and experience of out-of-home-care, and are used by academics, stakeholders[15] and service providers.

Children's commissions and child guardians in most states and territories have a monitoring and reporting function in respect of the child protection system.

Strategic policy and research

The Children's Commission contributes to the development of policy and legislation to promote and protect the rights, interests and wellbeing of children and young people by:

- developing evidence-based submissions on issues affecting children and young people, including those in the child protection system
- supporting, conducting and analysing research data to identify emerging and ongoing issues in relation to prevention and early intervention services provided to children and young people in Queensland
- identifying and promoting networks and alliances in research with academic, government and non-government partners
- learning and reporting on the views of children and young people on a range of issues affecting their safety and wellbeing.

Some of the current strategic policy and research priorities of the Commission for Children and Young People and Child Guardian are the relationship between child protection and the Family Court of Australia, and conducting two-yearly surveys of children and young people in foster care and residential facilities.

Policy, research and advocacy functions are carried out by all state and territory children's commissions and child guardians.

Employment screening

The Commission for Children and Young People and Child Guardian's employment screening and blue card system complements the statutory oversight model by managing risks to children and young people in service environments. The blue card check is a national criminal history check that assesses:

- any charge or conviction for an offence (even if no conviction was recorded)
- child protection prohibition orders (whether a person is a respondent or subject to an application)
- disqualification orders
- if a person is subject to reporting obligations under the *Child Protection (Offender Reporting) Act 2004* or the *Dangerous Prisoners (Sexual Offenders) Act 2003*
- disciplinary information held by certain professional organisations, including those for teachers, child care licensees, foster carers and certain health practitioners
- information that the Police Commissioner may provide in relation to police investigations into allegations of serious child-related sexual offences, even if no charges were laid.

A person whose application is approved is issued with a positive notice letter and a blue card. If a person's application is refused, they are issued with a negative notice that prohibits them from carrying on a business or providing child-related activities in the categories regulated by the Commission for Children and Young People and Child Guardian Act.

A subset of the blue card screening function includes screening and monitoring of employees, organisations and government agencies that deliver services to children in out-of-home care. This includes those working in or operating residential facilities, foster and kinship carers, and businesses relating to licensed care service under the Child Protection Act.[16]

The Commission for Children and Young People and Child Guardian also:

- monitors police information relating to all applicants and card holders; if the information changes, the Commission can take steps to immediately protect children from harm, including suspending or cancelling a card
- monitors and audits service providers' compliance with blue card system obligations to ensure that appropriate safeguards are being implemented and maintained
- monitors organisations and self-employed people who fall within the scope of the blue card system to ensure that there are appropriate policies and procedures in place to identify and minimise the risk of harm to children, including codes of conduct, procedures for recruiting, managing and training staff, and policies for identifying and reporting disclosures or suspicions of harm.

Currently, the statutory application fee of $72.50 applies to obtain a blue card, although this fee is waived for volunteers such as foster carers, kinship carers, adult occupants also living in the same home as foster and kinship carers, volunteers in licensed care facilities and student trainees.[17]

Over 850,000 blue cards have been issued since 2009–10 and daily monitoring of changes in criminal history occurs for blue and exemption card holders and applicants. The screening has provided negative notices to nearly 2,200 applicants.[18]

Most states and territories have introduced, or are working towards, legislation providing for child-related employment pre-screening. The legislation identifies broad categories of child-related work where employers, employees and volunteers must fulfil screening requirements. There are important differences across jurisdictions in the types of screening programs that are in place, what records are checked and information considered, who is required to undergo screening, where the responsibility is placed (employer or individual) and renewal timeframes.

In addition, there is variation across Australia in terms of the government agency responsible for undertaking these checks. For example, in the Northern Territory, Victoria, South Australia and the Australian Capital Territory, 'working with children' checks are primarily delivered by justice and police agencies, and in Western Australia the checks are undertaken by the Department of Child Protection. The Commission for Children and Young People manages the 'working with children' check process in New South Wales.

9.3.2 External oversight by the Child Death Case Review Committee

As outlined above, the Tier 1 review of the death of a child or young person known to the department within three years of his or her death is conducted by the department. The Tier 2 review is undertaken by the Child Death Case Review Committee against a set of criteria that includes whether any action or inaction of the service system was linked to the child's death.

The Child Death Case Review Committee was established under s 116 of the Commission for Children and Young People and Child Guardian Act in response to the Crime and Misconduct Commission Inquiry (2004). The Child Death Case Review Committee is not under the control of any other entity, and must act independently in performing its functions.[19] The committee is chaired by the Commissioner for Children and Young People and Child Guardian, and has a multi-disciplinary membership of experts from fields including paediatrics, forensic pathology, investigations and child protection. There are also two Aboriginal and Torres Strait Islander representatives. The objective is to better inform government action directed towards the prevention of child deaths, and its primary focus is to identify shortcomings in the child safety service system implicated in a child's death.

The criteria used by the Child Death Case Review Committee in reviewing an 'original review' are to determine the following:

- Were any actions or inactions of the service system linked to the child's death?
- What risk factors were relevant to the child's death?
- Were any service system issues relevant to any adverse outcomes experienced by the child (while he or she was living)?
- Are there any recurring or unrectified risk factors or service system issues that require further action?
- Was the original review of sufficient quality to enable timely responses to any relevant risk factors or service system issues, or is further action required?

The Child Death Review Committee may make recommendations to the Director-General of the department about:

- improving policies that affect services to children in the child safety service system
- improving relationships between Child Safety and other agencies involved with children and their families
- whether disciplinary action should be taken against any departmental staff member in relation to their involvement with a child.

All reviews are to be completed within a three-month timeframe. A copy of the final review report, with recommendations made by the Child Death Case Review Committee, is provided to the Director-General of the department and to the Coroner to inform a coronial inquiry. Recommendations are monitored to ensure that appropriate implementation has taken place.

The Child Death Case Review Committee contributes to broader policy and practice development and child death prevention strategies. Over a period of seven years, the committee 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.[20]

Nearly every state and territory has an external child death review function that is carried out by agencies including the children's commission, the ombudsman or other government departments. One of the main differences between the jurisdictions relates to the category of case that is considered for review.

9.3.3 External oversight undertaken by the Queensland Ombudsman

External oversight also provides a quality control mechanism for any internal review process within government agencies. Although complainants are encouraged to use the department's internal complaints and review systems, they also have an option for their complaints to be resolved externally if they remain dissatisfied (NSW Ombudsman

2010). A complainant's right of external review in relation to the decisions or actions of the department is to the Queensland Ombudsman (Department of Communities, Child Safety and Disability Services 2011c).

The Queensland Ombudsman is an independent statutory officer who provides the public with a means of challenging the decisions of government agencies by investigating the administrative actions of state government agencies.[21] The majority of investigations undertaken arise from complaints received, but the Ombudsman's Office may also conduct investigations on its own initiative. The Ombudsman is authorised to provide a report after the investigation and can make recommendations for administrative improvement to agencies.[22] Its decisions and recommendations are not enforceable, but it tables an annual report in Parliament.

The Queensland Ombudsman has jurisdiction to respond to complaints raised about the department and other government agencies that provide services to children and young people in care. However, its jurisdiction does not extend to non-government agencies, carers or private service providers. The Ombudsman can decline to take action on a complaint if the complainant has not exhausted the agency's internal complaints management system before contacting the office, or if the action giving rise to the complaint became known to the complainant more than 12 months before the complaint was raised.

In 2011–12, the Ombudsman received 330 complaints about the department (Queensland Ombudsman 2012, p13) and completed five investigations involving actions of the department (Queensland Ombudsman 2012, p15). The Ombudsman's Office also has jurisdiction to receive complaints about the Commission for Children and Young People and Child Guardian. In 2011–12, it received 20 complaints about the actions and decisions of the Commission (Queensland Ombudsman 2012, p14).

In New South Wales, the Ombudsman has a broader oversight function as it also undertakes the review of child deaths (as does the Western Australian Ombudsman) and administers the New South Wales community visitor program.

9.3.4 External oversight through inter-agency committees

The Child Safety Directors Network was established to support coordinated responses to child safety across government. Child safety directors represent agencies with a key role in the promotion of child protection. The network includes representatives from human service departments, the Commission for Children and Young People and Child Guardian, Queensland Treasury and the Department of Justice and Attorney-General.

The Interagency Complaints Management Committee was established in 2005 with managers of complaints management teams from the Commission for Children and Young People and Child Guardian, the Queensland Ombudsman and the Department of Communities, Child Safety and Disability Services. The committee's role is to develop protocols and to work cooperatively.

Question 34

Are the external oversight mechanisms – community visitors, the Commission for Children and Young People and Child Guardian, the child death review process and the Ombudsman – operating effectively? If not, what changes would be appropriate?

9.4 Tier 3: Judicial oversight

Judicial oversight refers to the Queensland Civil and Administrative Tribunal and the courts. These are reviewed in Chapter 10 of this discussion paper.

Question 35

Does the collection of oversight mechanisms of the child protection system provide accountability and transparency to generate public confidence?

Question 36

Do the current oversight mechanisms provide the right balance of scrutiny without unduly affecting the expertise and resources of those government and non-government service providers which offer child protection services?

[1] *Commissions of Inquiry Order (No. 1) 2012.*
[2] *Child Protection Act 1999* (Qld) s 248.
[3] Statement of Michael Bond, 11 December 2012 [p3: para 26].
[4] *Child Protection Act 1999* (Qld) s 246A.
[5] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 86.
[6] Submission of Department of Communities, Child Safety and Disability Services, December 2012 [pp114-5].
[7] Submission of Commission for Children and Young People and Child Guardian, 21 September 2012 [p94: para 339]. This figure also includes issues raised by young people in detention centres.
[8] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) ch 4.
[9] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 64(1).
[10] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) ch 4.
[11] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 80(4).
[12] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 83.
[13] Exhibit 23, Statement of Elizabeth Fraser, 8 August 2012 [p24: para 88.4].
[14] Monitoring agreements are available at www.ccypcg.qld.gov.au/support/monitoring/index.html.
[15] Submission of Bravehearts, 5 November 2012 [p36].
[16] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) sch 1.
[17] Commission for Children and Young People and Child Guardian response to information request from QCPCI, 7 November 2012.
[18] *State Budget 2012–13*, Service Delivery Statements, Commission for Children and Young People and Child Guardian, p36.
[19] *Commission for Children and Young People and Child Guardian Act 2000* (Qld) s 118.
[20] Exhibit 23, Statement of Elizabeth Fraser, 8 August 2012 [p24: para 88.6].
[21] *Ombudsman Act 2001* (Qld) s 14.
[22] *Ombudsman Act 2001* (Qld) s 50.