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This and the following 2 pages is the annexure marked **"A"** to the affidavit of Elizabeth Fraser affirmed on 8 August 2012 before me

Signed: ……

Role and Functions of CCYPCG Community Visitors

One of the most visible and direct ways the Commission for Children and Young People and Child Guardian (CCYPCG) monitors and advocates for improvements within the child protection and youth justice systems is through its Community Visitors.

The CCYPCG has been delivering a comprehensive visiting program to children and young people in foster care, residential care and detention since 2005 to directly support its position as an independent statutory body promoting and protecting the rights, interests and wellbeing of children and young people in Queensland. By visiting regularly and frequently, Community Visitors are able to provide both an early alert on the safety and wellbeing of children and young people within the context of a dynamic care system and robust independent verification of their circumstances.

Independence

The CCYPCG's independence is critical to it achieving its vision of a better life for Queensland children and young people, particularly those who are most vulnerable. While Community Visitors have a role to actively engage with children and young people alongside other service providers, the role of a Community Visitor is distinct in its direct application of the CCYPCG's independence. Community Visitors work to no other agenda but to maintain the accountability of government and non-government service providers. By engaging with and giving voice to the concerns, views and wishes of children and young people in out-of-home care, Community Visitors can achieve positive, meaningful and sustainable outcomes.

Role and functions

Under section 93 of the *Commission for Children and Young People and Child Guardian Act 2000* the Community Visitors have the following functions:

- In relation to children residing at visitable sites (shelters, residential facilities and detention centres) and visitable homes (foster care):
    - To develop trusting and supportive relationships with the children, so far as possible
    - To advocate on behalf of the children by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances
    - To seek information about, and facilitate access by the children to, support services appropriate to their needs provided by service providers
    - To assess the adequacy of information given to the children about their rights
    - To assess the physical and emotional wellbeing of the children
    - For visitable sites (exclusively):
        - To inspect the sites and assess their appropriateness for the accommodation of the children or the delivery of services to them

(having regard to relevant State and Commonwealth laws, policies and standards)
        - To observe the treatment of children, including the extent to which their needs are met by staff of the sites, and
        - To assess the morale of the staff of the sites, and
        - For detention centres – to assess whether the programs for the release of children subject to detention orders adequately and appropriately prepare them for release.
    - For visitable homes (exclusively):
        - To assess the appropriateness for the accommodation of children, and
        - To observe the treatment of the children, including the extent to which their needs are met by persons caring for them at the homes.

Community Visitors are representatives of the community who bring to the role a diverse range of knowledge and skills and have a proven history of working with children. The CCYPCG provides Community Visitors with a range of training and development initiatives and opportunities to support them to perform the key functions of the position. This, together with a comprehensive suite of policies and procedures, enables the Commission to achieve consistency in visiting practice.

Purpose of visiting

Effective engagement with children and young people supports Community Visitors to hear directly from the children and young people they visit whether their needs are being met, or not met, in their placement.

Community Visitors verify whether children and young people in out-of-home care are:

- safe and stable in their placement
- benefiting from individually tailored and culturally sensitive services and supports which respect their rights and enhance their wellbeing
- supported to achieve sustainable benefits by the competent efforts of care and service providers

Based on information gathered during visits, Community Visitors can advocate for a broad range of issues impacting on the safety and care of visitable children and young people from serious issues to those issues that can be resolved locally.

While other government departments are responsible for meeting the needs of children and young people within the child safety and youth justice systems as prescribed by legislated standards, Community Visitors advocate to these service providers on behalf of children and young people where concerns are raised about standards not being met.

Reporting on visits

Community Visitors have a specific function to report to the Commissioner following visits to children and young people residing in visitable locations. Reporting provides a snapshot of a child or young person's experiences and circumstances at the time of the visit and contributes to the suite of information used by the CCYPCG to rigorously analyse and assist key stakeholders and decision makers better understand the circumstances and experiences of children and young people in Queensland.

Engaging with children and young people, listening to and giving voice to issues important to them and facilitating the resolution of their concerns and grievances places Community

Visitors in a unique position to raise early alerts and highlight areas of systemic risk. Visiting has supported the CCYPCG to establish both base line and credible independent reporting mechanisms for assessing child safety and youth justice systems from the perspective of achieving positive outcomes for children and young people in out-of-home care.

Role description

Role Title:	Community Visitor
Team/Program/Group:	Central North Zone Individual Advocacy and Resolution Program Policy, Advocacy and Reporting Group
Location:	Emerald and Rockhampton
Classification:	Casual ($42.94 per hour inclusive of 23% casual loading)
Job Ad Reference:	QLD/CCYP7015/12
Closing date:	Monday 16 July 2012
Employment Status:	Casual for up to 2 years
Contact Officer details:	Helen Murray on 1800 008 175

Your opportunity

To regularly visit children and young people living in out-of-home care to verify their safety, and if necessary respond to any issues of concern. Community Visitors also must provide information and reports to the Commissioner in accordance with the *Commission for Children and Young People and Child Guardian Act 2000.*

Our Mandate

The Commission for Children and Young People and Child Guardian was created under the *Commission for Children and Young People and Child Guardian Act 2000* ("the Act"). The Act provides for the establishment of the Commission's mandate to promote and protect the rights, interests and wellbeing of children and young people in Queensland.

The objectives sought by the Commission are:

- The rights, interests, safety and wellbeing of all Queensland children and young people are upheld and enhanced.
- Vulnerable children and young people in Queensland have appropriate support and early intervention services.
- Effective child safety and youth justice systems to protect and support children and young people where legislative intervention is appropriate.

There are four core values that guide every aspect of our work in helping to make Queensland a safer place for children and young people:

Integrity – our ethical principles.
Leadership – our ability to make a difference.
Innovation – our ability to do our work better.
Collaboration – our ability to work with others.

To find out more about our vision, mission and values and organisational structure please refer to our internet site www.ccypcg.qld.gov.au.

Key Accountabilities

- Visit children and young people in out-of-home care in accordance with the functions outlined in the Commission for *Children and Young People and Child Guardian Act 2000*, and the policies and procedures of the Commission. In particular:
    - Build rapport and form trusting and supportive relationships with children and young people, demonstrating empathy for and understanding of children and young people from a vulnerable background
    - Build rapport and open communication with carers, monitoring the care provided to ensure the best interests of children and young people
    - Identify care issues on behalf and/or in conjunction with the child or young person
    - Prepare reports on visits for the Commissioner in a timely and professional manner, entering all relevant information into the Community Visitor system (Jigsaw)
    - Attempt to achieve local resolution on relevant care issues in consultation with the Zonal Managers and other internal and/or external stakeholders, and
    - Escalate serious care issues when required.
- Undertake and action work allocations from the Zonal Manager, check work allocations and update these records on the Community Visitor system (Jigsaw).
- Utilise written communication and information technology literacy skills to compile and prepare written reports and correspondence efficiently and effectively and submit reports online through the Community Visitor system (Jigsaw) ensuring reporting requirements are fulfilled.
- Liaise with the Zonal Manager regarding workload, discussing any care issues or concerns and formulating collaborative and shared solutions.
- Collate and prepare other reports as required by the Commissioner.
- Maintain confidential and up-to-date records and information, ensuring all work and documentation is completed in an accountable and efficient manner, and submit accurate and timely timesheets and expense claims.
- Attend and actively participate in all relevant training, team meetings, supervision sessions and maintain up-to-date knowledge of all relevant legislation and policies.
- Participate in providing feedback and suggestions to team members and actively participating in knowledge sharing.

- Assist the Commission in the process of conducting surveys to obtain views of children and young people in foster care, residential care and detention centres.

Delegations

The resource requirements of the Individual Advocacy and Resolution Program are driven by demand and are dependent on the number, geographical location and frequency of the visiting schedule of children and young people in out-of-home care. The quantity, type and frequency of work allocated to Community Visitors during the term of appointment will depend upon the varying operational needs of the Commission.

Community Visitors are required to visit all locations allocated to them by the Zonal Manager and fulfill all associated work requirements.

This position reports to the Zonal Manager responsible for the Zone within which the Community Visitor will work.

Mandatory Requirements

1. In accordance with section 107 (5) of the *Commission for Children and Young People and Child Guardian Act 2000*, A person may not hold office as a community visitor while the person is-

   (a) a member of the police service; or

   (b) a public service employee employed in the child safety department or a department whose primary responsibilities include health, disability services or correctional institutions; or

   (c) engaged in any capacity in relation to a correctional institution, other than as an official visitor under the *Corrective Services Act 2006*; or

   (d) an approved carer.

2. This role falls within the category of regulated employment as defined under schedule 1 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) or child related duties as determined by the Commissioner. Applicants being considered for engagement in this role will be required to provide consent to and undergo employment screening under the blue card system. Applicants must meet employment screening arrangements to be eligible for appointment. Possession of a Blue Card or positive exemption card at all times is a mandatory requirement for this role.

3. It is a condition of employment that Community Visitors must have a computer with a minimum operating system of Windows XP (service pack 3), though Windows Vista or Windows 7 are preferred. Apple Macintosh OSX with Intel processor or Linux with Kernel version 2.6 is not preferred as support to these operating systems will only be provided on a best effort basis. The computer must also have a minimum of 2GB of RAM, Internet Explorer 8 or higher, a 3.0GHz processor or equivalent processor or any higher specification. Appropriate virus protection and firewall software must be installed on the computer. A connection to the internet through a reliable Internet Service Provider is essential. An ADSL connection is preferred as the minimum requirement when available. The computer used to undertake the work required in the role must be one which is private and on which material cannot be accessed by persons not authorised to do so.

4. Successful applicants must possess a current C class drivers licence. Allowances are paid for usage of a private vehicle for work related travel and for official communication expenses. It is a requirement of the position that Community Visitors have a roadworthy motor vehicle which

is registered in the State of Queensland, has Compulsory Third Party (CTP) and full comprehensive insurance.

Key Result Areas

You will be assessed on your capability and capacity for the following in the context of the accountabilities of the role.

Key Result Area	Skills, knowledge and abilities
Communication and interpersonal skills	Build rapport with children, young people and adults, including the capacity to build strong professional relationships while dealing with challenging situations and adjust communication style to suit audience needs. Strong written communication and information technology skills to prepare accurate, comprehensive and concise reports and correspondence in a timely manner in accordance with legislative provisions.
Self management	Demonstrates high level time management, organisational and planning skills which involves the ability to establish work priorities and coordinate concurrent tasks, including the capacity and emotional maturity to understand and accept practical impacts and legislative boundaries of the role and display honesty, integrity and empathy in dealing with vulnerable children and young people.
Problem solving and analytical skills	Creatively and innovatively problem solve, demonstrating a high level of ability to make decisions within legislative and policy frameworks and facilitate resolution of concerns and grievances in order to achieve outcomes which are in the best interests of children and young people.
Team focus	Actively participate and share information/knowledge with local, regional and state-wide teams; contribute to the effective functioning of the workgroup within a complex and changing environment and work towards the Commission's objectives, vision, and values.

How to Apply

Applicants are required to:-
Provide three pieces of information, to initially assess suitability for this role:

1. An Advertised Position Application Form (for offline applicants only);
2. A current resume, outlining previous work or voluntary experience, education / qualifications and any other information that is relevant to the responsibilities of this role including the names and contact details of two referees (one referee should be a recent supervisor), and
3. A concise statement of no more than two pages addressing the key result areas

The Commission's *Role Description*, *Advertised Position Application* and *Guidelines for Applicants* will assist applicants in preparing their application.

All applicants are encouraged to utilise the apply on-line facility by visiting the www.jobs.qld.gov.au Smart Jobs and Careers Website.

Off-line applications may be submitted via post or hand delivered to the:-

HR Coordinator (Recruitment Services)
Corporate Administration Agency
PO Box 3159 or 35 Merivale Street, South Brisbane Q 4101

Or via facsimile: 07 3842 9393
Or via Email: recruitment@caa.qld.gov.au
(Job Ad Reference number and position title in subject line)

For further enquiries regarding this advertised vacancy and associated selection process, please contact Helen Murray on 1800 008 175.

NOTE: All information submitted by an applicant for this role is subject to the *Right to Information Act 2009*. As a result, information submitted by all applicants may be released under the Act if requested.

Additional Information

- For further information about the role and responsibilities of the Commission, please visit www.ccypcg.qld.gov.au.
- For further information about working for the Queensland Government please visit www.qld.gov.au.
- To obtain information relating to the fortnightly and yearly salary rates which apply to this role please refer to the Revised Salary/wages schedules for employees under the relevant State Government Departments Certified Agreement available at http://www.justice.qld.gov.au/fair-and-safe-work/industrial-relations/queensland-government-employees/awards-and-agreements
- This role description details the minimum knowledge, skills and abilities required to perform the duties of this role.
- Whilst the Commission values the enhanced work performance derived from the expanded knowledge and skill base resulting from tertiary study, it also acknowledges that enhanced work performance can result from other learning experiences, including: on-the-job training and structured professional development or life experiences.
- Persons who are being considered for engagement in the Commission, including child related duties or duties which fall within the category of regulated employment as defined under schedule 1 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) may be required to consent to and undergo a criminal history check and/or meet employment screening requirements before commencing duties in the role.

  Persons will be required to provide written consent and disclose any criminal history through the completion of a Criminal History Declaration and Consent form.

The Commissioner may obtain a formal Criminal History Check from Queensland Police regarding the preferred applicant, prior to confirmation of the preferred applicant's appointment to the position. The possession of a criminal history is not an automatic bar to employment as the nature of the circumstances of any offences will be taken into consideration.

A person will be given a reasonable opportunity to make representations about criminal history information before an assessment is made about suitability for appointment. Information obtained through the criminal history check will only be used for the purpose of assessing a person's suitability for employment with the Commission and will be treated confidentially and stored securely.

Please note: The Blue Card system disqualifies certain persons from applying for a Blue Card and working in prescribed employment (i.e. regulated or child related duties). A person who holds a current negative notice or current negative exemption notice must not apply for a role or start or continue in a role that involves regulated employment. It is an offence for a disqualified person to sign a blue card application.'

- The successful applicant will be required to sign a Confidentiality Agreement upon commencement of duty.
- A probationary period may apply to successful candidates external to the public sector.
- To be eligible for appointment as a tenured (permanent) public service officer a person must reside in Australia and have permission under Commonwealth law to work in Australia and remain indefinitely. To be eligible for temporary appointment, applicants must provide proof that they can legally work in Australia.
- A non-smoking policy is effective in Queensland Government buildings, offices and motor vehicles.
- The Commission for Children and Young People and Child Guardian will use any information you provide in support of your job application to process the application. The information will only be accessed by the selection panel members and support staff who assist in the selection process.
- Applications received will remain current for 12 months from the closing date of advertising.
- The Commission for Children and Young People and Child Guardian is committed to supporting and maintaining a healthy work-life balance for its employees. Where it meets operational and business requirements, short-and long-term arrangements of flexible work arrangements will be considered.
- Any applicant recommended for appointment who is a current or previous public sector employee is required to disclose previous serious disciplinary action taken against them.
- Newly-appointed public service employees are obliged to disclose within one month of starting duty, a disclosure of employment as a lobbyist in the previous two years.
- The Commission is committed to equal employment opportunity which aims to employ a workforce more representative of the wider community.

Commission for Children and Young People and Child Guardian

Monitoring Plan 2011-12 – Department of Communities

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Commission will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to the Department of Communities (the Department) for the period 1 July 2011 to 30 June 2012
- consolidate the Commission's monitoring and data priorities for 1 July 2011 to 30 June 2012 to enable the Department to plan for timely and accurate provision of information required for the Commission's monitoring and reporting activities, and
- enable the Commission to provide the Department with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Scope

This Monitoring Plan:

- supports the overarching Memorandum of Understanding (MoU) between the Commission and the Department of Communities, and satisfies the work program requirements contained in the MoU
- replaces the 2010-11 Monitoring Plan previously negotiated by the Commission and the Department, and prior to that the Monitoring Plans negotiated by the Commission with the former departments of Child Safety, Communities, Housing and Disability Services Queensland; and
- will be reviewed and updated annually, prior to the start of each financial year.

The Commission has a number of separate documents in place (or in the process of being developed and negotiated with the Department), to support the other legislative functions of the Commission. This includes a separate:

- Protocol for Complaints (finalised)
- Protocol for Investigations (finalised)
- Protocol for Child Death Case Review Committee (finalised)
- Protocol for Community Visitor program (Disability Services and Youth Justice) (in progress)
- Updated Visitable Sites and Visitable Homes Protocol (in progress), and
- Protocol for Child Deaths (in progress).

1.3 The Commission's Child Guardian monitoring functions

Under section 18(1) of the Act the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child safety system
- monitor, audit and review the handling of individual cases of children in the child safety system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

[1] Service providers to which the monitoring powers apply are defined under s 39 of the Commission's Act to include the "Child Safety Department" and "a department that is mainly responsible for" community services, adult corrective services, the administration of justice, Aboriginal and Torres Strait Islander policy, disability services, education, housing services and public health. Certain non-government organisations that are licensed under the *Child Protection Act 1999* are also included as service providers.

The Commission's Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the Department as the department responsible for service delivery in the following areas:

- child safety
- Aboriginal and Torres Strait Islander policy
- community services
- disability services
- youth justice services, and
- housing services.

In performing its monitoring functions, the Commission must work cooperatively with service providers to the greatest extent possible[2], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[3]. Accordingly, this monitoring plan is intended to fulfil these legislative obligations and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

1.4 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Commission must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[4].

Furthermore, the Commission's obligations to service providers as outlined in section 1.3 above must not limit its legislative obligation to act independently and in the best interests of children[5].

If the Commission identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Commission may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

[2] Section 23(2)(a)(i) of the Act.
[3] Section 23(2)(b)(i) of the Act.
[4] Section 22(1)(a) of the Act.
[5] Section 22(2) of the Act.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Commission will use information and data provided by the Department under this plan to produce the following public reports:

Commission Report	Frequency	Purpose	Appendix
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.	B
Snapshot – Children and Young People in Queensland	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).	A
Child Guardian Report (Child Protection System)	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.	B
Child Guardian Report (Youth Justice System)	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.	C / D
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care.	E
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.	E
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres	NA for this plan
Annual Report - Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.	F

The consultation process outlined in clause 10.10 of the Memorandum of Understanding between the Commission and the Department[6] (the Memorandum) will be followed in relation to these public reports.

[6] As executed on 20 January 2010.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Commission will collect data to inform its monitoring frameworks for both the child protection and youth justice systems.

These indicators will assist the Commission to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

The Commission recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Commission will work with the Department to amend the Appendices (see Section 2.5) if there appears to be opportunities to streamline the information that the Department is required to provide at both national and state level.

2.3 Quarterly and annual reporting of system-wide data by the Department

Appendix A outlines the data to be provided by the Department for the Snapshot report for the 2011-12 period.

Appendix B and C outline the data to be provided by the Department against the child protection system and youth justice system key outcome indicators for the 2011-12 period.

Appendix D outlines the information to be provided by the Department about harm to young people in detention centres (as required under s 37 of the *Youth Justice Regulation 2003*). Similar requirements exist in relation to harm to children and young people placed under s 82(1) of the *Child Protection Act 1999* (s 13 *Child Protection Regulation 2000*). Appendix B includes these requirements.

Appendix E outlines the data to be provided for the Views of children and young people in foster care survey and the Views of young people in residential care survey for the 2011-12 period.

No data are required for the Views of young people in youth detention centres for the 2011-12 period as these requests are scheduled to occur in the 2012-13 period. The data requirements for this work will be the same as discussed and negotiated for the 2010-11 year (see section 2.5 about ongoing negotiation about data).

Appendix F outlines the data to be provided for the purposes of the annual Child Death Report.

The Commission expects that:

- the Department will provide the Commission with corporate performance data in the first instance that has been quality assured and is accurate. If corporate data is not available for a particular data request, the department will provide operational or manual data in that order on the understanding that this data should be used with caution for the purposes of reporting.
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the Department at the earliest possible stage.

The Commission will:

- seek further information from the Department if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the Department's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the Department's data in the context of the Commission information (for example Community Visitor data)
- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the Department identifies
- identify any trends or issues arising from the data analysis, and
- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Commission activities that may be required.

2.4 Data requests excluded from monitoring plan

The following data provided by the Department to the Commission are excluded from this monitoring plan as they are subject to separate protocols between the Commission and the Department and are deemed outside the scope of this monitoring plan:

- information to the Commission to allow it to determine whether a child who died was in social housing (see MOU – Schedule 3);
- information provided to the Commission on a monthly basis to inform visits to children under the guardianship of the Chief Executive Officer by Community Visitors; (see MOU – Schedule 3); and
- information provided to the Commission on blue cards (see MOU – Schedule 3)

2.5 Ongoing negotiation and requests for new data

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the Department and the Commission agreeing to the amendment.

Appendix G outlines data that will be negotiated further during the period 2010-2011. If agreement is reached about any of these requests then a subsequent amendment will be made to the relevant Appendix to provide for provision of the data by the Department.

Amendments to existing data requests and/or further requests for new data will be initiated and discussed at the Monthly senior executive forum under clause 10.6 of the Memorandum of Understanding.

The Department has extremely limited capacity to provide data in addition to that included in the monitoring plan under Appendices A to F.

In all requests for new or amended data the Commission:

- will provide an appropriate lead time between requesting the new or amended data and expecting the Department to be in a position to report the data (depending on the activity required to report the data)
- actively seek the Department's views about appropriate uses for the new or amended data and whether it will inform improvements to outcomes for children and young people, and
- consult with the Department so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The Department will:

- provide advice about the effort required to respond to requests for new or amended data, and
- establish whether there are any alternative options where it is determined that the new or amended data requested would be too difficult/costly to report.

2.6 Process for provision of data by Department

All information contained within the Monitoring Plan will be approved by the Director-General, Department of Communities prior to its release to the Commission. The Director-General has delegated this approval to the Deputy Director-General, Child Safety, Youth and Families and all information will be provided to the Commission via the Office of the Deputy Director-General, Child Safety, Youth and Families.

The provision of information will either be emailed or provided in hard copy depending on the data type and will be provided to the Commission's lead contact, unless otherwise specified by the Commission. For data that is published on the department's website the Department will advise the Commission via email that the data is now available on the website and the Commission will retrieve the data from the website accordingly.

It should be noted that contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.

3. Ad hoc monitoring and review activities

The Commission may also conduct ad hoc monitoring and review activities which may involve:

- system level data analysis of information held by the Department and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the Department conduct its own review of an aspect of service delivery, this review then being evaluated by the Commission.

3.1 Selection of ad hoc monitoring and review activities

In the interests of using the Department's and the Commission's resources effectively the Commission agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Commission suggests that children and young people in the child safety system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring and review activities

For each ad hoc monitoring activity, the Commission agrees to, in writing:

- advise the Director-General that the Commission is considering undertaking a new monitoring activity

- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the Department's views regarding the proposed monitoring activity
- seek the Department's views about the best way for the required information or documents to be provided to the Commission
- seek the Department's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Commission expects the Department to:

- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the Department, the Commission will either formally commence its monitoring activity through the issue of a notice under the Act or initiate an informal review activity and issue a letter notifying of the commencement of the activity and requesting relevant information. When issuing such notices or letters the Commission agrees to:

- take into account all issues raised and requests made by the Department during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the Department and assist the Department to fulfil the requirements of the notice by the due date/s specified in the notice/letter.

Statutory notices may require the Department to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Commission recognises that these documents may be current working files. Timeframes will be negotiated between the Department and the Commission and there will be provision for an extension of time when appropriate. The Department must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the Department must seek this formally in writing to the Commission.

The Commission expects the Department to note that a failure to comply with a statutory notice issued under the Act may result in the Commission reporting the non-compliance to the relevant Minister[7].

3.3 Provisional reporting process about ad hoc monitoring and review activities

The Commission will:

- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[8], and
- provide a copy of the provisional report to the Department, and any officers adversely named in the report, to comply with requirements of procedural fairness[9].

[7] Under section 51 (1) (a) of the Act.
[8] Section 50(1) of the Act provides that the Commissioner may make recommendations to the Department about matters arising from the performance of the monitoring functions.
[9] Sections 50 (2) and 85 of the Act .

The Department and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and be provided with a reasonable opportunity to respond.

Where appropriate, parties will meet to discuss the critical issues arising from the response.

3.4 Final report about ad hoc monitoring and review activities

After the Department's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Commission will prepare its final report and provide it to the Department. In finalising its final report, the Commission will:

- give serious consideration to all responses received
- include the Department's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the Department and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the Department outlining how the Department's feedback has been dealt with.

The Commission will also provide a copy of the final report to the relevant Minister[10].

3.5 Implementation of accepted recommendations

The Commission may also request evidence that the Department has implemented the accepted recommendations made in the final report after a reasonable period of time.

The Commission also expects that the Department understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Commission[11].

3.6 Public reporting about ad hoc monitoring activities

The Commission has the ability to make de-identified reports about its monitoring activities public by either releasing them onto the Commission's website or asking the Minister to table them in Parliament[12].

The Commission will make its reports public when they meet the following criteria.

Criteria 1

The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer

AND

Criteria 2

a) The public release of the report will further the understanding of, and participation in, the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child protection

[10] As required by section 50(3) of the Act.
[11] Under section 51(2) of the Act.
[12] Under Chapter 4 Division 6 of the Act.

system, the youth justice system and other vulnerable children,
OR
b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child protection system.

4. Review

The monitoring plan will be reviewed annually by both parties.

5. Agreement

The signatures below represent agreement by the Commissioner and Director-General of the Department to the terms of this Monitoring Plan.

ELIZABETH FRASER **Commissioner for Children and Young People and Child Guardian** **Date** 2.12.12	**LINDA APELT** **Director-General,** **Department of Communities** **Date** 12.12.12

Appendix A – Data for the Snapshot Report

Contacts:[13]
Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 323 59400. In addition, existing contacts are indicated by category.
CCYPCG: Strategic Policy and Research, Fiona Boorman, Manager Research, ph 3211 6961

Measure	Reference periods for data	Request by date	CCYPCG comment
Child Safety Services Nil			Child protection figures to be published in Snapshot are drawn from data provided to CCYPCG for the Child Guardian Report and from publically available sources.
Disability Services Users of Commonwealth State Territory Disability Agreement Services by age (age groups: under 5 years, 5-14 years, 15-17 years) by Indigenous status, Queensland, 2008-09	2010-11	28/01/12	Update on annually provided data. [Existing contact: Aaron Key, A/Project Manager - Principal Data Analyst, Evidence, Reporting and Performance Branch Ph: 07 3247 6222]
Users of Commonwealth State Territory Disability Agreement Services by age (age groups: under 5 years, 5-14 years, 15-17 years) by Type of disability, Queensland, 2008-09 Disability categories: • Intellectual / learning [intellectual, specific learning, autism, developmental delay] • Psychiatric [psychiatric] • Sensory / speech [deafblind, vision,			

[13] Contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.

Measure	Reference periods for data	Request by date	CCYPCG comment
hearing, speech] • Physical / diverse [physical, acquired brain impairment, neurological] • Other / not adequately described			
Youth Justice Average daily number and population rate of young people in youth detention by Indigenous status, gender, age, and legal status (remand vs custody).	2010-11	28/01/12	Update of data provided in 2011. [Existing contact: Darren Hegarty, Director, Youth Justice Policy, Performance, Programs and Practice, Ph: 07 3239 0093, Email: Darren.hegarty@communities.qld.gov.au]
Admissions to youth detention by Indigenous status, gender, age			
Young people subject to supervision orders by Indigenous status, gender, age and order type (community service, detention, probation etc)			
Measure to reflect length of time young people spend in detention (yet to be specified)	2010-11	28/01/12	The specific details of this measure are currently being finalised with Communities.

Appendix B – Data for child protection system key outcome indicators

Contacts:[14]
Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Amy Miller, Principal Project Officer, Ph: 3404 3555
Child Guardian Contact: Systemic Monitoring and Review Program, Tania Dunn, A/Manager Monitoring, ph 3211 6778

Measure	Reference period for data	Request by date	CCYPCG Comment
Child protection system outcome 1: Effective Assessments			
Number of Intakes recorded in the Reference period (including discrete children), by region	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Number of unborn children subject to a notification and number of unborn children subject to a substantiation	Annual for the 10-11 year	31/10/11	As above
Number of notifications recorded in reference period (including discrete children), by region, and age group (under 1 year, 1–4 years, 5–9 years, 10–14 years, 15–17 years)	Annual for the 10-11 year	31/10/11	As above
Number of substantiations recorded in reference period (including discrete children), by region	Annual for the 10-11 year	31/10/11	As above
Number of substantiations recorded in reference period, disaggregated by harm type and region	Annual for the 10-11 year	31/10/11	As above
Number of notifications requiring investigation by assessment outcome, disaggregated by region and age group	Annual for the 10-11 year	31/10/11	As above

[14] Contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.

Measure	Reference period for data	Request by date	CCYPCG Comment
Number and % of Investigation and Assessments that are responded to in the timeframe (24 hour, 5 and 10 day) determined during intake, by region, response timeframe	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above
Number and % of Investigations and Assessments that were finalised within 60 days, disaggregated by response timeframe and region	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above
Number of children subject to a Child Concern Report, who are subject to a subsequent Child Concern Report or Notification recorded within 12 months	Annual for the 10-11 year	31/10/11	As above
Child protection system outcome 2: Appropriate interventions			
Number of children subject to protective Orders by indigenous status, placement type and Region as the last day of the reference period	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Number of children subject to intervention with Parental Agreement as the last day of the reference period	Annual for the 10-11 year	31/10/11	As above
Number of children in out-of-home care as at last day in reference period	Annual for the 10-11 year Quarterly for the 11-12 year[15]	31/10/11 Ongoing from 31/10/11	As above
Number of children subject to a Child Protection Order by order type and placement type as at last day of reference period	Annual for the 10-11 year	31/10/11	As above

[15] Quarterly information will be available from the end of the subsequent quarter.

Measure	Reference period for data	Request by date	CCYPCG Comment
Number of children living away from home as at the last day of the reference period, disaggregated by order type, gender and Aboriginal and Torres Strait Islander status and Region	Annual for the 10-11 year	31/10/11	As above
Number of children and young people subject to ongoing intervention, by ongoing intervention type, and Region in the reference period	Annual for the 10-11 year	31/10/11	As above
Number of the families referred to Referral for Active Intervention (RAI) in reference period, disaggregated by Aboriginal and Torres Strait Islander status	Annual for the 10-11 year	31/10/11	As above
The number of families referred to RAI, by source of referral in reference period	Annual for the 10-11 year	31/10/11	As above
Number of families engaging with a RAI, by Aboriginal and Torres Strait Islander status	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above
Number and % of families who exhibit improvement in presenting factors at exit from RAI	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above

Measure	Reference period for data	Request by date	CCYPCG Comment
Child protection system outcome 3: Safe out of home care			
Number of Matters of Concern Notifications, by assessment outcome in reference period, disaggregated by Region (case and child count)	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011. (Please note that in previous years, only the case count was requested and provided. The Commission would like to receive the data as a child count as well in order to determine rates. This reporting is a requirement of s 13 of the *Child Protection Regulation 2000*.)
Number of Matters of Concern – Child Placement Concern Reports in reference period, disaggregated by Region (case and child count)	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011. (Please note that in previous years, only the case count was requested and provided. The Commission would like to receive the data as a child count as well in order to determine rates. This reporting is a requirement of s 13 of the Child Protection Regulation 2000).
Number of Matters of Concern substantiated by harm type, Region and Indigenous status (case and child count)	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	On track for provision by the Department on 31 October 2011. This reporting is a requirement of s 13 of the *Child Protection Regulation 2000*.
Number of children and young people who were in out-of-home care during the reference period by Region and Indigenous status.	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011. Please note that in 2010, only the regional breakdown was requested and provided. The Commission would like to receive the Indigenous status breakdown in order to determine rates.
Number of children living away from home subject to an active suicide risk alert, in reference period by Region	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
List of residential and co-ordination point licences in the scope of licensing at a reference date, including organisation name, service name, application status and count of licenses per organisation	Annual for the 10-11 year	31/10/11	As above

Measure	Reference period for data	Request by date	CCYPCG Comment
Number of substantiated Matters of Concern per year, by harm type, Region	Annual for the 10-11 year	31/10/11	As above
Child protection system outcome 4: Stable out-of-home care			
Number of children who exited care in the reference period by length of time in care and number of difference placements	Annual for the 10-11 year Quarterly for the 11-12 year	31/10/11 Ongoing from 31/10/11	On track for provision by the Department on 31 October 2011.
Number of carers, by approved status, Indigenous status, by Region	Annual for the 10-11 year	31/10/11	As above
Proportion of children who are placed with their siblings	Annual for the 10-11 year	31/10/11	As above
Number of children and young people in out-of-home care who self-placed to a non-departmentally approved placement	Annual for the 10-11 year	31/10/11	As above
Child protection system outcome 5: Individual needs being met			
Number and % of children and young people under the custody of guardianship of the Chief Executive	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Number and % of children and young people in out-of-home care who have a current case plan	Annual for the 10-11 year Quarterly for the 11-12 year	31/10/11 Ongoing from 31/10/11	As above

Measure	Reference period for data	Request by date	CCYPCG Comment
Child protection system outcome indicator 6: Best education possible			
Number of children and young in out-of-home care enrolled at a Queensland State School or private school (as at date with reporting period)	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Proportion of children placed away from home who were at or above the national minimum standard in Reading, Writing, Spelling, Grammar and Punctuation, and Numeracy.	Annual for the 10-11 year	31/10/11	As above
Number and % of eligible children and young people with an Education Support Plan	Annual for the 10-11 year	31/10/11	As above
Child protection system outcome 7: Best possible health			
Number and % of children and young people under the custody or guardianship of the Chief Executive	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	On track for provision by the Department on 31 October 2011.
Proportion of children in out-of-home care who received a CSTDA service.	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above
Child protection system outcome 8: Special needs of Aboriginal and Torres Strait Islander Children and young people are met.			
Number of Aboriginal and Torres Strait Islander children and young people subject to an intake, by intake and age group (by age group Under 1 year, 1–4 years, 5–9 years, 10–14 years, 15–17 years).	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	On track for provision by the Department on 31 October 2011.
Number of Aboriginal and Torres Strait Islander children and young people subject to a substantiated Notification	Annual Quarterly for the 11-12 year	31/10/11 Ongoing from 31/10/11	As above

Measure	Reference period for data	Request by date	CCYPCG Comment
Number of Aboriginal and Torres Strait Islander children and young people subject to an Intervention with Parental Agreement	Annual for the 10-11 year	31/10/11	As above
Number of Aboriginal and Torres Strait Islander children and young people subject to a protective order	Annual for the 10-11 year	31/10/11	As above
Number of Aboriginal and Torres Strait Islander children and young people living away from home	Annual for the 10-11 year Quarterly for the 11-12 year	31/10/11 Ongoing from 31/10/11	As above
Number of Aboriginal and Torres Strait Islander children and young people placed in out-of-home care	Annual for the 10-11 year	31/10/11	As above
Number of Aboriginal and Torres Strait Islander children and young people who exited care in reporting period	Annual for the 10-11 year	31/10/11	As above
Number of Aboriginal and Torres Strait Islander children and young people in out-of-home care subject to a Matter of Concern substantiation	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	As above
Aboriginal and Torres Strait Islander children and young people subject to ongoing intervention, by ongoing intervention type, and Region	Annual for the 10-11 year	31/10/11	As above
Number of children living away from home, by primary placement (home-based care, residential care, other) and Indigenous status as at reference date	Annual for the 10-11 year	31/10/11	As above
Number and percentage of Aboriginal and Torres Strait Islander children and	Annual for the 10-11 year	31/10/11	As above

Measure	Reference period for data	Request by date	CCYPCG Comment
young people placed with Aboriginal and Torres Strait Islander carers.			
Child protection system outcome 9: Successful reunifications			
Number of children who exited out-of-home care during reference period (disaggregated by Region, age and Aboriginal and Torres Strait Islander status)	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Child protection system outcome 10: Successful transitions to independence			
Number of children who exited out-of-home care during reference period (disaggregated by Region, age and Aboriginal and Torres Strait Islander status)	Annual for the 10-11 year	31/10/11 Ongoing from 31/10/11	On track for provision by the Department on 31 October 2011.
Number and % of Year 12 completers identified as being in out-of-home care, who were either learning, earning or neither (Source: Next Step Survey)	Annual for the 10-11 year	31/10/11	As above
Number of children subject to a finalised child protection order for more than 12 months who were admitted to a supervised youth justice order at some time during the year.	Annual for the 10-11 year	31/10/11	As above. Please note that this figure may also be used in the Child Guardian Report: Youth Justice System.
Number and % of young people who have a current Leaving Care Plan	Annual for the 10-11 year	31/10/11	On track for provision by the Department on 31 October 2011.
Number and % of young people who were involved in the development of their Leaving Care Plan	Annual for the 10-11 year	31/10/11	As above.

Appendix C – Data for the youth justice system key outcome indicators

Contacts: [16]
Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 3235 9400
Child Guardian: Systemic Monitoring and Review Program, Greg Crowley, Senior Analyst, 3211 6950

Annual Measures[17] **Reference period for data: 10-11 financial year** **Due date for data: 31 October 2011**	**Reference period for information**	**Request by date**	**CCYPCG comment**
Number of youth justice conference referrals received disaggregated by referral source. For example, court (indefinite or otherwise) and police.	Annual for the 10-11 year	31 October 2011	On track for provision by the Department on 31 October 2011.
Number of youth justice conference referrals received disaggregated by age, gender and Indigenous status of young people.	Annual for the 10-11 year	31 October 2011	As above
Number of sites funded to administer youth justice conferences.	Annual for the 10-11 year	31 October 2011	As above
Average cost of youth justice conferencing in the nominated financial year.	Annual for the 10-11 year	31 October 2011	As above
Number of youth justice referrals conferenced by the Department of Communities, disaggregated by referral source (indefinite court referral or police), age, gender, Indigenous status and site. Please include the reasons why referrals are not conferenced.	Annual for the 10-11 year	31 October 2011	As above
Number of all youth justice conferences terminated (referred back to the court), disaggregated by reason.	Annual for the 10-11 year	31 October 2011	As above
Number and percentage of youth justice conferencing agreement outcomes (e.g. apologies, restitution etc)	Annual for the 10-11 year	31 October 2011	As above
Total number and distinct number of young people admitted to youth justice supervision order disaggregated by age, gender and Indigenous status.	Annual for the 10-11 year	31 October 2011	As above

[16] Contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.
[17] Data is subject to successful validation and acceptance testing including data quality.

Average daily number of young people in detention, disaggregated by Indigenous status, age, gender and legal status.	Annual for the 10-11 year	31 October 2011	As above
Number and distinct number of young people remanded into custody, disaggregated age, gender and Indigenous status.	Annual for the 10-11 year	31 October 2011	The Department has advised that this data item may not be available in time for 31 October 2011 and will advise the Commission of the availability once known. Depending on when the data becomes available, the Commission may still be able to include in it's 2010-11 Report.
Distinct, total number and percentage of young people in detention by legal status.	Annual for the 10-11 year	31 October 2011	On track for provision by the Department on 31 October 2011.
Number of alleged harm incidents reported by young people accommodated in Queensland youth detention centres.	Annual for the 10-11 year	31 October 2011	As above
Number of young people subject to youth justice supervision who had a completed case plan within required timeframe, disaggregated by Indigenous status and detention/community-based orders.	Annual for the 10-11 year	31 October 2011	As above
Number of pre-sentence reports completed.	Annual for the 10-11 year	31 October 2011	As above
Number of escapes from custody, included during escorted movement.	Annual for the 10-11 year	31 October 2011	As above
Average length of time young people spend on remand, disaggregated by age, gender and Indigenous status.	Annual for the 10-11 year	31 October 2011	The Department has advised that this data item may not be available in time for 31 October 2011 and will advise the Commission of the

			availability once known. Depending on when the data becomes available, the Commission may still be able to include in it's 2010-11 Report.
Number of deaths of young people in custody.	Annual for the 10-11 year	31 October 2011	On track for provision by the Department on 31 October 2011.
Total number and distinct number of young people in detention attending education or training, for the reporting period.	Annual for the 10-11 year	31 October 2011	As above
Daily average education or training attendance levels of young people in detention, for the reporting period.	Annual for the 10-11 year	31 October 2011	As above

Appendix D– Reporting of harm in Youth Detention Centres

Contacts: [18]
Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 323 59400
Child Guardian: Systemic Monitoring and Review Program, Cathryn Richard-Preston, Assistant Analyst, 32116781

Data to be e-mailed to generic Commission data e-mail address after approval by Director-General. E-mail address is data@ccypcg.qld.gov.au.

Information	Reference period for information	Request by date	Comment
Reports of harm as required by s 268 (3) of the *Youth Justice Act 1992* and s 35, 36 & 37 *Youth Justice Regulations 2003* the following information is legislatively required to be provided to the Commission: • child's name, age and gender • details of the basis for the detention centre employee becoming aware of harm or reasonably suspecting, that harm has been caused to the child • details of harm or suspected harm, and • particulars of the identity of anyone who the detention centre knows or reasonably suspects caused the harm or suspected harm or is able to give information about the harm or suspected harm. The Department has also agreed to provide the following information to the Commission in the regular reports of harm or suspected harm: • detention centre who reported the harm or the suspected harm incident • date of harm or suspected harm incident • Youth Detention Centre Reference Number • cultural status of young person subject to the harm or suspected harm • specification of breached youth justice principle/s • type of harm or suspected harm caused according to the departmental coding system • details of previous harm or suspected harm incidents involving subject child	Monthly	End of following month	The Commission is currently working with Youth Detention Operations regarding the level of detail required, specifically data quality.

[18] Contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.

• specification if force was used by the detention centre staff • reasons for use of force used by the detention centre staff • specification if the harm or suspected harm incident was referred to the Queensland Police Service • specification if the harm or suspected harm was substantiated by the Department • outcome of harm or suspected harm incident.			

Appendix E– Data for the 2011 Views of Children and Young People in Foster Care and Residential Care Surveys

Contacts:
Department of Communities, Child Safety Services, Kate Showell, Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, ph: 323 59400
CCYPCG: Strategic Policy and Research, Jennifer Sanderson, Senior Research Officer, ph 3221 6997

Measure	Reference period for data	Request by date	CCYPCG comment/rationale
Children and young people exiting care in 2010/11[19]			
Children and young people exiting care (a) during the year, by age at the time of exit.	2010-11	28/01/12	Data measures have been negotiated based on the Department of Communities' data capture and reporting capabilities.
Children and young people exiting care (a) during the year, by sex.	2010-11	28/01/12	
Children and young people exiting care (a) during the year, by Indigenous status.	2010-11	28/01/12	
Children and young people exiting care (a) during the year, by Region at the time of exit.	2010-11	28/01/12	
Children and young people exiting care (a) during the year, by length of current placement (categories).	2010-11	28/01/12	
Children and young people exiting care (a) during the year, by continuous length of time in care (categories).	2010-11	28/01/12	

[19] Data is based on nationally agreed reporting definitions, and counts the distinct number of children who exited out-of-home care at anytime during the 12 month period; who did not return to out-of-home care within two months of their exit; who spent at least one month continuously in out-of-home care; and who were subject to a protective order (child protection order or court assessment order) granting custody or guardianship to the chief executive at some point in the six months prior to exiting. While this data includes children exiting home-based care (such as with a foster or kinship carer) or a residential care service, these placement types are not separately identified. It is anticipated that future data releases may include placement types.

Measure	Reference period for data	Request by date	CCYPCG comment/rationale
Children and young people exiting care (a) during the year, by number of different placements during the continuous length of time in care (categories).	2010-11	28/01/12	
Children and young people in care as at 30 June 2011[20]			
Children and young people in care (b) as at the reference date, by placement type (c) and age.	30 June 11	28/01/12	Data measures have been negotiated based on the Department of Communities' data capture and reporting capabilities.
Children and young people in care (b) as at the reference date, by placement type (c) and sex.	30 June 11	28/01/12	
Children and young people in care (b) as at the reference date, by placement type (c) and Indigenous status.	30 June 11	28/01/12	
Children and young people in care (b) as at the reference date, by placement type (c) and Region.	30 June 11	28/01/12	
Children and young people in care (b) as at the reference date, by placement type (c) and length of current placement (categories).	30 June 11	28/01/12	
Children and young people in care (b) as at the reference date, by placement type (c) and continuous length of time in care (categories).	30 June 11	28/01/12	

[20] Includes children placed in out-of-home care on the reference date who were also subject to a protective order (child protection order or court assessment order) granting custody or guardianship to the chief executive. Placement type will indentify whether the child was placed in home-based care (such as with a foster or kinship carer) or a residential care service.

Appendix F – Data for annual Child Death Report

Contacts: [21]
Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 323 59400
Child Guardian: Systemic Monitoring and Review Program, Josie Thomas, Child Death Review, ph: 3211 6776

Measure	Reference period for data	Request by date	Comment
Total number of children known to Child Safety Services in the last three years. This is to include the number of children recorded in the 3 years prior to the current reporting period as being subject to child concern reports, notifications, Investigation and Assessments, Orders or Placements.	Distinct children known in 3 year period before 2010–11 financial year	31 July 2011	

[21] Contact officers as listed in these Appendices are for the purposes of data requests as outlined in this monitoring plan only. For all other matters, contacts for reports as outlined in Schedule 5 of the Memorandum of Understanding between the Commission and the Department apply.

Appendix G – Data items to be negotiated

Please note the Commission has undertaken to work through these measures with the Department in early 2012, in order to determine the availability for future reporting and the priority measures for the Commission.

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
Child protection system key outcome indicators Contacts: Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 323 59400 Child Guardian: Systemic Monitoring and Review Program, Tania Dunn, A/Manager, Monitoring, Ph 3211 6778			
Select SCAN data items in relation to the overall performance of SCAN.	Annual 2011-12	**The Department and the Commission to determine the SCAN data items to be reported publicly in the future, after the SCAN Performance Framework Annual Report has been released in late 2011.**	
Number and % of children and young people subject to an intervention who are re-notified, substantiated or placed under a protective order within 12 months of the initial intervention	Annual	**DoCS:** Data specifications are currently being reviewed for the following alternative measure: Proportion of children and young people subject to ongoing intervention who are notified and subsequently substantiated (KPI).	This data item to be kept on the future data priority list and be subject to further discussions.
Number of children aged 17 to 18 years in out-of-home care who received a vocational qualification from TAFE, an OP, or who were OP eligible	Annual	**DoCS:** Negotiations are underway with DET/QSA for data for this measure. Once available, it will be incorporated into Child Safety Services' performance reporting framework. This will be an annual measure only.	This data item to be kept on the future data priority list and be subject to further discussions.
Number of young people in out-of-home care who completed year 12 in the reporting period	Annual	**DoCS:** Negotiations are underway with DET for data for the following alternative	This data item to be kept on the future data priority list and be subject to further discussions.

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
		measure: Proportion of young people placed away from home who complete Year 12 or equivalent. Once available, it will be incorporated into Child Safety Services' performance reporting framework. This will be an annual measure only.	
Number of children and young people with a completed health plan/assessment (or Child Health Passport) as at reference date	Annual	**DoCS:** This measure has been discontinued. In August 2009, new ICMS fields were introduced to capture data on Child Health Passports. However, it will take some time for data from these news fields to be recorded. Once data becomes available, it will be subject to assessment and validation before the measure can be implemented.	This data item to be kept on the future data priority list and be subject to further discussions.
Number and % of placement decisions that comply with section 83 of the *Child Protection Act 1999*	Annual	**DoCS:** Fields relating to s 83 have recently been included in ICMS (Release 5). This data is now subject to data quality assessment. Initial data extraction indicates data quality issues, with a high percentage of missing data. As a result, this measure is currently unable to be reported.	This data item to be kept on the future data priority list and be subject to further discussions.
Number and % of children and young people who were reunified with their family and were subject to a Notification within 3 and 12 months of exiting out-of-	Annual	**DoCS:** Fields have recently been added to ICMS providing reason for child exiting care.	This data item to be kept on the future data priority list and be subject to further discussions.

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
home care		Work to develop a complex report in relation to this measure is underway.	
Number and % of children and young people who were reunified with their family and were subject to a substantiated Notification within 3 and 12 months of exiting out-of-home care	Annual	As above.	**As above**
Youth Justice Key Outcome Indicators Contact officers: Department of Communities: Office of the Deputy Director-General, Child Safety, Youth & Families, Community Participation, Kate Showell, Principal Executive Officer, Ph: 3235 9400 Child Guardian: Systemic Monitoring and Review Program, Greg Crowley, Senior Analyst, 3211 6950			
Average daily cost per young person in detention.	Annual	Nil. This is the first time this data has been requested	The Commission is aware that the Department is currently developing a performance framework for the Youth Justice System and therefore will participate in discussions and negotiations about this data once the framework has been further established.
Average number of hours which young people in youth detention spend outside in either free time or scheduled recreational activities, quarterly.	Annual	Nil. This is the first time this data has been requested	As above
Department of Communities' crime prevention initiatives, for example the Youth Murri Court, and the Coordinated Response to Young People at Risk (CRYPAR) Program.	Annual	Nil. This is the first time this data has been requested	As above

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
Number and percentage of bail support interventions, disaggregated by completions, still active / current, intervention type (court-ordered bail support, CBP, voluntary bail support), court jurisdiction, court location, region, service centre, specified reporting period, distinct young person count and statistical calculations.	Annual	Nil. This is the first time this data has been requested	As above
Number of community service orders for young people that are successfully completed, disaggregated by age, gender and Indigenous status.	Annual	Nil. This is the first time this data has been requested	As above
Number of community-based youth justice supervision orders that are successfully completed.	Annual	Nil. This is the first time this data has been requested	As above
Number of formal breach proceedings, disaggregated by intervention type (court-ordered bail support, CBP, voluntary bail support), proceeding type, non-compliance reason, court jurisdiction, court location, age, gender, Indigenous status, region, service centre, specified reporting period, distinct young person count and statistical calculations.	Annual	Nil. This is the first time this data has been requested	As above
Number of partially-clothed searches in youth detention centres, including the outcomes from search.	Annual	Nil. This is the first time this data has been requested	As above
Number of referrals received by the Youth Bail Accommodation Support Service, disaggregated by successful and unsuccessful referral. That is number of young people out of all referrals that were able to be supported by the program.	Annual	Nil. This is the first time this data has been requested	As above
Number of staff injured as a result of an assault (by a young person).	Annual	Nil. This is the first time this data has been requested	As above
Number of young people discharged from youth justice interventions, disaggregated by intervention type (statutory order or bail support, statutory order type, bail)	Annual	Nil. This is the first time this data has been requested	As above

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
support intervention type, discharge reason, age, gender, Indigenous status, region, service centre, specified reporting period, distinct young people count.			
Number of young people exiting youth detention centres who had one or more of the following supports organised by the transitional officer: employment, education and/or sporting.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people in custody injured as the result of an assault	Annual	Nil. This is the first time this data has been requested	As above
Number of young people in youth detention recorded as a suicide risk, per year.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people in youth detention who were visited by their family, (no. and % that were financially assisted).	Annual	Nil. This is the first time this data has been requested	As above
Number of young people known to child safety services who were sentenced to a supervised youth justice order.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people in youth detention centres recorded as a suicide risk.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people referred (subject to youth justice conference) to an offending specific program funded by DoCS, disaggregated by program, age, Indigenous status and gender, referral rate and completion rate. Programs include CHART, Art and RAP-P.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people sentenced to a youth justice supervision order who had previous youth justice history.	Annual	Nil. This is the first time this data has been requested	As above

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
Number of young people sentenced to youth justice supervision orders, conditional bail and remand who had the following categories identified as a risk/need under the YSL/CMI22 risk/needs assessment: • prior and current offence dispositions • family circumstances/parenting • peer relations • substance abuse • education and employment • personality/behaviour, and • financial and/or accommodation problems	Annual	Nil. This is the first time this data has been requested	As above
Number of young people subject to a finalised child protection order for more than 12 months who were sentenced to a supervised youth justice order.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people subject to supervision order under each contact/supervision level (minimum, medium and maximum; disaggregated by age, gender, Indigenous status, remoteness etc)	Annual	Nil. This is the first time this data has been requested	As above
Number of young people in youth detention centres subject to the use of separation techniques	Annual	Nil. This is the first time this data has been requested	As above
Number of young people who re-offend following completion of a youth justice supervision order.	Annual	Nil. This is the first time this data has been requested	As above
Number of young people who were sentenced to a youth justice supervision order who had previous youth justice history.	Annual	Nil. This is the first time this data has been requested	As above

[22] Youth Level of Service/Case Management Inventory

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
Number of youth justice supervision orders that are successfully completed, disaggregated by length of order, order type and Indigenous status	Annual	Nil. This is the first time this data has been requested	As above
Quarterly reports on the number of young people remanded into custody, disaggregated by age, gender, Indigenous status, reason for remand and length of time on remand.	Annual	Nil. This is the first time this data has been requested	As above
Queensland youth detention centres whose harm allegation is substantiated.	Annual	Nil. This is the first time this data has been requested	As above
Regional location (by Department of Communities' boundaries) of young people sentenced to supervision orders, conditional bail and remand.	Annual	Nil. This is the first time this data has been requested	As above
The average number of cases per youth justice caseworker, disaggregated by region.	Annual	Nil. This is the first time this data has been requested	As above
The average number of cases per detention based youth justice caseworker, disaggregated by detention centre.	Annual	Nil. This is the first time this data has been requested	As above
The number and percentage of youth justice conferencing which are successfully concluded.	Annual	Nil. This is the first time this data has been requested	As above
Number and distinct number of young people who are or who have been subject to a youth justice supervision order, in the reporting period, disaggregated by order type, gender, age and Indigenous status.	Annual	Further discussion to occur.	As above
Number and percentage of complaints received that arise following an alleged incident of harm in a youth detention centre. Disaggregated by alleged person (police, detention staff or other) responsible, and complainant type (young person (self, other), parent,	Annual	Further discussion to occur.	As above

Measure	Reference period for data	Department comments in 2011	Commission comment for 2011-12
staff etc).			
Number of absconds from unescorted leave.	Annual	Further discussion to occur.	As above

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Monitoring Plan – Department of Community Safety

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Child Guardian will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to the Department of Community Safety (the Department) for the period 1 July 2010 to 30 June 2013
- consolidate the Child Guardian's monitoring and data priorities for 1 July 2010 to 30 June 2013 to enable the Department to plan for timely and accurate provision of information required for the Child Guardian's monitoring and reporting activities, and
- enable the Child Guardian to provide the Department with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Child Guardian monitoring functions

Under section 18(1) of the Act the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child protection system
- monitor, audit and review the handling of individual cases of children in the child protection system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

The Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the Department as the department responsible for adult corrective services[2].

In performing its monitoring functions, the Child Guardian must work cooperatively with service providers to the greatest extent possible[3], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[4].

Accordingly, this monitoring plan is intended to fulfil the legislative obligations of the Child Guardian to the Department, and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

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[1] Service providers to which the monitoring powers apply are defined in the Act under s 39 to include the Departments of Child Safety, Communities, Corrections, Justice and Attorney-General, Education and Training, and Housing, Queensland Health and the Queensland Police Service. Certain non-government organisations are also included as service providers.
[2] Section 39 (c) of the Act.
[3] Section 23(2)(a)(i) of the Act.
[4] Section 23(2)(b)(i) of the Act.

1.3 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Child Guardian must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[5].

Furthermore, the Child Guardian's obligations to service providers as outlined in section 1.2 above must not limit its legislative obligation to act independently and in the best interests of children[6].

If the Child Guardian identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Child Guardian may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Child Guardian will use information and data provided by various government agencies under this and other monitoring plans to produce the following public reports:

Child Guardian Report	**Frequency**	**Purpose**
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.
Snapshot	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).
Child Protection System	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.
Youth Justice System	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres.
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care
Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.

[5] Section 22(1)(a) of the Act.
[6] Section 22(2) of the Act.

The Department will always be provided with the opportunity to comment on a draft version of a public report that contains data or comment about the service delivery of the Department.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Child Guardian will collect data to inform the Child Guardian key outcome indicators for both the child protection and youth justice systems.

These indicators will assist the Child Guardian to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

2.3 Quarterly and annual reporting of system-wide data by the Department

Appendix A outlines the data to be provided by the Department against the youth justice system key outcome indicators for the 2010-11 period.

Appendix B outlines the data to be provided for the purposes of the annual Child Death Report or other mandated functions.

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the Department and the Child Guardian agreeing to the amendment. In particular, the Child Guardian recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Child Guardian will work with the Department to amend the Appendices if there appears to be opportunities to streamline the information that the Department is required to provide at both national and state levels.

The Child Guardian expects that:

- the Department will provide the Child Guardian with data which is accurate and has been quality assured
- the data provided by the Department will be capable of being used to inform reporting, and
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the Department at the earliest possible stage.

The Child Guardian will:

- seek further information from the Department if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the Department's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the Department's data in the context of the Child Guardian information (for example Community Visitor data)
- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the Department identifies
- identify any trends or issues arising from the data analysis, and
- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Child Guardian activities that may be required.

2.4 Ongoing negotiation and requests for new data

In any requests for new data the Child Guardian:

- will provide an appropriate lead time between requesting the new data and expecting the Department to be in a position to report the data (depending on the activity required to report the data)
- actively seek the Department's views about appropriate uses for the new data and whether it will inform improvements to outcomes for children and young people, and
- consult with the Department so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The Department will:

- provide advice about the effort required to respond to requests for new data, and
- establish whether there are any alternative options where it is determined that the new data requested would be too difficult/costly to report.

3. Ad hoc monitoring activities

The Child Guardian may also conduct ad hoc monitoring activities which may involve:

- system level data analysis of information held by the Department and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the Department conduct its own review of an aspect of service delivery, this review then being evaluated by the Child Guardian.

3.1 Selection of ad hoc monitoring activities

In the interests of using the Department's and the Child Guardian's resources effectively the Child Guardian agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Child Guardian suggests that children and young people in the child protection system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring activities

For each ad hoc monitoring activity, the Child Guardian agrees to, in writing:

- advise the Director-General that the Child Guardian is considering undertaking a new monitoring activity
- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the Department's views regarding the proposed monitoring activity
- seek the Department's views about the best way for the required information or documents to be provided to the Child Guardian
- seek the Department's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Child Guardian expects the Department to:

- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the Department, the Child Guardian will formally commence its monitoring activity through the issue of a notice under the Act. When issuing notices the Child Guardian agrees to:

- take into account all issues raised and requests made by the Department during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the Department and assist the Department to fulfil the requirements of the notice by the due date/s specified in the notice

Statutory notices may require the Department to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Child Guardian recognises that these documents may be current working files. Timeframes will be negotiated between the Department and the Child Guardian and there will be provision for an extension of time when appropriate. The Department must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the Department must seek this formally in writing to the Commission.

The Child Guardian expects the Department to note that a failure to comply with a statutory notice issued under the Act may result in the Child Guardian reporting the non-compliance to the relevant Minister[7].

3.3 Provisional reporting process about ad hoc monitoring activities

The Child Guardian will:

- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[8], and
- provide a copy of the provisional report to the Department, and any officers adversely named in the report, to comply with requirements of procedural fairness[9].

The Department and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and respond to them by a nominated date (no less than 14 working days from the date of the delivery of the provisional report).

The Child Guardian expects that the Department understands that failure to respond to a provisional report within the nominated timeframe without receiving an extension of time from the Child Guardian will mean that it is deemed that the Department has accepted the provisional report and any proposed recommendations in full.

Where appropriate, parties will meet to discuss the critical issues arising from the response.

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[7] Under section 51 (1) (a) of the Act.
[8] Section 50(1) of the Act provides that the Commissioner may make recommendations to the Department about matters arising from the performance of the monitoring functions.
[9] Sections 50 (2) and 85 of the Act .

3.4 Final report about ad hoc monitoring activities

After the Department's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Child Guardian will prepare its final report and provide it to the Department. In finalising its final report, the Child Guardian will:

- give serious consideration to all responses received
- include the Department's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the Department and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the Department outlining how the Department's feedback has been dealt with.

The Child Guardian will also provide a copy of the final report to the relevant Minister[10].

3.5 Implementation plans for recommendations

Depending on the nature and scope of the recommendations made in the report the Child Guardian may ask the Department to develop and provide an implementation plan including timeframes.

The Child Guardian may also request evidence that the Department has implemented the recommendations made in the final report after a reasonable period of time.

The Child Guardian expects the Department to provide implementation plans and information about implementation upon request by the Child Guardian.

The Child Guardian also expects that the Department understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Child Guardian[11].

3.6 Public reporting about ad hoc monitoring activities

The Child Guardian has the ability to make de-identified reports about its monitoring activities public by asking the Minister to table them in Parliament[12].

The Child Guardian will make its reports public when they meet the following criteria:

Criteria to release a report publicly

The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer

AND

a) The public release of the report will further the understanding of, and participation in, the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child safety system, the youth justice system and other vulnerable children,

OR

b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child safety system.

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[10] As required by section 50(3) of the Act.
[11] Under section 51(2) of the Act.
[12] Under Chapter 4 Division 6 of the Act.

4. Agreement

The signatures below represent agreement by the Commissioner and Director-General of the Department to the terms of this Monitoring Plan.

Elizabeth Fraser **Commissioner for Children and Young People and Child Guardian** **Date** 17/8/10	**Jim McGowan** **Director-General, Department of Community Safety** **Date** 20/8/10

Appendix A – Data for youth justice system key outcome indicators

Contacts: Department of Community Safety, to be advised.

Child Guardian: Systemic Monitoring and Review Program, Casey Bruekers, Assistant Analyst, 3211 6781

Please note: The due date for data to be provided to the Child Guardian is to be negotiated with Department of Community Safety.

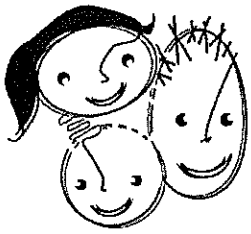
Annual Measures **Reference period for data: 1 July 2010 - 30 June 2011, 1 July 2011 - 30 June 2012, 1 July 2012 – 30 June 2013**
Total number of 17 year olds accommodated in adult correctional facilities in the reporting period and as at 30 June, disaggregated by remand/sentence, age, gender, Indigenous status, offence type and high or low security location.
Total number of 17 year olds subject to court supervision and post prison orders in the reporting period, disaggregated by age, gender, Indigenous status and offence type.
Total number of 17 year olds subject to a court or custodial supervision order (including remand) who are subject to a child protection order.
Total number of 17 year olds subject to court supervision in the reporting period who complete a rehabilitation program, including but not limited to, programs targeting substance abuse, sexual offending, anger management and/or cognitive skills. Disaggregated by age, gender and Indigenous status.
Total number of 17 year olds accommodated in adult correctional facilities who completed an educational or vocational course, or other transitional support program disaggregated by age, gender and Indigenous status.

Appendix B – Data for annual Child Death Report

Contacts: Department of Community Safety, to be advised.

Child Guardian: Systemic Monitoring and Review Program, Angela Oetting, Manger, Child Death Review, ph: 3211 6771

Measure	Legislative provision or administrative agreement	Reference period for data	Comments
Provision of information to enable performance of Commission's child death functions	s.147 *Commission for Children and Young People and Child Guardian Act 2000* Agreement between Commission for Children and Young People and Child Guardian and Department of Emergency Services (16 April 2007)	Ad hoc as need for information is identified	Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably necessary to fulfil the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions. The Commission has previously entered into an agreement with the former Department of Emergency Services for the provision of Queensland Ambulance Service data relating to children who have died due to suspected suicide, fatal assault or neglect.



commission for
children and young people
and child guardian

Monitoring Plan – Department of Justice and Attorney-General

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Child Guardian will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to the Department of Justice and Attorney-General (the Department) for the period 1 July 2010 to 30 June 2013
- consolidate the Child Guardian's monitoring and data priorities for 1 July 2010 to 30 June 2013 to enable the Department to plan for timely and accurate provision of information required for the Child Guardian's monitoring and reporting activities, and
- enable the Child Guardian to provide the Department with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Child Guardian monitoring functions

Under section 18(1) of the Act the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child protection system
- monitor, audit and review the handling of individual cases of children in the child protection system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

The Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the Department as the department responsible for service delivery in the administration of justice[2].

In performing its monitoring functions, the Child Guardian must work cooperatively with service providers to the greatest extent possible[3], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[4].

Accordingly, this monitoring plan is intended to fulfil the legislative obligations of the Child Guardian to the Department, and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

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[1] Service providers to which the monitoring powers apply are defined in the Act under s 39 to include the Departments of Child Safety, Communities, Corrections, Justice and Attorney-General, Education and Training, and Housing, Queensland Health and the Queensland Police Service. Certain non-government organisations are also included as service providers.
[2] Section 39 (c) (ii) of the Act.
[3] Section 23(2)(a)(i) of the Act.
[4] Section 23(2)(b)(i) of the Act.

1.3 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Child Guardian must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[5].

Furthermore, the Child Guardian's obligations to service providers as outlined in section 1.2 above must not limit its legislative obligation to act independently and in the best interests of children[6].

If the Child Guardian identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Child Guardian may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Child Guardian will use information and data provided by various government agencies under this and other monitoring plans to produce the following public reports:

Child Guardian Report	Frequency	Purpose
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.
Snapshot	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).
Child Protection System	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.
Youth Justice System	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres.
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care
Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.

[5] Section 22(1)(a) of the Act.
[6] Section 22(2) of the Act.

The Department will always be provided with the opportunity to comment on a draft version of a public report that contains data or comment about the service delivery of the Department.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Child Guardian will collect data to inform the Child Guardian key outcome indicators for both the child protection and youth justice systems.

These indicators will assist the Child Guardian to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

2.3 Quarterly and annual reporting of system-wide data by the Department

Appendix A outlines the data to be provided by the Department for the Snapshot report.

Appendix B outlines the data to be provided by the Department against the youth justice system key outcome indicators for the 2010-11 period.

Appendix C outlines the data to be provided for the purposes of the annual Child Death Report and other mandated functions.

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the Department and the Child Guardian agreeing to the amendment. In particular, the Child Guardian recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Child Guardian will work with the Department to amend the Appendices if there appears to be opportunities to streamline the information that the Department is required to provide at both national and state levels.

The Child Guardian expects that:

- the Department will provide the Child Guardian with data which is accurate and has been quality assured
- the data provided by the Department will be capable of being used to inform reporting, and
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the Department at the earliest possible stage.

The Child Guardian will:

- seek further information from the Department if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the Department's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the Department's data in the context of the Child Guardian information (for example Community Visitor data)
- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the Department identifies
- identify any trends or issues arising from the data analysis, and

- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Child Guardian activities that may be required.

2.4 Ongoing negotiation and requests for new data

In any requests for new data the Child Guardian:

- will provide an appropriate lead time between requesting the new data and expecting the Department to be in a position to report the data (depending on the activity required to report the data)
- actively seek the Department's views about appropriate uses for the new data and whether it will inform improvements to outcomes for children and young people, and
- consult with the Department so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The Department will:

- provide advice about the effort required to respond to requests for new data, and
- establish whether there are any alternative options where it is determined that the new data requested would be too difficult/costly to report.

3. Ad hoc monitoring activities

The Child Guardian may also conduct ad hoc monitoring activities which may involve:

- system level data analysis of information held by the Department and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the Department conduct its own review of an aspect of service delivery, this review then being evaluated by the Child Guardian.

3.1 Selection of ad hoc monitoring activities

In the interests of using the Department's and the Child Guardian's resources effectively the Child Guardian agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Child Guardian suggests that children and young people in the child protection system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring activities

For each ad hoc monitoring activity, the Child Guardian agrees to, in writing:

- advise the Director-General that the Child Guardian is considering undertaking a new monitoring activity
- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the Department's views regarding the proposed monitoring activity
- seek the Department's views about the best way for the required information or documents to be provided to the Child Guardian
- seek the Department's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Child Guardian expects the Department to:

- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the Department, the Child Guardian will formally commence its monitoring activity through the issue of a notice under the Act. When issuing notices the Child Guardian agrees to:

- take into account all issues raised and requests made by the Department during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the Department and assist the Department to fulfil the requirements of the notice by the due date/s specified in the notice

Statutory notices may require the Department to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Child Guardian recognises that these documents may be current working files. Timeframes will be negotiated between the Department and the Child Guardian and there will be provision for an extension of time when appropriate. The Department must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the Department must seek this formally in writing to the Commission.

The Child Guardian expects the Department to note that a failure to comply with a statutory notice issued under the Act may result in the Child Guardian reporting the non-compliance to the relevant Minister[7].

3.3 Provisional reporting process about ad hoc monitoring activities

The Child Guardian will:

- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[8], and
- provide a copy of the provisional report to the Department, and any officers adversely named in the report, to comply with requirements of procedural fairness[9].

The Department and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and respond to them by a nominated date (no less than 14 working days from the date of the delivery of the provisional report).

The Child Guardian expects that the Department understands that failure to respond to a provisional report within the nominated timeframe without receiving an extension of time from the Child Guardian will mean that it is deemed that the Department has accepted the provisional report and any proposed recommendations in full.

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[7] Under section 51 (1) (a) of the Act.
[8] Section 50(1) of the Act provides that the Commissioner may make recommendations to the Department about matters arising from the performance of the monitoring functions.
[9] Sections 50 (2) and 85 of the Act .

Where appropriate, parties will meet to discuss the critical issues arising from the response.

3.4 Final report about ad hoc monitoring activities

After the Department's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Child Guardian will prepare its final report and provide it to the Department. In finalising its final report, the Child Guardian will:

- give serious consideration to all responses received
- include the Department's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the Department and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the Department outlining how the Department's feedback has been dealt with.

The Child Guardian will also provide a copy of the final report to the relevant Minister[10].

3.5 Implementation plans for recommendations

Depending on the nature and scope of the recommendations made in the report the Child Guardian may ask the Department to develop and provide an implementation plan including timeframes.

The Child Guardian may also request evidence that the Department has implemented the recommendations made in the final report after a reasonable period of time.

The Child Guardian expects the Department to provide implementation plans and information about implementation upon request by the Child Guardian.

The Child Guardian also expects that the Department understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Child Guardian[11].

3.6 Public reporting about ad hoc monitoring activities

The Child Guardian has the ability to make de-identified reports about its monitoring activities public by asking the Minister to table them in Parliament[12].

The Child Guardian will make its reports public when they meet the following criteria:

Criteria to release a report publicly

The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer

AND

a) The public release of the report will further the understanding of, and participation in, the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child safety system, the youth justice system and other vulnerable children,

OR

b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child safety system.

---

[10] As required by section 50(3) of the Act.
[11] Under section 51(2) of the Act.
[12] Under Chapter 4 Division 6 of the Act.

4. Agreement

The signatures below represent agreement by the Commissioner and Director-General of the Department to the terms of this Monitoring Plan.

Elizabeth Fraser **Commissioner for Children and Young People and Child Guardian** **Date** 22/10/10	**Philip Reed** **Director-General, Department of Justice and Attorney-General** **Date** 5/11/10

Appendix A – Data for Snapshot Report

Contacts: Department of Justice and Attorney General, to be advised (existing contact Daryl Villalba, Principal Statistical Advisor, Statistics Analysis Unit)
Childrens Court data: Terese Meyer, Manager, Court Performance and Reporting Unit, ph 3239 6097
Childrens Court of Queensland annual reporting data: Associate to the President of the Childrens Court of Queensland, ph 3247 4448
Youth Murri Court data: Greg Wiman, Manager, Implementation and Evaluation, ph 3247 3350
Youth drug diversion data: Jo-Anne Irwin, Court Diversion Manager, ph 3836 0677

Child Guardian: Strategic Policy and Research, Travis Heller, Senior Research Officer, ph 3211 6975

Measure	Reference periods for data	Due date for data provision	Comment/rationale
Juvenile defendants aged 10-16 appearing in Queensland courts (all court levels) by Indigenous status, Queensland	Annually (financial year)	1 Feb 2011, 2012 and 2013	Update of annually provided data.
Defendants aged 17 years appearing in adult courts by Indigenous status, Queensland	Annually (financial year)	1 Feb 2011, 2012 and 2013	Update of annually provided data.
Juvenile defendants aged 10-16 found or pleading guilty (all court levels) by Indigenous status by most serious penalty, Queensland	Annually (financial year)	1 Feb 2011, 2012 and 2013	Update of annually provided data.
Defendants aged 17 years appearing in adult courts found or pleading guilty by Indigenous status by most serious penalty, Queensland	Annually (financial year)	1 Feb 2011, 2012 and 2013	Update of annually provided data.

Appendix B – Data for Child Guardian youth justice system monitoring framework

Contacts: Department of Justice and Attorney-General.
Childrens Court data: Terese Meyer, Manager, Court Performance and Reporting Unit, ph 3239 6097
Childrens Court of Queensland annual reporting data: Associate to the President of the Childrens Court of Queensland, ph 3247 4448
Youth Murri Court data: Greg Wiman, Manager, Implementation and Evaluation, ph 3247 3350
Youth drug diversion data: Jo-Anne Irwin, Court Diversion Manager, ph 3836 0677

Child Guardian: Systemic Monitoring and Review Program, Casey Bruekers, Assistant Analyst, 3211 6781

Domains	Reference periods for data	Due date for data provision	Measure	Comment
Youth offending and prevention	1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	31 July 2011, 31 July 2012, 31 July 2013	1. Number of young people whose case were disposed of in Queensland courts (all court levels), disaggregated by age[13], gender, Indigenous status, disposal outcome, penalty received and offence type.	The Child Guardian is aware that the total number of young people whose case are disposed in the Childrens Court are made publicly available in the Childrens Court of Queensland annual reports. For the purposes of timely analysis it would be appreciated if DJAG is able to provide this information electronically following approval of the Childrens Court statistical data for print/publication.
		31 July 2011, 31 July 2012, 31 July 2013	2. Total number of charges against young people disposed of in Queensland courts (all court levels) disaggregated by age, gender, Indigenous status and offence type.	The Child Guardian is aware that the total number of charges against young people whose case are disposed in the Childrens Court are made publicly available in the Childrens Court of Queensland annual reports. For the purpose of timely analysis it would be appreciated if DJAG is able to provide this information electronically following approval of the Childrens Court Statistical data for print/publication.

[13] For measures 1-7 which specify disaggregation by age, the Child Guardian would like information for each individual age group (i.e. 10, 11, 12, 13, 14, 15, 16, 17)

		31 July 2011, 31 July 2012, 31 July 2013	3. Total number of young people who appeared for re-sentencing in the Childrens Court of Queensland (as constituted by a Childrens Court judge) following a breach of youth justice orders, disaggregated by age, gender, Indigenous status and non-compliance reason (non-criminal breach of condition or criminal breach of condition).	The Child Guardian considers it would be beneficial to include this information in the Child Guardian Youth Justice report series to analyse the prevalence of breaches and the impact on service demand. DJAG notes this information is only available in the Childrens Court of Queensland (youth justice matters heard by a Childrens Court judge). In the event that data in relation to this measure becomes available the Child Guardian will negotiate with DJAG to receive this data.
		31 July 2011, 31 July 2012, 31 July 2013	4. Total number of young people whose case were disposed of in the Murri Court, disaggregated by age, gender, disposal outcome, penalty received and offence type.	
		To be negotiated	5. Total number of young people who attended court for the first time in the reporting period disaggregated by age, gender, Indigenous status and offence type.	DJAG has indicated that it is not able to provide data on first time offenders. In the event that data in relation to this measure becomes available the Child Guardian will negotiate with DJAG to receive this data.
Diversions	1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	31 July 2011, 31 July 2012, 31 July 2013	6. Total number of young people referred to youth justice conferences disaggregated by gender, age, Indigenous status, offence type, indefinite or before sentence matters.	The Child Guardian is aware that the total number of young people who are referred to youth justice conference by the Childrens Court are made publically available in the Childrens Court of Queensland annual reports. For the purpose of timely analysis it would be appreciated if DJAG is able to provide this information

				electronically following approval of the Childrens Court statistical data for print/publication. Her Honour Judge Dick, President of the Childrens Court of Queensland had agreed to provide the Child Guardian with the data when it has been analysed by the Office of Economic and Statistical Research and this will be a few weeks before the annual report is finalised.
		31 July 2011, 31 July 2012, 31 July 2013	7. Total number of young people referred to drug assessment and education session by Queensland courts (all levels), disaggregated by age, gender, Indigenous status and compliance/non-compliance.	

Appendix C – Data for annual Child Death Report

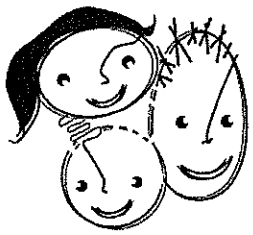
Contacts: Department of Justice and Attorney-General
Births, Deaths and Marriages data: David Johns, Registrar-General, ph 2224 7289
Office of the State Coroner data: Bigita White, Registrar of the Office of State Coroner
Workplace Health and Safety data: Brian Geraghty, Assistant Director, Workplace Health and Safety, ph 3247 5494

Child Guardian: Systemic Monitoring and Review Program, Angela Oetting, Manager, Child Death Review, ph: 3211 6771

Agency	Measure	Data required	Legislative provision or administrative agreement	Reference period for data	Comments
Registry of Births, Deaths and Marriages	Notice of registration of child death	• registration number • child's name • child's place of birth • child's usual place of residence • child's age • child's sex • child's occupation • duration of last illness • date and place of death • cause of death	s.48A *Births, Deaths and Marriages Registration Act 2003*	Ongoing provision on monthly basis	
	Additional death registration information	• Aboriginal and Torres Strait Islander status • Date of birth • Mode of dying	s.48B *Births Deaths and Marriages Registration Act 2003* Memorandum of Understanding for the Provisions of Child Death Data (15 September 2008)	Ongoing provision on monthly basis	Section 48B of the Act enables the Registrar to enter into an arrangement with the Commissioner to provide additional data. The data listed is currently provided by administrative arrangement only.
	Birth registration information	• If multiple birth, state order • Child's birth weight • Mother's name including maiden surname • Mother's date of birth and age • Mother's place of birth • Mother's usual place of residence • Mother's usual occupation • Mother's Aboriginal and Torres Strait Islander status			

Agency	Measure	Data required	Legislative provision or administrative agreement	Reference period for data	Comments
		• Father's name • Father's date of birth and age • Father's place of birth • Father's usual place of residence • Father's usual occupation • Father's Aboriginal and Torres Strait Islander status • Marriage details of father to mother of child • Name/s of previous children of relationship, and • Date/s of birth and age of previous children of relationship.			
Office of the State Coroner	Notification of 'reportable' deaths	• Police Report of Death to a Coroner (Form 1)	s.10A *Coroners Act 2003*	Ongoing provision as cases arise	
	Coroner's findings	• Coroner's findings relating to the identity and cause of every 'reportable' child death in Queensland • Coroner's comments arising from deaths investigated at inquest	s.45 *Coroners Act 2003* s.46 *Coroners Act 2003*	Ongoing provision as cases are finalised	
	Investigation documents	• Any additional investigation documents held by the State Coroner	s.54A *Coroners Act 2003* Agreement between the Commission for Children and Young People and Child Guardian and Office of the State Coroner and the Department of Justice and Attorney General (3 August 2005)	Ongoing provision as cases are finalised	The agreement between the Office of the State Coroner and the Commission has been developed in accordance with the provisions of section 54A of the *Coroners Act 2003.*

Agency	Measure	Data required	Legislative provision or administrative agreement	Reference period for data	Comments
Workplace Health and Safety Queensland	Notification of fatality or serious injury of child	• Under negotiation	s.147 *Commission for Children and Young People and Child Guardian Act 2000*	Under negotiation	Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably necessary to fulfil the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions. The Commission is currently in the process of renewing existing MOU agreements with Workplace Health and Safety Queensland.



commission for
children and young people
and child guardian

Monitoring Plan – Department of Education and Training

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Child Guardian will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to the Department of Education and Training (the Department) for the period 1 July 2010 to 30 June 2013
- consolidate the Child Guardian's monitoring and data priorities for 1 July 2010 to 30 June 2013 to enable the Department to plan for timely and accurate provision of information required for the Child Guardian's monitoring and reporting activities, and
- enable the Child Guardian to provide the Department with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Child Guardian monitoring functions

Under section 18(1) of the Act the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child protection system
- monitor, audit and review the handling of individual cases of children in the child protection system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

The Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the Department as the department responsible for education service delivery[2].

In performing its monitoring functions, the Child Guardian must work cooperatively with service providers to the greatest extent possible[3], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[4].

Accordingly, this monitoring plan is intended to fulfil the legislative obligations of the Child Guardian to the Department, and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

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[1] Service providers to which the monitoring powers apply are defined in the Act under s 39 to include the Departments of Child Safety, Communities, Corrections, Justice and Attorney-General, Education and Training, and Housing, Queensland Health and the Queensland Police Service. Certain non-government organisations are also included as service providers.
[2] Section 39 (c) of the Act.
[3] Section 23(2)(a)(i) of the Act.
[4] Section 23(2)(b)(i) of the Act.

1.3 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Child Guardian must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[5].

Furthermore, the Child Guardian's obligations to service providers as outlined in section 1.2 above must not limit its legislative obligation to act independently and in the best interests of children[6].

If the Child Guardian identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Child Guardian may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Child Guardian will use information and data provided by various government agencies under this and other monitoring plans to produce the following public reports:

Child Guardian Report	**Frequency**	**Purpose**
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.
Snapshot	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).
Child Protection System	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.
Youth Justice System	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres.
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care
Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.

[5] Section 22(1)(a) of the Act.
[6] Section 22(2) of the Act.

The Department will always be provided with the opportunity to comment on a draft version of a public report that contains data or comment about the service delivery of the Department.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Child Guardian will collect data to inform the Child Guardian key outcome indicators for both the child protection and youth justice systems.

These indicators will assist the Child Guardian to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

2.3 Quarterly and annual reporting of system-wide data by the Department

Appendix A outlines the data to be provided by the Department for the Snapshot report.

Appendix B and C outline the Department's data reported as part of the child protection system and youth justice system key outcome indicators for the 2010-11 period.

Appendix D outlines the data to be provided for the purposes of the annual Child Death Report or other mandated functions.

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the Department and the Child Guardian agreeing to the amendment. In particular, the Child Guardian recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Child Guardian will work with the Department to amend the Appendices if there appears to be opportunities to streamline the information that the Department is required to provide at both national and state levels.

The Child Guardian expects that:

- the Department will provide the Child Guardian with data which is accurate and has been quality assured
- the data provided by the Department will be capable of being used to inform reporting, and
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the Department at the earliest possible stage.

The Child Guardian will:

- seek further information from the Department if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the Department's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the Department's data in the context of the Child Guardian information (for example Community Visitor data)
- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the Department identifies
- identify any trends or issues arising from the data analysis, and

- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Child Guardian activities that may be required.

2.4 Ongoing negotiation and requests for new data

In any requests for new data the Child Guardian:

- will provide an appropriate lead time between requesting the new data and expecting the Department to be in a position to report the data (depending on the activity required to report the data)
- actively seek the Department's views about appropriate uses for the new data and whether it will inform improvements to outcomes for children and young people, and
- consult with the Department so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The Department will:

- provide advice about the effort required to respond to requests for new data, and
- establish whether there are any alternative options where it is determined that the new data requested would be too difficult/costly to report.

3. Ad hoc monitoring activities

The Child Guardian may also conduct ad hoc monitoring activities which may involve:

- system level data analysis of information held by the Department and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the Department conduct its own review of an aspect of service delivery, this review then being evaluated by the Child Guardian.

3.1 Selection of ad hoc monitoring activities

In the interests of using the Department's and the Child Guardian's resources effectively the Child Guardian agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Child Guardian suggests that children and young people in the child protection system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring activities

For each ad hoc monitoring activity, the Child Guardian agrees to, in writing:

- advise the Director-General that the Child Guardian is considering undertaking a new monitoring activity
- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the Department's views regarding the proposed monitoring activity
- seek the Department's views about the best way for the required information or documents to be provided to the Child Guardian
- seek the Department's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Child Guardian expects the Department to:

- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the Department, the Child Guardian will formally commence its monitoring activity through the issue of a notice under the Act. When issuing notices the Child Guardian agrees to:

- take into account all issues raised and requests made by the Department during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the Department and assist the Department to fulfil the requirements of the notice by the due date/s specified in the notice

Statutory notices may require the Department to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Child Guardian recognises that these documents may be current working files. Timeframes will be negotiated between the Department and the Child Guardian and there will be provision for an extension of time when appropriate. The Department must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the Department must seek this formally in writing to the Commission.

The Child Guardian expects the Department to note that a failure to comply with a statutory notice issued under the Act may result in the Child Guardian reporting the non-compliance to the relevant Minister[7].

3.3 Provisional reporting process about ad hoc monitoring activities

The Child Guardian will:

- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[8], and
- provide a copy of the provisional report to the Department, and any officers adversely named in the report, to comply with requirements of procedural fairness[9].

The Department and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and respond to them by a nominated date (no less than 14 working days from the date of the delivery of the provisional report).

The Child Guardian expects that the Department understands that failure to respond to a provisional report within the nominated timeframe without receiving an extension of time from the Child Guardian will mean that it is deemed that the Department has accepted the provisional report and any proposed recommendations in full.

Where appropriate, parties will meet to discuss the critical issues arising from the response.

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[7] Under section 51 (1) (a) of the Act.
[8] Section 50(1) of the Act provides that the Commissioner may make recommendations to the Department about matters arising from the performance of the monitoring functions.
[9] Sections 50 (2) and 85 of the Act .

3.4 Final report about ad hoc monitoring activities

After the Department's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Child Guardian will prepare its final report and provide it to the Department. In finalising its final report, the Child Guardian will:

- give serious consideration to all responses received
- include the Department's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the Department and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the Department outlining how the Department's feedback has been dealt with.

The Child Guardian will also provide a copy of the final report to the relevant Minister[10].

3.5 Implementation plans for recommendations

Depending on the nature and scope of the recommendations made in the report the Child Guardian may ask the Department to develop and provide an implementation plan including timeframes.

The Child Guardian may also request evidence that the Department has implemented the recommendations made in the final report after a reasonable period of time.

The Child Guardian expects the Department to provide implementation plans and information about implementation upon request by the Child Guardian.

The Child Guardian also expects that the Department understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Child Guardian[11].

3.6 Public reporting about ad hoc monitoring activities

The Child Guardian has the ability to make de-identified reports about its monitoring activities public by asking the Minister to table them in Parliament[12].

The Child Guardian will make its reports public when they meet the following criteria:

Criteria to release a report publicly

The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer

AND

a) The public release of the report will further the understanding of, and participation in, the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child safety system, the youth justice system and other vulnerable children,

OR

b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child safety system.

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[10] As required by section 50(3) of the Act.
[11] Under section 51(2) of the Act.
[12] Under Chapter 4 Division 6 of the Act.

4. Agreement

The signatures below represent agreement by the Commissioner and Director-General of the Department to the terms of this Monitoring Plan.

Elizabeth Fraser **Commissioner for Children and Young People and Child Guardian** **Date** 21/7/11	**Julie Grantham** **Director-General, Department of Education and Training** **Date** 30/3/11

Appendix A – Data for Snapshot Report

Contacts: Department of Education and Training, to be advised (existing contact Craig Blair, Manager (Education Performance Information) Performance Monitoring and Reporting, Corporate Strategy & Performance Division)

Child Guardian: Strategic Policy and Research, Travis Heller, Senior Research Officer, ph 3211 6975

Measure	Reference periods for data	Date data to be provided to the Commission by	Comment/rationale
Years 8 to 12 Apparent Retention Rates - Aboriginal and Torres Strait Islander Students, government and non-government schools, Queensland, 2009	Annual	1 March 2011, 2012 and 2013	ABS data from Schools, Australia (cat. no. 4221.0) does not usually include this measure

Appendix B – Data for child protection system key outcome indicators

Contacts: Department of Education and Training, to be advised.

Please note: The following measures have been included below to demonstrate DET data that will be reported in the *Child Guardian Report: Child Protection System*. DET is not required to provide this information directly to CCYPCG. CCYPCG will obtain this data from DoCs, who receive this data from DET as part of their regular performance measurement process. By signing this Monitoring Plan, DET agrees to allow DoCs to release these aggregated data, in a form not reasonably capable of identifying any individual, to CCYPCG for the purpose of reporting in the above report.

Child Guardian Contact: Systemic Monitoring and Review Program, Jennifer Loakes, Senior Project Officer, Ph 3211 6957

Measure	Reference period for data	Date data to be provided to the Commission by	Comment
Child protection system outcome 6: Best education possible			
Number of children and young people in out-of-home care enrolled at a Queensland State School or private school (as at date with reporting period).	Annual	NA	Please note that DET is not required to provide this data to the CCYPCG directly. CCYPCG will obtain this information from DoCs who receive this data from DET as part of their performance measurement process.
Proportion of children and young people placed away from home who were at or above the national minimum standard in Reading, Writing, Spelling, Grammar and Punctuation, and Numeracy.	Annual	NA	Please note that DET is not required to provide this data to the CCYPCG directly. CCYPCG will obtain this information from DoCs who receive this data from DET as part of their performance measurement process.
Number of young people aged 17 to 18 years in out-of-home care who received a vocational qualification from TAFE, an OP, or who were OP eligible.	Annual	NA	Please note that DET is not required to provide this data to the CCYPCG directly. CCYPCG will obtain this information from DoCs who receive this data from DET as part of their performance measurement process.

Appendix C – Data for Child Guardian youth justice system monitoring framework

Contacts: Craig Blair, Manager (Education Performance Information), Performance Monitoring and Reporting, 3237 9917.
Child Guardian: Systemic Monitoring and Review Program, Candace Wakeham, Principal Analyst, 3211 6780

Please note: The Child Guardian notes that some of the data requested has been included in the 2009 School Annual Reports available via the schools website. The Child Guardian requests that all data requests are provided electronically with any relevant methodologies, counting rules or explanatory text. The Child Guardian will negotiate this request with DET to ensure the level of disaggregation provided will not result in the possible identification of individuals.

Domains	Reference period for data	Date data to be provided to the Commission by	Measure
Youth offending and prevention	To be negotiated	To be negotiated	To date, no Department of Education and Training data as been identified as relevant to the crime prevention indicator. The Commission would welcome any information or data sets that the Department considers may be relevant to inform this indicator.
Diversions	To be negotiated	To be negotiated	To date, no Department of Education and Training data as been identified as relevant to the diversion indicator. The Commission would welcome any information or data sets that the Department considers may be relevant to inform this indicator.
Supervision, intervention and reintegration	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013[13]	Total number of young people who attend Cleveland Education and Training Centre (CETC) and Brisbane Youth Education and Training Centre (BYETC).
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Average daily number of young people attending CETC and BYETC.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Outcomes of the educational diagnostic assessments for young persons attending CETC and the BYETC.
	1 January to 31 December 2010,	31 July 2011, 2012, 2013	Minimum, maximum and average number of days young people attending CETC and BYETC.

[13] The 31 July data request date has been based upon the Department's release of the BYETC and CETC 2009 School Annual Report in June 2010. The Child Guardian is satisfied to negotiate this date.

Domains	Reference period for data	Date data to be provided to the Commission by	Measure
	2011, 2012		
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people in detention[14] who successfully completed a Vocational Education and Training (VET) certificate/qualification.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people in detention who received a senior statement.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people in detention who received a Queensland Certificate Individual Achievement.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people in detention who received a Queensland Certificate of Education (QCE).
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people in detention who completed a School-based Apprenticeship or Traineeship (SAT).
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of students in detention receiving an Overall Position.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Total number of young people who attend CETC and BYETC who have an identified/diagnosed learning disability/impairment.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Outcomes of student, parent and teacher satisfaction surveys administered at CETC and BYETC.
	1 January to 31 December 2010, 2011, 2012	31 July 2011, 2012, 2013	Outcome of the Year 12 post-school destinations survey, Next Step – Student Destination Report.

[14] The Child Guardian will consult with the Department of Education and Training to receive the specific counting rules and methodology about how this measure, in terms of young people in detention, is populated.

Appendix D – Data for annual Child Death Report

Contacts: Department of Education and Training, to be advised.

Child Guardian: Systemic Monitoring and Review Program, Angela Oetting, Child Death Review, ph: 3211 6771

Measure	Legislative provision or administrative agreement	Reference period for data	Comments
Provision of information to enable performance of Commission's child death functions	s.147 *Commission for Children and Young People and Child Guardian Act 2000* Agreement between Commissioner for Children and Young People and Child Guardian and the Director-General, Department of Education, Training and the Arts (11 December 2007)	Ad hoc as need for information is identified	Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably necessary to fulfil the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions. Provision has been made for personal information to be provided to the Commissioner by DET to be used to conduct research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable in an administrative agreement developed under this section of the Act.

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Monitoring Plan – Queensland Health

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Child Guardian will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to Queensland Health for the period 1 July 2010 to 30 June 2013
- consolidate the Child Guardian's monitoring and data priorities for 1 July 2010 to 30 June 2013 to enable the Department to plan for timely and accurate provision of information required for the Child Guardian's monitoring and reporting activities, and
- enable the Child Guardian to provide the Department with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Child Guardian monitoring functions

Under section 18(1) of the Act the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child protection system
- monitor, audit and review the handling of individual cases of children in the child safety system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

The Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the Department as the department responsible for public health[2].

In performing its monitoring functions, the Child Guardian must work cooperatively with service providers to the greatest extent possible[3], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[4].

Accordingly, this monitoring plan is intended to fulfil the legislative obligations of the Child Guardian to the Department, and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

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[1] Service providers to which the monitoring powers apply to are defined under s 39 of the Act and include: (a) the child safety department, (b) a service provider holding a license to provide care services under the *Child Protection Act 1999* (a licensee), (c) a department that is mainly responsible for any of the following matters – (i) Aboriginal and Torres Strait Islander policy; (ii) administration of justice, (iii) adult corrective services; (iv) community services; (v) disability services; (vi) education; (vii) housing services; (viii) public health, (d) the director of public prosecutions, (e) Legal Aid Queensland, (f) the Public Trust Office and (g) the police service.

[2] section 39 (c) (viii) of the Act.

[3] Section 23(2)(a)(i) of the Act.

[4] Section 23(2)(b)(i) of the Act.

1.3 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Child Guardian must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[5].

Furthermore, the Child Guardian's obligations to service providers as outlined in section 1.2 above must not limit its legislative obligation to act independently and in the best interests of children[6].

If the Child Guardian identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Child Guardian may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Child Guardian will use information and data provided by various government agencies under this and other monitoring plans to produce the following public reports:

Child Guardian Report	**Frequency**	**Purpose**
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.
Snapshot	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).
Child Protection System	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.
Youth Justice System	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres.
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care
Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.

[5] Section 22(1)(a) of the Act.
[6] Section 22(2) of the Act.

The Department will always be provided with the opportunity to comment on a draft version of a public report that contains data or comment about the service delivery of the Department.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Child Guardian will collect data to inform the Child Guardian key outcome indicators for both the child protection and youth justice systems.

These indicators will assist the Child Guardian to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

2.3 Quarterly and annual reporting of system-wide data by the Department

Appendix A outlines the data to be provided by the Department for the Snapshot report.

Appendix B outlines the data to be provided to inform the youth justice system key outcome indicators. Appendix B outlines the data which is to be provided by the Department as well as the health related data which will be obtained from the Department of Communities to inform these indicators.

Appendix C outlines the data to be provided for the purposes of the annual Child Death Report or other mandated functions.

Appendix D outlines data priorities on health related issues which the Commission will negotiate to receive from either the Department or where appropriate, the Department of Communities in the future.

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the Department and the Child Guardian agreeing to the amendment. In particular, the Child Guardian recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Child Guardian will work with the Department to amend the Appendices if there appears to be opportunities to streamline the information that the Department is required to provide at both national and state levels.

The Child Guardian expects that:

- the Department will provide the Child Guardian with data which is accurate and has been quality assured
- the data provided by the Department will be capable of being used to inform reporting, and
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the Department at the earliest possible stage.

The Child Guardian will:

- seek further information from the Department if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the Department's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the Department's data in the context of the Child Guardian information (for example Community Visitor data)

- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the Department identifies
- identify any trends or issues arising from the data analysis, and
- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Child Guardian activities that may be required.

2.4 Ongoing negotiation and requests for new data

In any requests for new data the Child Guardian:

- will provide an appropriate lead time between requesting the new data and expecting the Department to be in a position to report the data (depending on the activity required to report the data)
- actively seek the Department's views about appropriate uses for the new data and whether it will inform improvements to outcomes for children and young people, and
- consult with the Department so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The Department will:

- provide advice about the effort required to respond to requests for new data, and
- establish whether there are any alternative options where it is determined that the new data requested would be too difficult/costly to report.

3. Ad hoc monitoring activities

The Child Guardian may also conduct ad hoc monitoring activities which may involve:

- system level data analysis of information held by the Department and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the Department conduct its own review of an aspect of service delivery, this review then being evaluated by the Child Guardian.

3.1 Selection of ad hoc monitoring activities

In the interests of using the Department's and the Child Guardian's resources effectively the Child Guardian agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Child Guardian suggests that children and young people in the child protection system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring activities

For each ad hoc monitoring activity, the Child Guardian agrees to, in writing:

- advise the Director-General that the Child Guardian is considering undertaking a new monitoring activity
- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the Department's views regarding the proposed monitoring activity

- seek the Department's views about the best way for the required information or documents to be provided to the Child Guardian
- seek the Department's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Child Guardian expects the Department to:
- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the Department, the Child Guardian will formally commence its monitoring activity through the issue of a notice under the Act. When issuing notices the Child Guardian agrees to:
- take into account all issues raised and requests made by the Department during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the Department and assist the Department to fulfil the requirements of the notice by the due date/s specified in the notice

Statutory notices may require the Department to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Child Guardian recognises that these documents may be current working files. Timeframes will be negotiated between the Department and the Child Guardian and there will be provision for an extension of time when appropriate. The Department must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the Department must seek this formally in writing to the Commission.

The Child Guardian expects the Department to note that a failure to comply with a statutory notice issued under the Act may result in the Child Guardian reporting the non-compliance to the relevant Minister[7].

3.3 Provisional reporting process about ad hoc monitoring activities

The Child Guardian will:
- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[8], and
- provide a copy of the provisional report to the Department, and any officers adversely named in the report, to comply with requirements of procedural fairness[9].

The Department and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and respond to them by a nominated date (no less than 14 working days from the date of the delivery of the provisional report).

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[7] Under section 51 (1) (a) of the Act.
[8] Section 50(1) of the Act provides that the Commissioner may make recommendations to the Department about matters arising from the performance of the monitoring functions.
[9] Sections 50 (2) and 85 of the Act .

The Child Guardian expects that the Department understands that failure to respond to a provisional report within the nominated timeframe without receiving an extension of time from the Child Guardian will mean that it is deemed that the Department has accepted the provisional report and any proposed recommendations in full.

Where appropriate, parties will meet to discuss the critical issues arising from the response.

3.4 Final report about ad hoc monitoring activities

After the Department's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Child Guardian will prepare its final report and provide it to the Department. In finalising its final report, the Child Guardian will:

- give serious consideration to all responses received
- include the Department's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the Department and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the Department outlining how the Department's feedback has been dealt with.

The Child Guardian will also provide a copy of the final report to the relevant Minister[10].

3.5 Implementation plans for recommendations

Depending on the nature and scope of the recommendations made in the report the Child Guardian may ask the Department to develop and provide an implementation plan including timeframes.

The Child Guardian may also request evidence that the Department has implemented the recommendations made in the final report after a reasonable period of time.

The Child Guardian expects the Department to provide implementation plans and information about implementation upon request by the Child Guardian.

The Child Guardian also expects that the Department understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Child Guardian[11].

3.6 Public reporting about ad hoc monitoring activities

The Child Guardian has the ability to make de-identified reports about its monitoring activities public by asking the Minister to table them in Parliament[12].

The Child Guardian will make its reports public when they meet the following criteria:

Criteria to release a report publicly
The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer **AND**
a) The public release of the report will further the understanding of, and participation in,

[10] As required by section 50(3) of the Act.
[11] Under section 51(2) of the Act.
[12] Under Chapter 4 Division 6 of the Act.

the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child safety system, the youth justice system and other vulnerable children, **OR**
b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child safety system.

4. Agreement

The signatures below represent agreement by the Commissioner and Director-General of the Department to the terms of this Monitoring Plan.

E Fraser **Elizabeth Fraser** **Commissioner for Children and Young People and Child Guardian** **Date** 22/12/10	MDO **Mick Reid** **Director-General** **Queensland Health** **Date** 31/1/2011

Appendix A – Data for Snapshot Report

Contacts: Queensland Health (contacts are indicated by category)

Child Guardian: Strategic Policy and Research, Brian Jenkins, Senior Research Officer, ph 3211 6955

Measure	Reference periods for data	Due date for data provision	Comment/rationale
Hospital separations (per 100,000) by sex and age (under 1 year, 1-4 years, 5-9 years, 10-14 years, 15-19 years[13]) for these chapters: • digestive system • diseases of the ear and mastoid process • factors influencing health status • infectious and parasitic • injury (external causes)' • respiratory system • symptoms, signs & abnormal findings • Total Additional chapters for under 1 year age group: • originating in the perinatal period • congenital malformations Additional chapters for 15-17 year olds: • mental and behaviour disorders • pregnancy, childbirth (females only)	Annually (financial year)	1 Feb 2011, 2012 and 2013	These data are updates on established data collections traditionally reported in Snapshot. [Contact: Sarah Muller, Analyst, Statistical Analyst Unit, Health Statistics Centre]

[13] If in the future it is possible for this measure to be reported for the 15-17 year old age group the Child Guardian will seek to obtain the information for this age group.

Measure	Reference periods for data	Due date for data provision	Comment/rationale
Injury-related causes of hospital separations (per 100,00) by sex and age (under 1 year, 1-4 years, 5-9 years, 10-14 years, 15-17 years) for: • falls • transport accidents • poisoning • burns and scalds • near drowning • intentional self-harm • assault	Annually (financial year)	1 Feb 2011, 2012 and 2013	These data are updates on established data collections traditionally reported in Snapshot [Contact: Sarah Muller, Analyst, Statistical Analyst Unit, Health Statistics Centre]
Notifications of Chlamydia by age group (5 year age groups) and sex, Queensland	Annually	1 February 2011, 2012 and 2013	These data are updates on established data collections traditionally reported in Snapshot [Existing contact: Craig Davis, Epidemiologist, Communicable Diseases Branch]
Coverage Rate (as at 31 December) - percentage of all babies born in Queensland who are now offered newborn hearing screening	Annually	1 March 2011, 2012 and 2013	Updated data have traditionally been provided for reporting in the Snapshot report. Historically, data have not been able to be provided by this early deadline, so may need to establish when the relevant data will become available each year. [Existing contact: Gavin Bott, Project Officer, Healthy Hearing Program]
Capture Rate (as at 31 December) - percentage of all babies born between 1 January 2009 and 31 December 2009 who received newborn hearing screening	Annually	1 March 2011, 2012 and 2013	
Referral for Second Hearing Screen (as at 31 December) - percentage of all babies screened who received a refer result on their first hearing screen and required a second hearing screen	Annually	1 March 2011, 2012 and 2013	

Measure	Reference periods for data	Due date for data provision	Comment/rationale
Referral to Audiology (as at 31 December) - percentage of all babies screened who received a refer result on their second hearing screen and were therefore referred for full diagnostic audiology assessment	Annually	1 March 2011, 2012 and 2013	
Targeted Surveillance (1 January to 31 December) - percentage of all babies screened who received a pass result on either their first or second hearing screen but had risk factors for late onset or progressive hearing loss and were therefore referred on for full diagnostic audiology assessment to occur sometime between 6 and 12 months of age (depending on the nature of the risk factor).	Annually	1 March 2011, 2012 and 2013	
Outcome of full diagnostic audiology assessment for targeted surveillance (1 January to 31 December) - appropriate indicator	Annually	1 March 2011, 2012 and 2013	
Rate of hearing loss (1 January to 31 December) - percentage of babies with permanent childhood hearing loss (moderate to severe)	Annually	1 March 2011, 2012 and 2013	

Appendix B – Data for youth justice system monitoring framework.

Contacts: Queensland Health (contacts are indicated by category)
Department of Communities indicated as contact where relevant (as negotiated with the Department of Communities under IPAC)

Child Guardian: Systemic Monitoring and Review Program, Tania Dunn, A/Manager, 3211 6778

Due date: 31 October 2010

Annual Measures	Reference period for data	Measure
Youth offending and prevention domain[14]	1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013.	Total number of young people referred to Forensic Child and Youth Services who had been identified as at risk of entering the youth justice system, disaggregated by age, gender and Indigenous status. [Contact: Nicole Mikulich, Team Leader, Forensic Child and Youth Services]
		Total number of young people referred to Forensic Child and Youth Services who had been identified at risk of entering the youth justice system who receive support, disaggregated by age, gender and Indigenous status. [Contact: Nicole Mikulich, Team Leader, Forensic Child and Youth Services]
Diversions domain[15]	1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013.	Total number of young people referred to a youth justice conference who were also referred to the Mater Youth and Family Counselling Service, disaggregated by age, gender and Indigenous status. [Contact: Judy Fox, Team Leader, Mater Youth and Family Counselling Service]
		Total number of young people who were referred to a youth justice conference who received support from the Mater Youth and Family Counselling Service, disaggregated by age, gender and Indigenous status. [Contact: Judy Fox, Team Leader, Mater Youth and Family Counselling Service]
Supervision, intervention and reintegration domain[16]	1 July 2010-30 June 2011, 1 July 2011-30 June 2012,	Number of 'episodes of service' provided to non-Indigenous male young people in youth detention (programs and services completed).

[14] Measures included in the Youth offending and prevention domain are to be sourced directly from Queensland Health
[15] Measures included in the Diversions domain are to be sourced directly from Queensland Health

Annual Measures	Reference period for data	Measure
	1 July 2012-30 June 2013.	Number of 'episodes of service' provided to non-Indigenous female young people in youth detention (programs and services completed).
		Number of 'episodes of service' provided to Indigenous male young people in youth detention (programs and services completed).
		Number of 'episodes of service' provided to Indigenous female young people in youth detention (programs and services completed).
		Young people, in detention, satisfaction with Mental Health Alcohol Tobacco and Other Drugs Service (MHATODS) services (programs and services promote participation by young person).
		Number of young people referred to MHATODS more than once in the data collection period (programs and services build on previous services young person has participated in).
		Percentage of young people, in detention, released prior to being seen by MHATODS. (programs and services are integrated and responsive to a young person's needs).
		Total number of 'episodes of service' provided to young people in youth detention (programs and services build on previous services young person has participated in).
		The percentage of Indigenous females in detention who refuse to be seen by MHATODS, after being offered an appointment (programs and services promote participation by young person).
		The percentage of Indigenous males in detention who refuse to be seen by MHATODS, after being offered an appointment (programs and services promote participation by young person).
		The percentage of non- Indigenous males in detention who refuse to be seen by MHATODS, after being offered an appointment (programs and services promote participation by young person).
		The percentage of non- Indigenous females in detention who refuse to be seen by MHATODS, after being offered an appointment (programs and services promote participation by young person).

[16] The measures included in the Supervision, intervention and reintegration domain will be directly sourced from the Department of Communities. This is based on advice received from Queensland Health and recent negotiations between the Department of Communities and the Commission. These measures correlate with the Interdepartmental Programs Advisory Committee (IPAC) measures used to support annual reporting for the Brisbane and Cleveland Youth Detention Centres. They have been included in this Monitoring Plan for the information of Queensland Health to ensure the Department is aware of the process that has been agreed by the Department of Communities and Queensland Health.

Annual Measures	Reference period for data	Measure
		The total number of young people in detention who refuse to be seen by MHATODS, after being offered an appointment as a percentage of all young people offered an appointment (programs and services promote participation by young person).
		The percentage of distinct young people who are held in custody for more than seven days and is age appropriate who commence an immunisation program while in a youth detention centre (programs and services completed).
		The percentage of distinct young people, in custody for more than seven days, who receive a dental health check (programs and services completed).
		The percentage of distinct young people, in custody for more than seven days, who have had a hearing screening completed.
		The percentage of distinct young people, in custody for more than seven days, who receive a sexual health assessment/sex health consultation including screening test Polymerase Chain Reaction/Bloods for sexually transmitted diseases and the percentage which test positive (programs and services completed).
		The percentage of distinct young people, in custody for more than seven days, who are provided with information through the sexual health program (programs and services are integrated and responsive to a young person's needs).

Appendix C – Data for annual Child Death Report

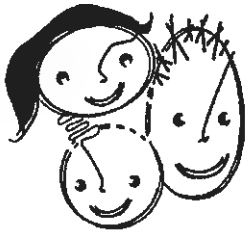
Contacts: Queensland Health, Corelle Davies, Executive Director, Primary Community Extended Care Branch

Child Guardian: Systemic Monitoring and Review Program, Angela Oetting, Manager, Child Death Review, ph: 3211 6771

Measure	Legislative provision or administrative agreement	Reference period for data	Comments
Provision of information to enable performance of Commission's child death functions	s.147 *Commission for Children and Young People and Child Guardian Act 2000*	Ad hoc as need for information is identified	Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably necessary to fulfil the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions. Queensland Health has previously agreed to provide health records relating to children and young people who have died as a result of suicide or fatal assault.

Appendix D – Future data priorities to be negotiated for the youth justice system monitoring framework

Annual Measures	Measure	Comments
Supervision, intervention and reintegration	The total number of young people accommodated in Brisbane and Cleveland Youth Detention Centre who received health services for the reporting period.	
	The number of episodes of service provided to young people in Brisbane and Cleveland Youth Detention Centres, disaggregated by service type for the reporting period.	The Commission considers it important to provide contextual information regarding the type of health service provided to the young people accommodated at Queensland youth detention centres. For example, the type of service provided to a young person could be in relation to a chronic or on-going health issue or an acute health issue such as a broken bone. At this stage further negotiations will be required to discuss definitions and the availability of this information.
	Number of young people referred to MHATODS who receive support for the reporting period.	
	Number of young people accommodated at the Brisbane and Cleveland Youth Detention Centres who were referred to health support services as part of their transition into the community	The Commissions considers it important to gather information about the health support services provided to young people who reintegrate back into the community. For example, as part of their reintegration plan a young person might be referred to: • Child and Youth Mental Health Service • Dental services • Sexual health services, or • Hearing services. At this stage further negotiations will be required to discuss definitions and the availability of this information.



commission for
children and young people
and child guardian

Monitoring Plan – Queensland Police Service

1. Background

1.1 Purpose of this plan

The purpose of this plan is to:

- outline how the Child Guardian will undertake its monitoring functions under Chapter 3 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act) in relation to the Queensland Police Service (the QPS) for the period 1 July 2010 to 30 June 2013
- consolidate the Child Guardian's monitoring and data priorities for 1 July 2010 to 30 June 2013 to enable the QPS to plan for timely and accurate provision of information required for the Child Guardian's monitoring and reporting activities, and
- enable the Child Guardian to provide the QPS with evidence-based reports and recommendations about service delivery to children and young people in the child protection system, the youth justice system and other vulnerable children.

1.2 Child Guardian monitoring functions

Under section 18(1) of the Act, the Commissioner's monitoring functions are to:

- monitor, audit and review the systems, policies and practices of the child safety department and other service providers[1] that affect children in the child protection system
- monitor, audit and review the handling of individual cases of children in the child safety system by the child safety department and licensees under the *Child Protection Act 1999*, and
- monitor compliance by the chief executive (child safety) with section 83 of the *Child Protection Act 1999*.

The Child Guardian monitoring functions are specific and complement the Commission's broader research, oversight and advocacy functions.

This plan applies to the QPS as a service provider under s 39 (g) of the Act.

In performing its monitoring functions, the Child Guardian must work cooperatively with service providers to the greatest extent possible[2], and exercise its powers in relation to service providers in a way that is fair and reasonable, having regard to service providers' capacities, and the resources available to service providers, to comply with requests or requirements[3].

Accordingly, this monitoring plan is intended to fulfil the legislative obligations of the Child Guardian to the QPS, and explain the monitoring priorities which have been developed with a focus on achieving the best possible outcomes for children and young people.

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[1] Service providers to which the monitoring powers apply to are defined under s 39 of the Act and include: (a) the child safety department, (b) a service provider holding a license to provide care services under the *Child Protection Act 1999* (a licensee), (c) a department that is mainly responsible for any of the following matters – (i) Aboriginal and Torres Strait Islander policy; (ii) administration of justice, (iii) adult corrective services; (iv) community services; (v) disability services; (vi) education; (vii) housing services; (viii) public health, (d) the director of public prosecutions, (e) Legal Aid Queensland, (f) the Public Trust Office and (g) the police service.

[2] Section 23(2)(a)(i) of the Act.

[3] Section 23(2)(b)(i) of the Act.

1.3 Overarching legislative requirement to act independently

In performing its functions and exercising its powers, the Child Guardian must act independently and in a way that promotes and protects the rights, interests and wellbeing of children[4].

Furthermore, the Child Guardian's obligations to service providers as outlined in section 1.2 above must not limit its legislative obligation to act independently and in the best interests of children[5].

If the Child Guardian identifies, during the performance of its monitoring functions, that a provision of this monitoring plan may limit its ability to act independently or in a way that promotes or protects the rights, interests or wellbeing of children, the Child Guardian may depart from this monitoring plan to the extent necessary to uphold or preserve its primary obligation towards children and its independence as an organisation.

2. Gathering and reporting on system-wide data on a regular basis

2.1 Public reports about system-wide data

The Child Guardian will use information and data provided by various government agencies under this and other monitoring plans to produce the following public reports:

Child Guardian Report	**Frequency**	**Purpose**
Quarterly Report – Child Protection System	Quarterly	Reports on the Child Protection Key Outcome Indicators and relevant Child Guardian activities for the quarter.
Snapshot	Annually	Contemporary representation of health and wellbeing of children and young people in Queensland (contains chapters on child protection and crime and justice).
Child Protection System	Annually	Reports on the child protection Key Outcome Indicators and the relevant Child Guardian activities for the year.
Youth Justice System	Annually	Reports on the youth justice Key Outcome Indicators and the relevant Child Guardian activities for the year.
Views of young people in residential care	Every 2 years	Reports on the outcomes of the survey of young people in residential care.
Views of young people in detention centres	Every 2 years	Reports on the outcomes of the survey of young people in detention centres.
Views of children and young people in foster care	Every 2 years	Reports on the outcomes of the survey of young people in foster care
Deaths of children and young people in Queensland	Annual	Reports on the deaths of children in Queensland with a focus on circumstances and risk factors.

[4] Section 22(1)(a) of the Act.
[5] Section 22(2) of the Act.

The QPS will always be provided with the opportunity to comment on a draft version of a public report that contains data or comment about the service delivery of the QPS.

2.2 Child protection system and youth justice system key outcome indicators

For the period 1 July to 30 June each year the Child Guardian will collect data to inform the Child Guardian key outcome indicators for both the child protection and youth justice systems.

These indicators will assist the Child Guardian to evaluate and report information across a broad spectrum of outcomes which have been identified as being critical for children and young people in the child protection and youth justice systems.

2.3 Quarterly and annual reporting of system-wide data by the QPS

Appendix A outlines the data to be provided by the QPS for the Snapshot report.

Appendix B outlines the data to be provided by the QPS against the youth justice system key outcome indicators for the 2010-11 period.

Appendix C outlines the data to be provided for the purposes of the annual Child Death Report or other mandated functions.

Any of these appendices may be amended from time to time throughout the life of this plan subject to both the QPS and the Child Guardian agreeing to the amendment. In particular, the Child Guardian recognises that there is currently work occurring within the national context to achieve consistent performance measures for the child protection and youth justice systems. The Child Guardian will work with the QPS to amend the Appendices if there appears to be opportunities to streamline the information that the QPS is required to provide at both national and state levels.

The Child Guardian expects that:

- the QPS will provide the Child Guardian with data which is accurate and has been quality assured
- the data provided by the QPS will be capable of being used to inform reporting, and
- any qualifications, methodologies, counting rules, explanatory text and limitations in relation to the data are highlighted and provided in full by the QPS at the earliest possible stage.

The Child Guardian will:

- seek further information from the QPS if it identifies that further information is required for proper analysis of the data
- request this further information in writing through the nominated contact
- contact the QPS's nominated officers in the Appendices if any further assistance is required to analyse and evaluate the data
- consider the QPS's data in the context of the Child Guardian information (for example Community Visitor data)
- compare and contrast all available data as applicable
- observe and accurately report any qualifications about the data that the QPS identifies
- identify any trends or issues arising from the data analysis, and
- use the outcomes of the data analysis to identify any future ad hoc monitoring activities or other Child Guardian activities that may be required.

2.4 Ongoing negotiation and requests for new data

In any requests for new data the Child Guardian:

- will provide an appropriate lead time between requesting the new data and expecting the QPS to be in a position to report the data (depending on the activity required to report the data)
- actively seek the QPS's views about appropriate uses for the new data and whether it will inform improvements to outcomes for children and young people, and
- consult with the QPS so that alternative options are discussed and considered and a cost benefit analysis of obtaining the data is understood by both parties.

The QPS will:

- provide advice about the effort required to respond to requests for new data, and
- establish whether there are any alternative options where it is determined that the new data requested would be too difficult/costly to report.

3. Ad hoc monitoring activities

The Child Guardian may also conduct ad hoc monitoring activities which may involve:

- system level data analysis of information held by the QPS and other service providers
- qualitative analyses of aspects of service delivery to children in the child protection system, the youth justice system and other vulnerable children, and
- a requirement that the QPS conduct its own review of an aspect of service delivery, this review then being evaluated by the Child Guardian.

3.1 Selection of ad hoc monitoring activities

In the interests of using the QPS's and the Child Guardian's resources effectively the Child Guardian agrees to select ad hoc monitoring activities using the following criteria for potential systemic issues:

- qualitative and quantitative information held or received by the Child Guardian suggests that children and young people in the child protection system may be experiencing poor outcomes as a result of a systemic issue
- the number of children and young people potentially experiencing the poor outcomes or the severity of the poor outcomes indicates that the matter warrants review, and
- there are no other quality assurance mechanisms or reviews in place capable of delivering a robust review of the systemic issue.

3.2 Commencing ad hoc monitoring activities

For each ad hoc monitoring activity, the Child Guardian agrees to, in writing:

- advise the Director-General that the Child Guardian is considering undertaking a new monitoring activity
- explain how the proposed monitoring activity fits the criteria outlined in section 2.2 above
- advise of the purpose and scope of the monitoring activity
- seek the QPS's views regarding the proposed monitoring activity
- seek the QPS's views about the best way for the required information or documents to be provided to the Child Guardian
- seek the QPS's advice in relation to its capacity to provide the information or documents within appropriate timeframes, and
- nominate an appropriate contact officer.

The Child Guardian expects the QPS to:

- provide accurate and timely advice about the existence and location of the relevant information and documents
- provide accurate and timely advice regarding its ability to provide the relevant information and documents within agreed timeframes
- nominate a contact officer to act as a point of contact to coordinate information requests and ensure that agreed timeframes are adhered to, and
- engage in consultation in a timely and open manner.

Following the consultation conducted with the QPS, the Child Guardian will formally commence its monitoring activity through the issue of a notice under the Act. When issuing notices the Child Guardian agrees to:

- take into account all issues raised and requests made by the QPS during the consultation to the greatest extent practicable, and
- nominate a contact officer to explain any requests to the QPS and assist the QPS to fulfil the requirements of the notice by the due date/s specified in the notice

Statutory notices may require the QPS to take certain action, such as providing original or copied documents or undertaking a review and providing a report, within set timeframes. The Child Guardian recognises that these documents may be current working files. Timeframes will be negotiated between the QPS and the Child Guardian and there will be provision for an extension of time when appropriate. The QPS must comply with a notice unless a relevant defence or excuse applies. If an extension of time is required to comply with the notice, the QPS must seek this formally in writing to the Commission.

The Child Guardian expects the QPS to note that a failure to comply with a statutory notice issued under the Act may result in the Child Guardian reporting the non-compliance to the relevant Minister[6].

3.3 Provisional reporting process about ad hoc monitoring activities

The Child Guardian will:

- compile the results of the monitoring activity into a provisional report, which may contain provisional findings or opinions and proposed recommendations[7], and
- provide a copy of the provisional report to the QPS, and any officers adversely named in the report, to comply with requirements of procedural fairness[8].

The QPS and relevant officers will then have the opportunity to consider any provisional findings and opinions, adverse comment and any proposed recommendations included in the report and respond to them by a nominated date (no less than 14 working days from the date of the delivery of the provisional report).

The Child Guardian expects that the QPS understands that failure to respond to a provisional report within the nominated timeframe without receiving an extension of time from the Child Guardian will mean that it is deemed that the QPS has accepted the provisional report and any proposed recommendations in full.

Where appropriate, parties will meet to discuss the critical issues arising from the response.

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[6] Under section 51 (1) (a) of the Act.
[7] Section 50(1) of the Act provides that the Commissioner may make recommendations to the QPS about matters arising from the performance of the monitoring functions.
[8] Sections 50 (2) and 85 of the Act .

3.4 Final report about ad hoc monitoring activities

After the QPS's and any relevant officers' responses to the provisional report are received or after the nominated date for the response has lapsed (whichever is sooner) the Child Guardian will prepare its final report and provide it to the QPS. In finalising its final report, the Child Guardian will:

- give serious consideration to all responses received
- include the QPS's and relevant officers' responses to the provisional report where appropriate
- alter findings, opinions and recommendations where the QPS and any relevant officers have provided sufficient evidence to support those alterations, and
- write to the QPS outlining how the QPS's feedback has been dealt with.

The Child Guardian will also provide a copy of the final report to the relevant Minister[9].

3.5 Implementation plans for recommendations

Depending on the nature and scope of the recommendations made in the report the Child Guardian may ask the QPS to develop and provide an implementation plan including timeframes.

The Child Guardian may also request evidence that the QPS has implemented the recommendations made in the final report after a reasonable period of time.

The Child Guardian expects the QPS to provide implementation plans and information about implementation upon request by the Child Guardian.

The Child Guardian also expects that the QPS understands that a failure by it to take appropriate action in response to a recommendation made in a final report may be reported to the relevant Minister by the Child Guardian[10].

3.6 Public reporting about ad hoc monitoring activities

The Child Guardian has the ability to make de-identified reports about its monitoring activities public by asking the Minister to table them in Parliament[11].

The Child Guardian will make its reports public when they meet the following criteria:

Criteria to release a report publicly
The report is able to be sufficiently de-identified so that it will not include any information identifying, or that is likely to lead to the identification of, a person as a complainant or a child who is, or has been, the subject of a complaint under the Act or a relevant officer **AND**
a) The public release of the report will further the understanding of, and participation in, the public debate of issues (including potential changes to legislation) that relate specifically to service delivery to children and young people in the child safety system, the youth justice system and other vulnerable children, **OR**
b) The public release of the report will promote accountability and transparency by public authorities for decisions made about service delivery to children in the child safety system.

[9] As required by section 50(3) of the Act.
[10] Under section 51(2) of the Act.
[11] Under Chapter 4 Division 6 of the Act.

4. Agreement

The signatures below represent agreement by the Commissioner's to the terms of this Monitoring Plan.

Elizabeth Fraser **Commissioner for Children and Young People and Child Guardian** **Date** 29/11/10	**Bob Atkinson APM** **Commissioner** **Queensland Police Service** **Date** 7/11/2011

Appendix A – Data for Snapshot Report

Contacts: Queensland Police Service, to be advised (existing contact – Annette Canton, Statistician, Information Management Branch)

Child Guardian: Strategic Policy and Research, Travis Heller, Senior Research Officer, ph 3211 6975

Measure	Reference periods for data	Due date for data provision	Comment/rationale
Victims of Crime by Age and Sex, Queensland	Annually (financial year)	1 February 2011, 2012 and 2013	Update of annually provided electronic data that is publicly available in the Queensland Police Service Annual Statistical Review
Offenders - Queensland by Age and Sex	Annually (financial year)	1 February 2011, 2012 and 2013	Update of annually provided electronic data that is publicly available in the Queensland Police Service Annual Statistical Review
Offenders - Indigenous - Queensland by Type of Action by Age	Annually (financial year)	1 February 2011, 2012 and 2013	Update of annually provided electronic data that is publicly available in the Queensland Police Service Annual Statistical Review
Offenders - Non-Indigenous - Queensland by Type of Action by Age	Annually (financial year)	1 February 2011, 2012 and 2013	Update of annually provided electronic data that is publicly available in the Queensland Police Service Annual Statistical Review

Appendix B – Data for youth justice system monitoring framework

Contacts: Queensland Police Service, to be advised.
Previous contact persons for the coordination of QPS data include:

- Miria Bastock, Manager, Policy and Research Unit, Community Safety and Crime Prevention Branch, Operations Support Command
- Debbie Jones, Senior Policy Officer, Child Safety Coordination Unit, Child Safety & Sexual Crime Group, and
- Peter Conroy, Manager, Statistical Services, Information Resource Centre, 3364 4387.

Child Guardian: Systemic Monitoring and Review Program, Tania Dunn, Manager, Monitoring 3211 6778

Please note: The due date for data to be provided to the Child Guardian is 31 October 2011[12].

Annual Measures	Reference period for data	Measure	Comment
Queensland youth offending	1 July 2009-30 June 2010, 1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	Number of offences by offence type[13] and number of youth offenders by age[14], by gender, by Indigenous status[15], by region	The Child Guardian is aware that the total number of offences committed by young people are made publically available in the QPS annual statistical reviews.
Crime Prevention	1 July 2009-30 June 2010, 1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	Total QPS funding provided to crime prevention initiatives targeted at young people and number of initiatives for the reporting year.	Similar information was provided by Manager, Policy and Research Unit Community Safety and Crime Prevention Branch in 2009.
		An example of a youth crime prevention initiative implemented in the reporting year, including description, location, number of participants and expected or achieved outcomes.	

[12] The Child Guardian will contact QPS in the months leading up to this date to negotiate and confirm the specific details of this request.
[13] Using the ANCO classification. Also note that as per advice provided by QPS, offence counts are based on the date in which the offence is reported to the police.
[14] As per advice provided by QPS, offender's age will be based on the date in which the offender is actioned (arrested, cautioned etc.).
[15] As per advice provided by QPS, the "all identifier" will be used to reduce the number of "not stated".

Annual Measures	Reference period for data	Measure	Comment
Diversions	1 July 2009-30 June 2010, 1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	Police response to youth offenders, by action type, offence type and Indigenous status[16] Action taken by police, by age, gender, and Indigenous status[17] Number of community conference referrals by police disaggregated by offence type, age, Indigenous status, region and gender.	As per advice provided by QPS Statistical Services.
		Number of youth offenders by principal offence type[18], by region and action taken by police[19]	As per advice provided by QPS Statistical Services.
		Number of youth offenders who had police contact (i.e. were actioned) more than once in less than 1 month, 1 month to less than 6 months, 6 months to less than 9 months and 9 months or greater	As per advice provided by QPS Statistical Services.
		Number of youth offenders who had police contact more than once, reported by offence type, by Indigenous status[20]	As per advice provided by QPS Statistical Services.

[16] Offence type classification – ANCO and Indigenous status to use 'all identifier'.
[17] Offence type classification – ANCO and Indigenous status to use 'all identifier'.
[18] Offence type classification – ASOC.
[19] As per advice provided by QPS, the action type taken against an offender will need to be prioritised to a level of seriousness. This will need to be further evaluated by QPS.
[20] As per advice provided by QPS, Indigenous status will need to be converted to a single status over the reporting period. ANCO classification to be used.

Annual Measures	Reference period for data	Measure	Comment
Rehabilitation	1 July 2009-30 June 2010, 1 July 2010-30 June 2011, 1 July 2011-30 June 2012, 1 July 2012-30 June 2013	To date, no QPS data as been identified as relevant to the Rehabilitation indicator. The Child Guardian would welcome any information or data sets that QPS considers may be relevant to inform this indicator.	

Appendix C – Data for annual Child Death Report

Contacts: Queensland Police Service, to be advised.

Child Guardian: Systemic Monitoring and Review Program, Angela Oetting, Manager, Child Death Review, ph: 3211 6771

Measure	Legislative provision or administrative agreement	Reference period for data	Comments
Provision of information to enable performance of Commission's child death functions	s.147 *Commission for Children and Young People and Child Guardian Act 2000* Agreement between Commissioner for Children and Young People and Child Guardian and Commissioner of Queensland Police Service 2008–2010	Ad hoc as need for information is identified	Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably necessary to fulfil the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions. Provision is made for full and unrestricted access to identifiable information contained in QPS records under the agreement between QPS and the Commission under this section of the Commission's Act.

commission for children and young people and child guardian

A better life for Queensland children

Snapshot 2011

Children and Young People in Queensland

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Authority	Commission for Children and Young People and Child Guardian
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Contact for enquiries

All enquiries regarding this document should be directed in the first instance to:

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This document has been security classified using the Queensland Government Information Security Classification (QGISCF) as PUBLIC and will be managed according to the requirements of the QGISCF.

Snapshot 2011

Children and Young People in Queensland

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Office of Economic and Statistical Research
Queensland Health
Queensland Police Service

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Foreword

It is my pleasure to present *Snapshot 2011: Children and Young People in Queensland*. *Snapshot 2011* is the ninth annual report published in this series which reports on the health, safety and wellbeing of children and young people in Queensland.

As Commissioner for Children and Young People and Child Guardian, I believe it is important that we, as a Queensland community, have a clear and current picture of how well our children are faring. This allows us to develop evidence-based strategies to protect and uphold their rights and interests.

To consider the wellbeing of children in Queensland, the Commission for Children and Young People and Child Guardian (the Commission) monitors laws, policies, practices and programs, and the resulting outcomes for children. *Snapshot 2011*, by collating information across a range of matters relating to both the general population of children and those most vulnerable and at risk, allows the Commission and our readers to access a contemporary representation of the status of all children and young people in Queensland.

While *Snapshot 2011* includes information relating to the wellbeing of our most vulnerable children, the Commission produces a number of other key publications with a particular focus on these matters, including *Views of Children and Young People in Foster Care, Views of Young People in Detention Centres, Views of Young People in Residential Care, Child Guardian Report* and *Deaths of Children and Young People Annual Report. Snapshot 2011* features some of the key findings from these publications, together with data drawn from an array of external sources. Information is gathered from state and federal government agencies and departments, as well as the non-government and community sectors.

Snapshot 2011 draws on newly available data to identify emergent issues on the wellbeing of children and young people. Where possible, data are supported by robust trend analyses to provide a longitudinal evidence base from which facts can be drawn to highlight areas of concern and improvement. These facts can be used to inform policy and program development and facilitate shared understandings across sectors to help ensure our collective practices are responsive to the issues identified.

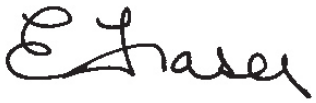
Snapshot 2011 identifies several areas of improvement for many of Queensland's children. Our children are generally healthy and provided with a broad range of educational and developmental opportunities. Mortality rates for children continue to decline and the proportions of children fully immunised are on the rise. Additionally, the rate of reported sexual offences committed against young people is decreasing and the majority of children in Queensland continue to meet the national minimum standards for reading and numeracy.

There are, however, also a number of areas of particular concern. Aboriginal and Torres Strait Islander children continue to fare poorly on a range of safety, health, education and social measures compared to their non-Indigenous peers, and more work needs to be done in the interests of the wellbeing of this cohort. The number of children placed in out-of-home care continues to rise, with a particular growth in the number of Indigenous children in out-of-home care and the overall number of young people living in residential care. Strengthening prevention and early intervention services in the

interests of children at risk of entering the child protection system, and providing universal and better-targeted access to these services, is of utmost importance.

It is my hope that *Snapshot 2011* will provide you with information and data that is of interest and which offers some critical insight and context for your area of work. Improvements to the wellbeing of children in Queensland are apparent when one looks at the changes in the profile of young people in our state since the inception of the *Snapshot* series. While it is promising to see that positive outcomes are being achieved, there is still much work to be done. By fostering a shared understanding of what is happening to our youth, we are able to continue to develop targeted intervention and preventative services.

The measure of our society is how well we treat our children. By working together to uphold their rights and interests, we can strengthen our community and ensure Queensland is a better place for all children to live.



Elizabeth Fraser
Commissioner for Children and Young People
and Child Guardian

At a glance

Early childhood

Mortality rates have decreased over the past 15 years. Deaths due to Sudden Infant Death Syndrome have also declined; however, this remains the leading cause of death of post-neonatal infants. The mortality rate for Indigenous infants has decreased somewhat, but remains almost twice the rate for non-Indigenous infants.

The proportions of babies born prematurely and with low birthweights have remained relatively stable over the past decade. Babies born to Indigenous mothers are more likely to have a low birthweight and be born prematurely, and both of these factors contribute to the significantly higher mortality rate for Indigenous babies.

The *Australian National Breastfeeding Strategy 2010-2015*, which aims to improve the health and wellbeing of infants and their mothers by promoting endorsed breastfeeding practices, is currently being implemented. Of concern is the finding that only a small proportion of Queensland babies are breastfed exclusively for the six months recommended by Queensland Health, the National Health and Medical Research Council and the World Health Organisation.

The vast majority of children in Queensland are fully vaccinated at 12 months of age, in accordance with the current national immunisation target.

There have been a number of recent key reforms to the early childhood education and care sector. A non-compulsory Preparatory Year of schooling (Prep) is now available to all children, and the Queensland Government continues to work towards providing universal access to kindergarten prior to commencement in Prep. Targeted early childhood education and care services are being provided to Indigenous children through the *National Partnership Agreement on Indigenous Early Childhood Development.* From 2012, government approved care services will be subject to the *National Quality Framework for Early Childhood Education and Care*. This framework will put in place a national quality standard with the aim of ensuring high quality and consistent early childhood education and care across Australia.

While the majority of children in their first year of schooling are making good progress, significant proportions remain vulnerable in at least one of the domains of the Australian Early Development Index. Language and cognitive skills remain areas of particular concern for a large proportion of Australian children.

Health and safety

Alcohol consumption among young people is an area of continued concern. While the proportions of young people reportedly using alcohol, tobacco and illicit drugs have generally been decreasing over the past decade, a considerable minority aged 16–17 years drink at levels that are classified as risky or high risk. This finding is particularly worrying as drinking excessively can have detrimental effects on school and work commitments, as well as contribute to longer-term medical and psychological problems.

Over one-half of Year 12 students report that they are sexually active, and the proportions that have engaged in sexual intercourse have increased over the past eight years. Female students are increasingly more likely to have engaged in some form of sexual activity than their male counterparts. Positively, the general knowledge of young people regarding sexually transmissible infections has improved since 2002, and the proportions of young people using unsafe sex practices continue to decline.

Only a minority of secondary students engage in the recommended daily physical activity requirements on a daily basis. Young people in the healthy body mass range and those living in rural areas are more likely to meet the daily requirements than their overweight or obese peers and those young people living in metropolitan areas.

Mortality rates for children and young people aged 1–17 years continue to decline. External causes of death, including transport incidents, drowning incidents and suicide, account for the majority of deaths of all young people. Young males are dying at greater rates than females, particularly as a result of transport incidents, drowning and suicide.

There have been reductions in some measures of child protection activity, including notifications, substantiations of harm and neglect and reports of children in need of protection.

The *Helping Out Families* program, funded by the Department of Communities, provides intensive case management services to children and families at risk of entering the child protection system. The program is being trialled in three locations in Queensland and will be evaluated in 2014.

The Department of Communities' *Referral for Active Intervention* services also provide support for children and families with complex needs and who are at risk of entering the child protection system. An evaluation of the initiative was conducted in 2010 and indicates that frequency of contact with the child protection system was reduced for families participating in the program across all locations.

Children and young people in out-of-home care

Over recent years, the numbers of children involved at key stages of the child protection system have grown. While the number of reports screened as notifications has declined, a growth in child concern reports has resulted in sustained increases in intakes overall. In addition, the numbers of children engaged in ongoing intervention and placed in out-of-home care have been trending upwards. The most significant growth has been observed in the number of Indigenous children in out-of-home care and the overall number of young people living in residential care.

Children and young people in care consistently achieve poorer educational outcomes than their peers, as evidenced by lower proportions meeting the minimum academic standards in literacy and numeracy. Academic underachievement is likely to restrict the further educational, training and employment opportunities available to these young people. This demonstrates the great challenge involved in helping children achieve major milestones if their environments have been significantly challenged or compromised.

The number of placements children experience prior to leaving out-of-home care remains stable, with more than three-quarters of those who exited the care of the state in 2009-10 having had three or fewer placements during their time in care.

It is positive to see that the majority of young people who participated in the *Views of Children and Young People in Foster Care 2010* and *Views of Young People in Residential Care 2009* report feeling

happy, safe and well treated in their care placement and being highly satisfied with their carer. However, the data also shows that many of our young people worry about things most or all of the time, and almost one-half feel they rarely or never have a say in what happens to them.

The *National Standards for Out-of-Home Care* have been developed to give children in care across Australia opportunities to reach their full potential in the key wellbeing areas of health and safety; learning and achieving; emotional development; spirituality; and culture and community. The standards will be progressively introduced by 2015.

Aboriginal and Torres Strait Islander children and young people

Indigenous children and young people in Queensland continue to experience significant disadvantage and poorer outcomes across a range of health, education, safety and social development measures.

- The mortality rate for Indigenous children is almost double the rate for non-Indigenous children.
- Babies born to Indigenous mothers are more likely to have a low birthweight and to be born prematurely.
- Indigenous infants have a mortality rate from Sudden Infant Death Syndrome that is almost seven times the rate for non-Indigenous infants.
- Indigenous young people are up to five times more likely to die from suicide than non-Indigenous young people.
- Indigenous young people are significantly more likely to be subject to notifications of harm and to have a rate of living in out-of-home care that is over eight times greater than the rate for their non-Indigenous peers.
- Fewer Indigenous children achieve the national minimum academic standards in literacy and numeracy.
- Indigenous students have lower school participation and retention rates than non-Indigenous students.
- Indigenous youth are significantly over-represented in the youth justice system.

The *Closing the Gap* initiative to reduce Indigenous disadvantage is now in its third year. The initiative aims to improve the lives of Indigenous people, including children and young people, while maintaining their cultural identity and sense of community. *Closing the Gap* has six key goals and these include to:

- halve the gap in mortality rate for Indigenous children aged under five years within a decade
- ensure access to early childhood education for all Indigenous children aged under four years in remote communities within five years
- halve the gap in reading, writing and numeracy achievement levels for Indigenous children within a decade, and
- halve the gap for Indigenous students in Year 12 attainment rates by 2020.

While there is currently limited data to inform progress towards these goals, there have been some improvements. Encouragingly, reading scores for Year 3 Indigenous students have increased notably and the gap between the Indigenous and Queensland infant mortality rates has narrowed in recent years. Yet, mortality rates for Indigenous young people are still significantly greater than the Queensland average. The gap between attendance rates for Indigenous and non-Indigenous students has also widened in some year levels, and Year 12 Indigenous students remain significantly less likely

to attain a Queensland Certificate of Education than their non-Indigenous peers. More work needs to be done in the interests of improving outcomes for this vulnerable group of children.

National data on progress towards *Closing the Gap* targets is available from the Productivity Commission's report *Overcoming Indigenous Disadvantage Key Indicators 2011*.

In addition to the *Closing the Gap* initiative, some important state and national schemes aimed at reducing areas of disadvantage for Indigenous children and young people include:

- *Indigenous Education Support Structures*
- *Embedding Aboriginal and Torres Strait Islander Perspectives in Schools*
- *Bound for Success Pre-Prep in Indigenous Communities*
- *Cape York/Gulf Remote Area Aboriginal and Torres Strait Islander Child Care, and*
- *Closing the Gap Education Strategy*.

Influencing positive change

Consistent with its legislated responsibility to promote and protect the right and interests of Queensland's children and young people, the Commission continues to actively undertake, contribute to and support a range of initiatives to improve outcomes for children and young people.

Some of the Commission's activities include:

- regularly visiting children and young people in foster care, residential care and in detention centres across Queensland through the Community Visitor Program, to monitor their safety and access to appropriate services and support
- receiving, investigating and resolving complaints made by, or on behalf of, children and young people in the child protection and youth justice systems
- surveying children and young people in foster care, residential care and in detention centres to build an evidence base for reporting and advocating on systemic issues
- reporting on the wellbeing of children and young people through a number of key reports, including:
  - *Snapshot*
  - *Child Guardian Report – Child Protection System*
  - *Views of Children and Young People in Foster Care*
  - *Views of Young People in Residential Care*
  - *Views of Young People in Detention Centres, and*
  - *Deaths of Children and Young People Annual Report.*
- promoting strategies to reduce child deaths, for example, through projects such as the Keeping Country Kids Safe and Reducing Youth Suicide in Queensland initiatives, and progressing work to establish national benchmarks for risks associated with child deaths
- administering the blue card system which requires child focused service providers to implement risk-management and screening provisions, and
- working to improve outcomes for Aboriginal and Torres Strait Islander children and young people, for example, by undertaking the Indigenous Child Placement Principle Audit 2010.

Chapter 1:

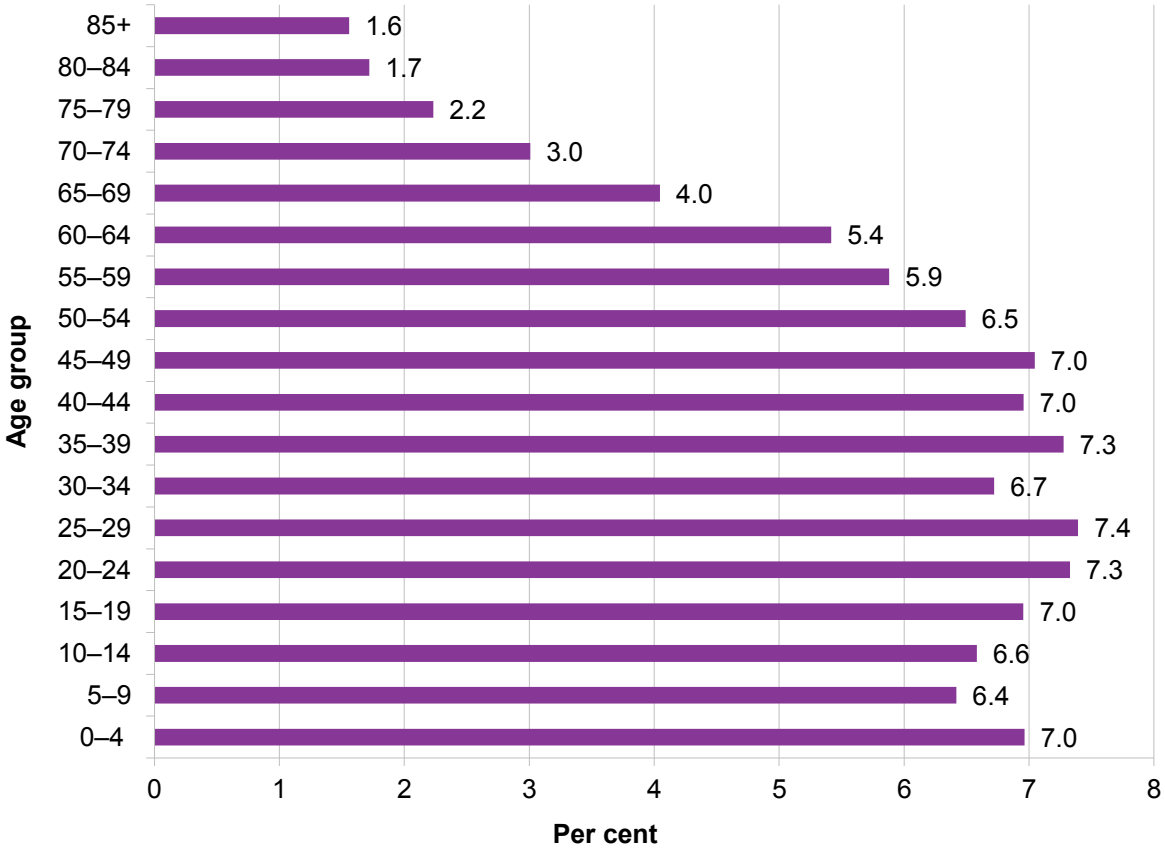
Demographics

This chapter uses data from the Australian Bureau of Statistics' *Census and Experimental Estimates and Projections* publications to provide a demographic snapshot of children and young people in Queensland, covering age profiles, Indigeneity and cultural background. Children born overseas are featured, as are children who speak languages other than English at home. This chapter also includes information drawn from the Australian Bureau of Statistics' Multi-Purposes Household Survey which provides information about family types and sizes and frequency of parental contact.

Age profile

At 30 June 2010, it is estimated that there were 1,088,135 children and young people (aged 17 years and younger) living in Queensland, accounting for 24.1% of the total population. This was an increase of 1.6% on the estimated population at the same time in 2009.

Figure 1.1 Estimated resident population by age, Queensland, June 2010



Source: ABS, *Population by Age and Sex, Regions of Australia, 2010*, cat. no. 3235.0

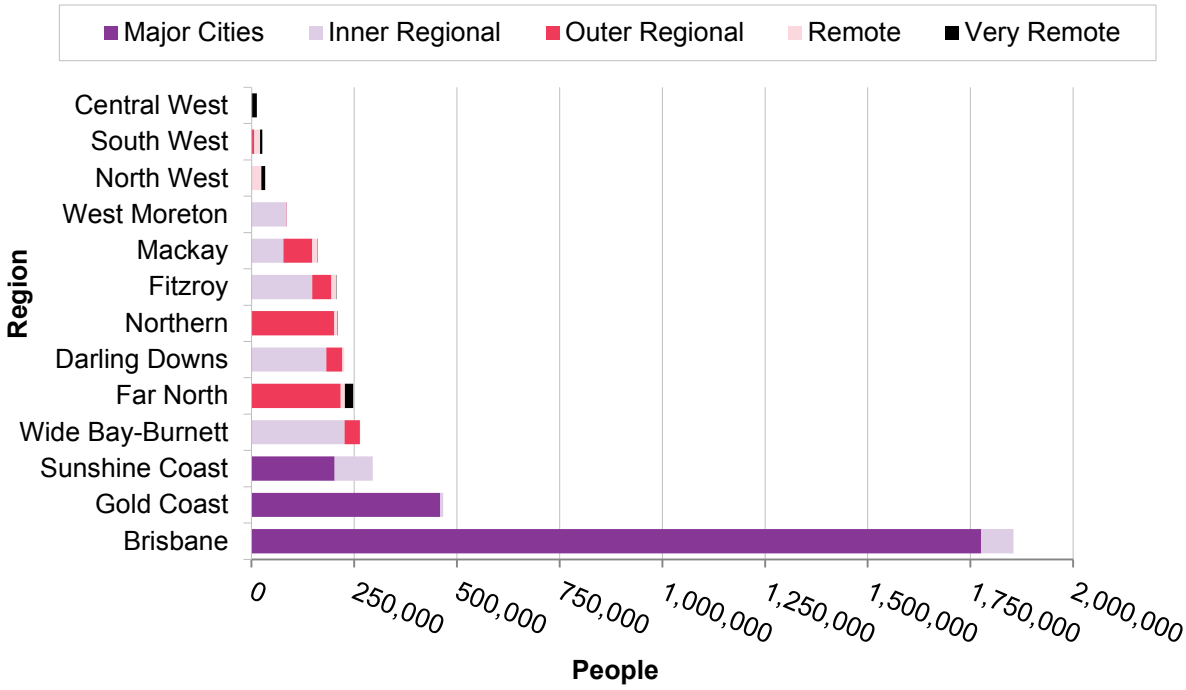
Location

The Accessibility/Remoteness Index of Australia (ARIA+) is used to score geographic areas in terms of their access to goods, services and opportunities for social interaction. Based on these ARIA+ scores, areas can be placed into five major categories:

- Major cities, characterised as having relatively unrestricted access to a wide range of goods, services and social opportunities
- Inner regional areas, characterised by some restriction
- Outer regional areas, characterised by significant restriction
- Remote areas, characterised by very restricted access, and
- Very remote areas, characterised by very little access.

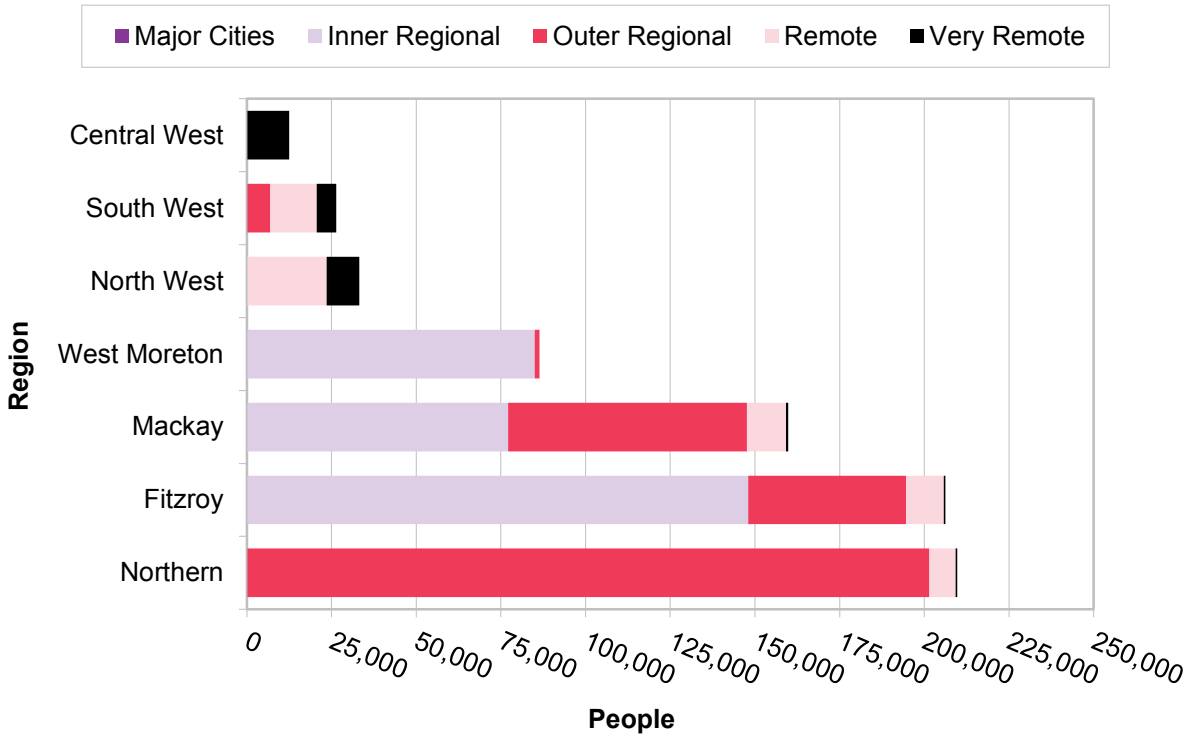
Figures 1.2.1 and 1.2.2 below show the proportions of Queensland's population within each statistical division experiencing each of these levels of access at the 2006 Census.

Figure 1.2.1 Population by statistical division and remoteness, Queensland 2006



Source: ABS, *Census 2006*

Figure 1.2.2 Population by selected statistical divisions and remoteness, Queensland 2006



Source: ABS, *Census 2006*

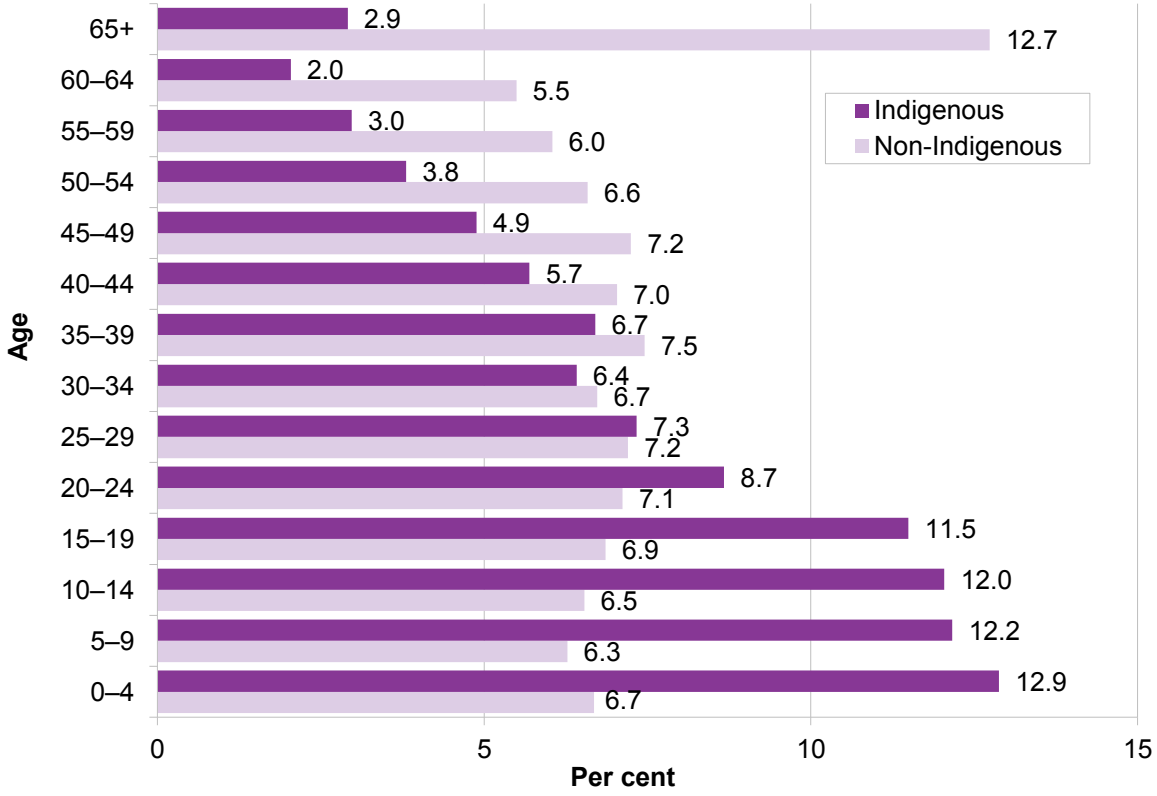
At the 2006 Census, 59.6% of the state's population lived in major cities located within the Brisbane, Gold Coast and Sunshine Coast statistical divisions. Including the smaller number of people living in these divisions classified as inner regional, these three divisions, all located in the south east of Queensland, account for 64.0% of the state's population.

While the majority of Queenslanders live in the south east corner of the state, a considerable number live in more remote locations where services and infrastructure are less accessible. At the 2006 Census, 2.1% of Queensland population were classified as remote and 1.2% were classified as very remote.

Cultural backgrounds

Aboriginal and Torres Strait Islander children and young people

Figure 1.3 Population by age and Indigenous status, Queensland, June 2009



Note: As an example of the data, 12.2% of the Indigenous population are aged 5–9 years, while 6.3% of the non-Indigenous population are aged 5–9 years.

Source: ABS, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2006 to 2021,* cat. no. 3738.0

In 2009, there were an estimated 69,200 Aboriginal or Torres Strait Islander children and young people aged 0–17 years in Queensland. This represented 6.5% of the Queensland population aged under 18. Based on experimental projections of the resident Indigenous population from the 2006 Census, there were approximately 39,200 children aged 0–9 years and 30,000 young people aged 10–17 years (Australian Bureau of Statistics, 2009).

The age profile of the Indigenous population differs markedly from that of the non-Indigenous population (Figure 1.3), with 44.2% of the Indigenous population aged 0–17 years compared with 23.6% in the non-Indigenous population. The higher proportions of children and young people in the Indigenous population compared with the non-Indigenous population is a reflection of the lower life expectancies and higher fertility rates experienced by Indigenous people.

Another factor contributing to the differences in the Indigenous and non-Indigenous profiles is the high proportion of Indigenous children who have only one Indigenous parent. Babies born to one Indigenous parent and one non-Indigenous parent are generally identified as Indigenous in birth registrations, and this effectively inflates the increase in the Indigenous population above that in a closed population.

Children and young people born overseas

The Census asks the country of birth for each person in the household. Responses for children and young people born outside of Australia are presented in Table 1.1 below.

Table 1.1 Birthplace of 0–17 year olds born overseas, Queensland, 2006

Birthplace	Number	Per cent
New Zealand	20,735	31.4
United Kingdom	11,115	16.8
South Africa	4,787	7.2
United States of America	2,023	3.1
Philippines	1,877	2.8
South Korea	1,703	2.6
Taiwan	1,431	2.2
Papua New Guinea	1,268	1.9
Japan	1,175	1.8
Other country	19,994	30.2
Total	**66,108**	**100.0**

Note: Excludes country not stated or inadequately described.
Source: ABS, *Census 2006*

Only 7.2% of 0–17 year olds in Queensland were born overseas (of those with birthplace stated). New Zealand was the most common overseas birthplace (31.4% of all overseas born), followed by the United Kingdom (16.8%) and South Africa (7.2%) (Table 1.1). However, a higher proportion of Queensland parents were born overseas, with 28.7% of dependent children aged under 18 having one or both parents born overseas (Australian Bureau of Statistics, 2007).

Language spoken at home

The Census asks whether each person in the household speaks a language other than English at home and these responses are coded using the Australian Standard Classification of Languages (ASCL), Second Edition, Revision 1. Respondents can only choose one language so the results presented below do not represent the diversity of languages used by individuals or within households.

Table 1.2 Language other than English spoken at home, 0–17 year olds, Queensland, 2006

	Number	Per cent
Vietnamese	4,884	7.7
Mandarin	4,768	7.5
Australian Indigenous languages	4,697	7.4
Cantonese	3,664	5.8
Samoan	3,577	5.6
Japanese	2,678	4.2
Arabic	2,139	3.4
Spanish	2,076	3.3
Korean	2,020	3.2
Other language	33,165	52.1
Total	**63,668**	**100.0**

Note: Excludes language not stated or inadequately described.
Source: ABS, *Census 2006*

In 2006, 93.1% of 0–17 year olds spoke only English at home (where language was stated). Languages spoken at home other than English included Vietnamese (7.7% of all other languages), Mandarin (7.5%) and Australian Indigenous languages (7.4%) (Table 1.2). An estimated 6.2% of Aboriginal and Torres Strait Islander children aged 4–14 years spoke an Indigenous language at home as their main language in Queensland in 2008 (Australian Bureau of Statistics, 2009). Almost one-third (32.3%) of Indigenous children speak an Indigenous language, even if it is not the primary language spoken at home.

Family

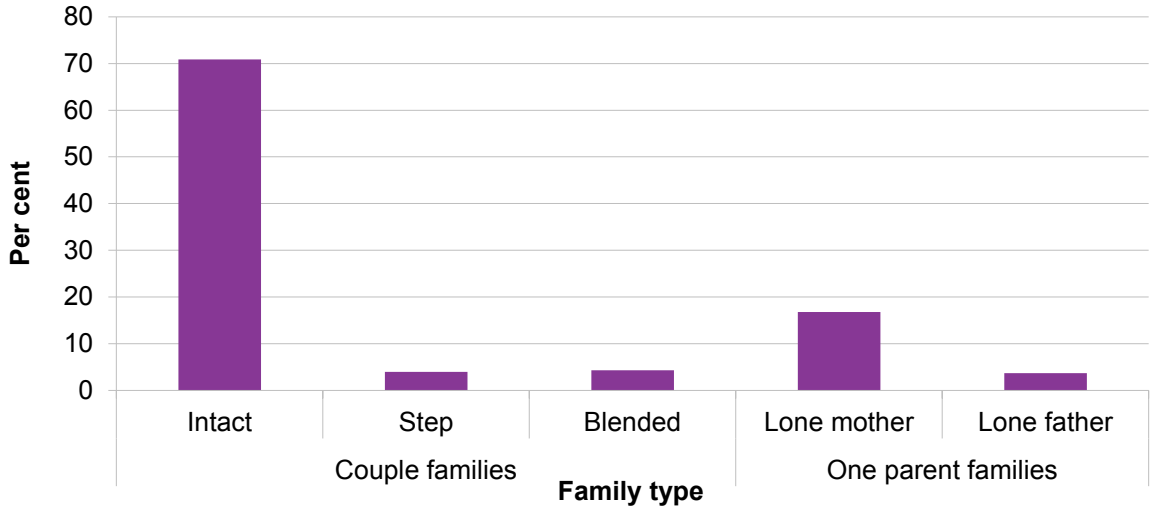
The definition of family is a contested area and can be difficult to articulate. In a narrow sense, family may refer only to individuals related by blood or marriage. In a broader sense, a family may include individuals who perform the functions usually ascribed to family such as providing emotional support, economic cooperation, reproduction and the socialisation of children (Tilman and Nam, 2008).

For the purpose of the Census, the Australian Bureau of Statistics regards families as “two or more persons, one of whom is at least 15 years of age, who are related by blood, marriage (registered or de facto), adoption, step or fostering, and who are usually resident in the same household” (Census data dictionary). These families are divided into various sub categories. Those that include children are:

- intact couple families, where both parents are the natural or adopted parents of all children
- step families, where for all children, only one of the parents is the child’s natural or adopted parent
- blended families, where for some children, only one of the parents is their natural or adopted parent and for some children, both parents are their natural or adopted parents
- lone mother families, where there is one female parent only in the household, and
- lone father families, where there is one male parent only in the household.

Figure 1.4 shows the proportions of families falling into each of these categories based on the Australian Bureau of Statistics’ (ABS) Multi-Purpose Household Survey which was conducted throughout Australia in the 2006-07 financial year and had a sample size of 31,300 individuals.

Figure 1.4 Families with children aged 0–17 by family type, Queensland, 2007

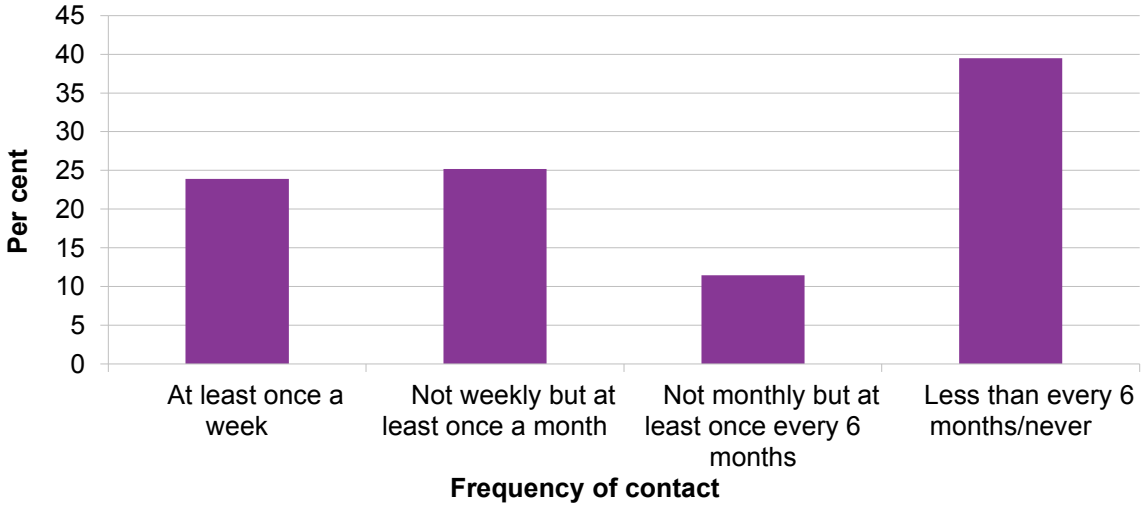


Source: ABS, *Multi-Purpose Household Survey 2007*

In 2007 in Queensland, the large majority (79.2%) of families with children included two parents. Overwhelmingly, intact couple families were the most common, making up 70.9% of families with children. The next most common family structure was the lone mother family, comprising 16.8% of families with children. Blended families (4.3%), step families (4.0%) and lone father families (3.7%) were the least common family structures.

Within the different family types described above, a number of children have a natural parent living elsewhere, including but not limited to most children living in single parent households, step and blended households and children in foster care. Based on the Multi-Purpose Household Survey, it was estimated that in 2007 some 224,000 children throughout the state had a natural parent living elsewhere.

Figure 1.5 Children aged 0–17 years with a natural parent living elsewhere, frequency of face-to-face contact, Queensland, 2007



Source: ABS, *Multi-Purpose Household Survey 2007*

Where contact arrangements with the non-resident parent could be ascertained, it was reported that 23.9% saw their non-resident parent at least once every week and a further 25.2% reported seeing their parent less often but at least once per month. Half (50.9%) saw their non-resident parent less often than once per month, including 39.5% who saw them less than every six months or never.

Chapter 2:

Health

This chapter features data from periodically released surveys covering a range of health issues affecting children and young people, including behavioural determinants of health and particular health conditions such as obesity, Type 1 diabetes, mental health and oral health. The *Queensland Perinatal Data Collection* and other data sources provide information on infancy, including risk factors such as premature birth, low birthweight and maternal alcohol intake, and protective factors such as immunisation and breastfeeding. Data provided by Queensland Health capture changes in injury-related causes of admission to hospital and information from the Department of Communities highlights the prevalence of various disability types among young people. Chapter 2 also covers a range of topics relating to lifestyle and social issues affecting the health of children and young people. Topics include physical activity, nutrition, sexual knowledge and activity and the use of tobacco, alcohol and illicit drugs.

Behavioural determinants of health

There are a variety of behaviours, both of parents and children, which contribute towards the overall health and wellbeing of children and young people. Behaviours can increase or decrease the risk of certain health conditions and can promote or detract from overall health and wellbeing in the short and long term. These behaviours have important implications for population health and disease prevention.

Breastfeeding

There is strong evidence that breastfed babies have a reduced risk of developing a range of conditions throughout infancy and childhood, including diabetes mellitus, otitis media (ear infection), diarrhoea and respiratory infections such as asthma and eczema (Al-Yaman, Bryant, & Sargeant, 2002; National Health and Medical Research Council, 2003; Horta, Bahl, Martines, & Victoria, 2007).

Breastfeeding is promoted at both a federal and state level evidenced by the *Australian National Breasfeeding Strategy 2010-2015*, which aims to improve the health and wellbeing of both infants and mothers by promoting and monitoring breastfeeding (Australian Health Ministers' Conference, 2009). Queensland Health recommends that babies be breastfed exclusively for the first six months and have both breast milk and solids until at least 12 months. These guidelines are consistent with the National Health and Medical Research Council (NHMRC) and World Health Organisation (WHO) guidelines.

According to the Queensland Perinatal Data Collection, 78.3% of babies in 2008 were fed only breastmilk at the time of discharge from hospital (Queensland Health – Health Information Centre, 2010). This was down from 82.7% in 2007.

The *Infant Nutrition Project 2006-07* attempted to measure breastfeeding of babies after they left hospital across three health districts in South-East Queensland. Results of this project are presented in Table 2.1.

Table 2.1 Consumption of breastmilk, breastmilk substitute and solid food by age, South-East Queensland[a], 2006–07

	2 months	5 months
	Per cent	
Breastfed	53.1	41.4
Exclusively breastfed	38.1	9.5
Fully breastfed[b]	41.5	11.8
Consumed solid foods	8.3	77.0
Consumed breastmilk substitute	57.5	69.0

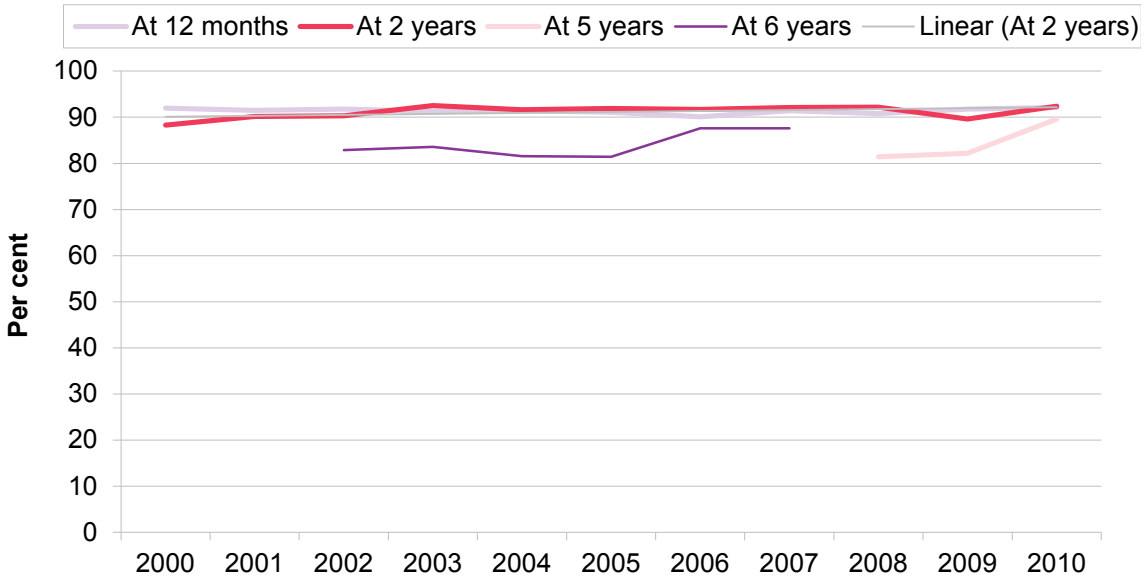
Notes: Mothers of children were asked about their child's consumption in the previous 24 hours.
a. Three South-East Queensland health services districts: Bayside, Logan-Beaudesert and West Moreton.
b. Breastmilk was the main source of nourishment.
Source: Queensland Health, *Infant Nutrition Project 2006–07*

In 2006-07, 38.1% of babies were exclusively breastfed at two months of age and 9.5% were exclusively breastfed at five months of age. While exclusive breastfeeding was relatively uncommon, a larger proportion of children were either fully breastfed (i.e. breastmilk was their main source of nourishment) or received some breastmilk in the preceeding 24 hours.

Immunisation

Since 31 March 2008, immunisation for children is measured and reported nationally at three milestones: 12 months, 2 years and 5 years of age. Prior to this, coverage was reported at 6 years instead of 5 years. The current national target is to have 95% of children at each age fully vaccinated. Since 2000, the proportion of children fully vaccinated at 1 and 2 years of age has remained relatively stable at just above 90% (Figure 2.1).

Figure 2.1 Age-appropriate immunisation coverage rates at December 31, Queensland, 2000 to 2010

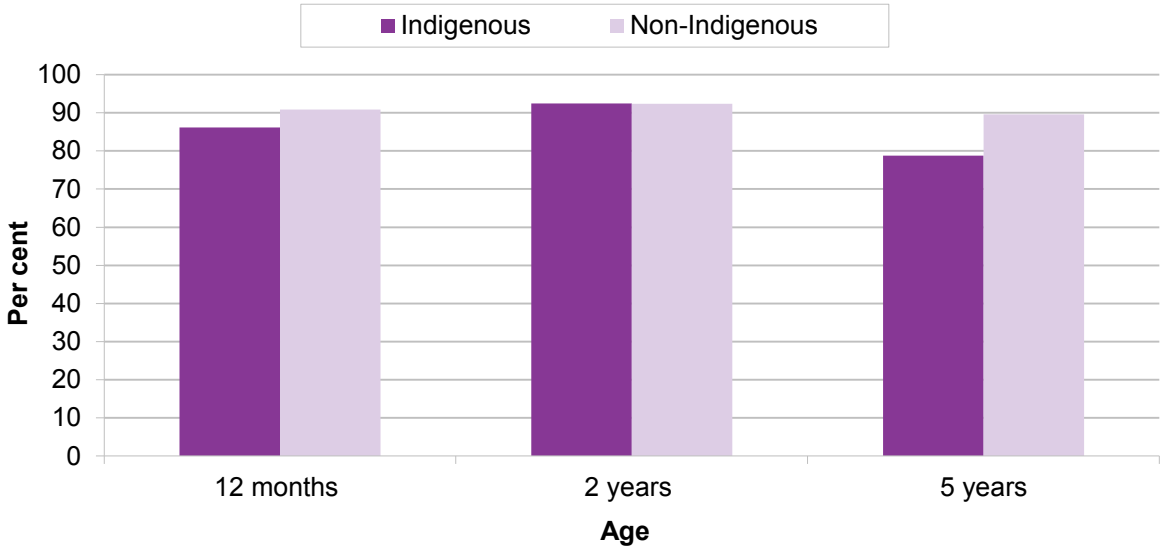


Source: Queensland Health – Communicable Diseases Branch; Medicare Australia, *Australian Childhood Immunisation Register.*

In 2010, 92.1% of 1 year olds were full vaccinated, as were 92.4% of 2 year olds. Since 2008, when the proportion of children fully vaccinated at 5 years of age was first recorded, the rate of full vaccination has improved from 81.4% to 89.6% at December 2010.

Recent improvements in recording Indigenous status – resulting from the encouragement of Aboriginal and Torres Strait Islander individuals to report their Indigenous status, the transfer of Medicare demographic data to the Australian Childhood Immunisation Register (ACIR), and the transfer of data from state and territory immunisation registers to the ACIR – contributed to an increase in reporting of Indigenous status from 42.0% in 2002 to 95.0% in 2005 (Rank and Menzies, 2007). Current comparisons of immunisation coverage by Indigenous status are more reliable than in previous years and these comparisons are presented in Figure 2.2.

Figure 2.2 Age-appropriate immunisation coverage rates by Indigenous status, Queensland, 2008

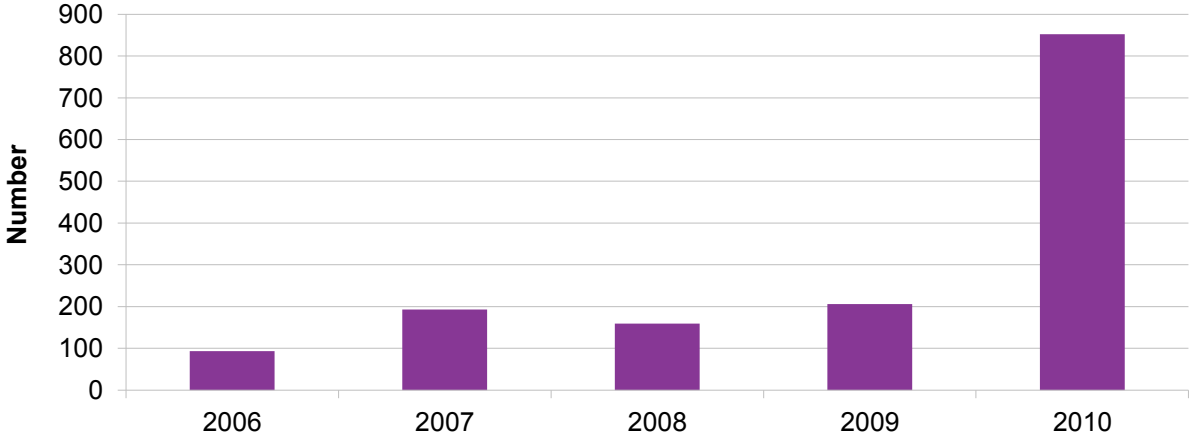


Source: Hull, Mahajan, Dey, Menzies and McIntyre, 2010

In 2010, immunisation rates for Indigenous children were slightly lower for 1 year olds (86.2% for Indigenous children compared to 90.9% for non-Indigenous children). At 2 years of age, immunisation coverage for Indigenous and non-Indigenous children was the same (92.5% and 92.4% respectively); however, at 5 years of age, Indigenous coverage rates were significantly lower. In 2008, 78.8% of Indigenous 5 year olds had complete vaccination coverage compared to 89.6% of their non-Indigenous counterparts.

While vaccinations provide protection against a variety of diseases, there is still a level of risk associated with providing any vaccine. Adverse events following immunisation (AEFI) are any serious or unexpected adverse events that follow vaccinations. They may be related to the vaccine itself, its handling or administration or may be merely coincidental. Numbers of AEFI are carefully monitored and reported by Queensland Health on a weekly basis (Figure 2.3).

Figure 2.3 Adverse events following immunisation in adults and children, Queensland, 2006 to 2010



Source: Queensland Health – Communicable Diseases Branch, *Queensland Health statewide weekly communicable diseases surveillance report 4 July 2011*

There were considerably more AEFIs in 2010 than in previous years. In 2010, there were 852 reported adverse events compared to 206 in 2009. This large increase is related to increased case ascertainment following the suspension nationally of seasonal influenza vaccination for children under 5 years. This suspension was due to an increase nationally in the reports of fever and febrile convulsions following seasonal influenza vaccination in this age group. To enable a thorough assessment, the case definition was also broadened to include all cases of fever following seasonal influenza vaccination where previously the case definition was for very high fever.

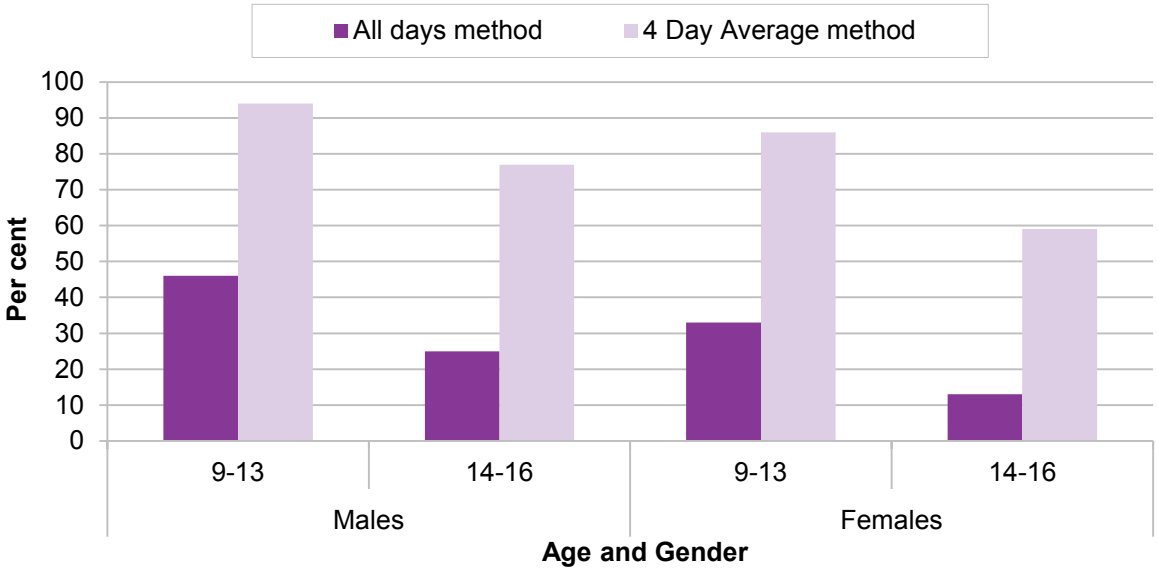
Physical activity

Physical activity is influenced by many factors including intra-personal factors and the broader social and physical environment. Children who are not physically active on a regular basis can notice gains in their weight and are at higher risk of type 2 diabetes, abnormal glucose metabolism, some forms of cancer, and cardiovascular disease as they age. As such, the Commonwealth Government's Department of Health and Ageing recommends Australian children aged 5-18 years get at least 60 minutes of moderate to vigorous activity each day.

The *2007 Australian National Children's Nutrition and Physical Activity Survey* was the first national investigation of children's nutrition and physical activity since 1995 (Commonwealth of Australia, 2008). This survey measured dietary intake and physical activity across 4,487 children and young people aged 2–16 years.

The survey calculates the proportions of children and young people who met the recommended minimum 60 minutes of moderate to vigorous activity in four ways. The most stringent requires the respondents to meet the recommended physical activity on all four of the previous days. The most relaxed method requires respondents to average at least 60 minutes of moderate to vigorous activity per day over the previous four days. Results using these two different methods are presented below.

Figure 2.4 Young people meeting guidelines for physical activity over previous four days by gender and age, Australia, 2007



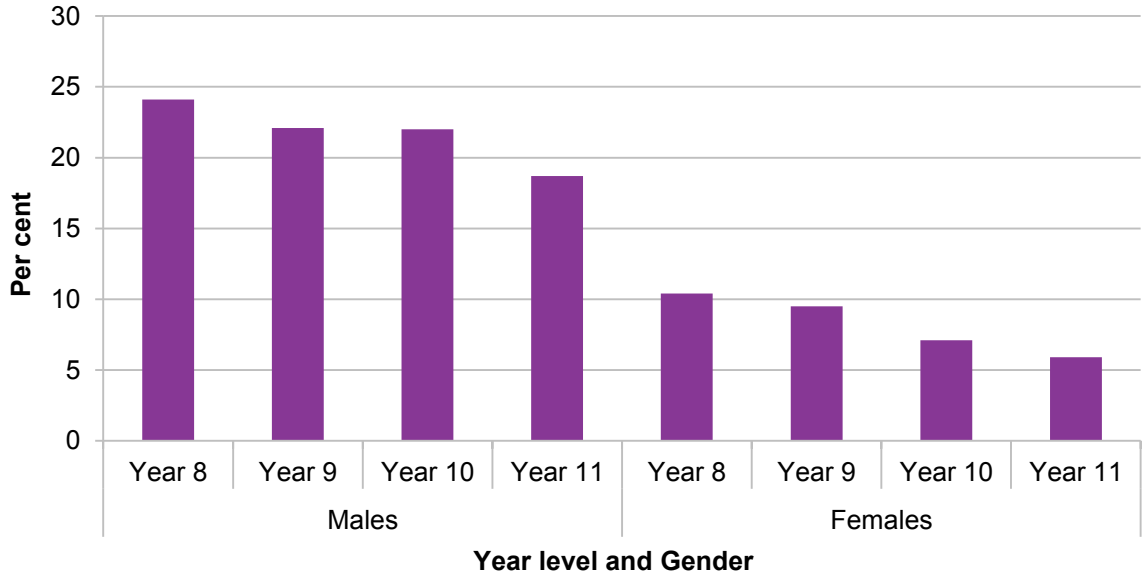
Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

Just under one-third (32%) of children and young people met the physical activity requirements on every one of the previous four days. Males were more likely to meet this requirement with 46% of 9–13 year olds and 25% of 14–16 year olds meeting the requirements compared to 33% of 9–13 year old females and 13% of 14–16 year old females. Younger children, both male and female, were more likely to meet the benchmark than their older counterparts.

Using the more relaxed method, which requires children and young people to average at least 60 minutes of exercise per day over the previous four days, just over four-fifths (82%) of respondents met the guidelines. Younger children aged 9–13 years were most likely to meet the requirements (94% of males and 86% of females). Young people aged 14–16 years were less likely to meet the requirements (77% of males and 59% of females).

The *National Secondary Students Diet and Activity Survey 2009-10*, which was conducted by the Cancer Council and the National Heart Foundation Australia, surveyed approximately 12,000 children in Years 8 to 11 across 237 Australian schools. Results were interpreted using a more strict method than the *2007 Australian National Children's Nutrition and Physical Activity Survey*, requiring young people to be active for at least 60 minutes on every one of the previous 7 days. Results for students in Years 8 to 11 are presented below.

Figure 2.5 Young people meeting guidelines for physical activity every day in the previous week by gender and year level, Australia, 2009-10



Source: Cancer Council and Heart Foundation, *Prevalence of meeting physical activity recommendations in Australian secondary students*

The *National Secondary Students Diet and Activity Survey 2009-10* found that, over the week the students were asked to complete the survey, 15% of students met the physical activity recommendations on every day. Males were consistently more likely to meet the requirements every day than females of the same age and older students of both genders were less likely to meet the requirements than younger students.

Other differences in meeting the recommendations were observed between students with body mass indexes (BMIs) in the healthy range (16.3%) and students with BMIs in the overweight or obese categories (12.7%) and between students in metropolitan areas (13.7%) compared to students in rural areas (17.8%).

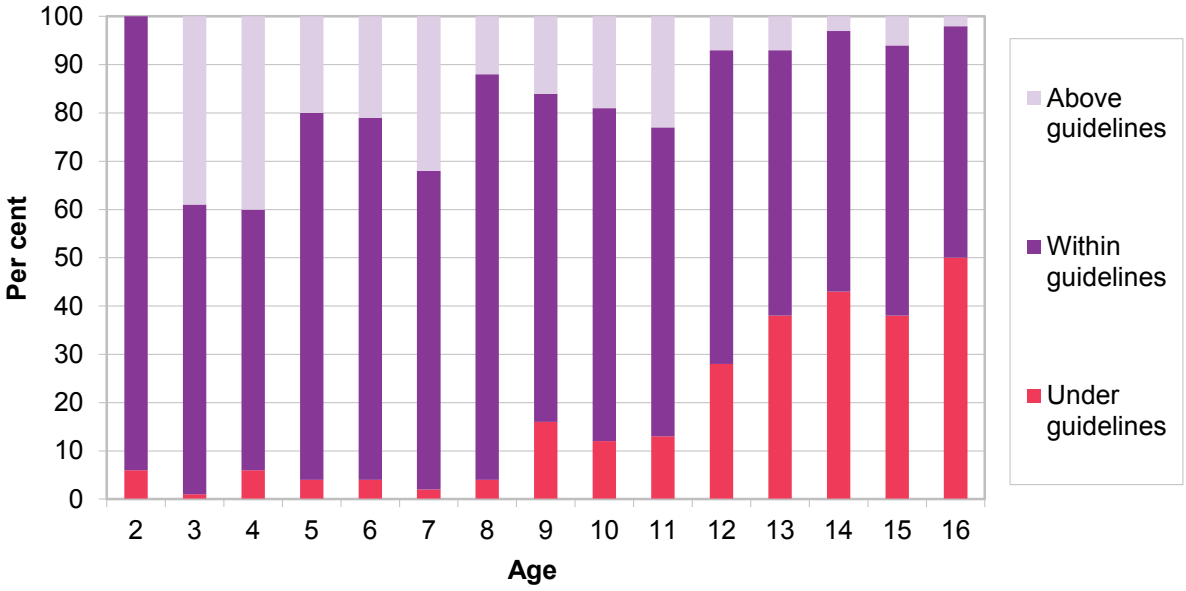
The survey also found that 38% of students were active between four to six days, while 41% were sufficiently active on one to three days of the week. Only 6% of students were not physically active for at least 60 minutes on any of the seven days of the survey period.

Nutrition

The *2007 Australian National Children's Nutrition and Physical Activity Survey* was the first national investigation of children's nutrition and physical activity since 1995 (Commonwealth of Australia, 2008). This survey measured dietary intake, selected food habits, use of supplements and other dietary measure across 4,487 children and young people aged 2–16 years.

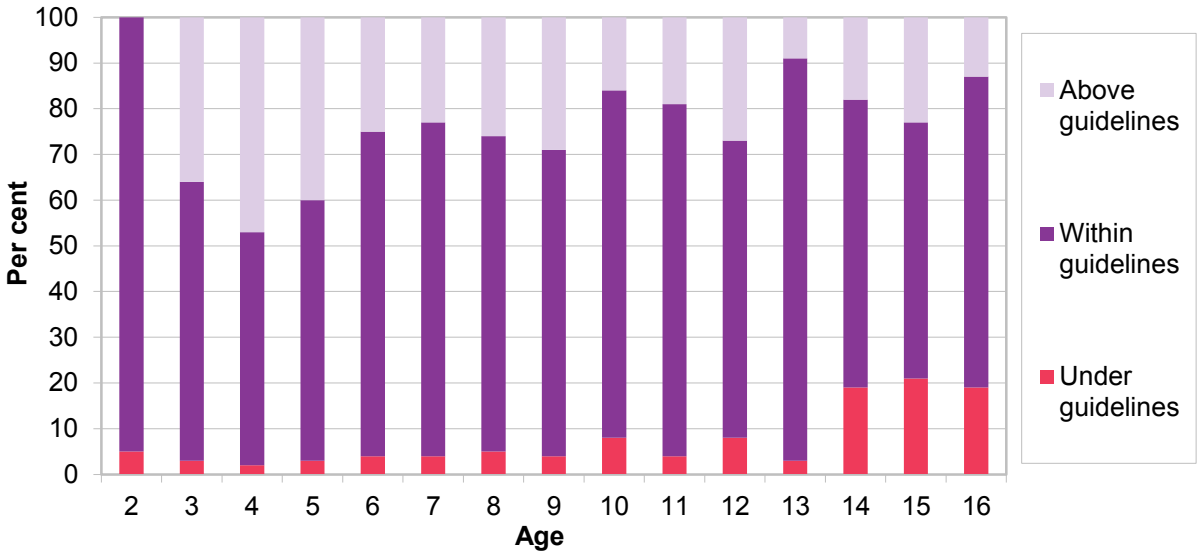
Based on these results, children and young people were categorised according to whether their energy intake was adequate, above the estimated energy requirements or below. Results by gender and age are presented in Figures 2.6.1 and 2.6.2.

Figure 2.6.1 Young females meeting guidelines for energy consumption by age, Australia, 2007



Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

Figure 2.6.2 Young males meeting guidelines for energy consumption by age, Australia, 2007



Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

Excess consumption was most prevalent in younger children peaking at four years of age (47% for males and 40% for females). Consuming less energy than required was more prevalent amongst older children, particularly amongst females. Rates of under-consumption peaked at 21% amongst 15 year olds for males and were highest amongst 16 year old females at 50%. It is important to note that high proportions of young people reporting that they consume less than is required may be affected by under-reporting, particularly for older females.

The *2007 Australian National Children's Nutrition and Physical Activity Survey* also reported on the proportions of children and young people meeting the estimated average requirements of a number of micronutrients. These included:

- protein
- vitamin A retinol equivalent
- thiamin
- riboflavin
- niacin equivalent
- folate (dietary folate equivalents)
- vitamin C
- calcium
- phosphorus
- magnesium
- iron
- zinc, and
- iodine.

The majority of children and young people met the estimated average requirements for all nutrients included in the survey, except calcium. Between 82% and 89% of girls aged 12–16 years did not meet the estimated daily requirements for calcium because of their relatively low intakes of dairy products. In addition, more than half (56%) of girls aged 14–16 years did not meet the daily requirement of magnesium intake.

The *Australian Guide to Healthy Eating* gives dietary guidelines for daily fruit and vegetable consumption. Guidelines for fruit consumption, where a serve of fruit is 150g, are:

- 4–7 year olds – 1 serve per day
- 8–11 year olds – 1 serve per day
- 12–18 year olds – 3 serves per day.

As displayed in Figure 2.7, the *2007 Australian National Children's Nutrition and Physical Activity Survey* adapted these guidelines to report for the following age groups:

- 2–3 year olds – 1 serve per day
- 4–8 year olds – 1 serve per day
- 9–13 year olds – 1 serve per day
- 14–16 year olds – 3 serves per day.

Figure 2.7 Children meeting guidelines for consumption of fruit by gender and age, Australia, 2007

Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

Where juice is included as a serve of fruit, around 9 out of 10 children aged 2–13 years, both males and females, met the daily guidelines. However, when juice is not included, only 70% of males aged 2–3 years, 63% of males aged 4–8 years and 50% of males aged 9–13 years met the guidelines. Likewise, 66% of females aged 2–3 years, 59% aged 4– 8 years and 52% aged 9–13 years met the guidelines. Young people aged 14–16 years were far less likely to meet the guidelines. When juice is included, 25% of males aged 14–16 years met the guidelines and 19% of females aged 14–16 years met the guidelines. When juice is excluded, only 2% of males and 1% of females met the guidelines.

According to the Australian Guide to Healthy Eating, where a serve is 75g, the guidelines for vegetable consumption are:

- 4–7 year olds – 2 serves per day
- 8–11 year olds – 3 serves per day
- 12–18 year olds – 4 serves per day.

As with the recommended fruit intakes, these recommendations were adapted for the age categories reported in the *2007 Australian National Children's Nutrition and Physical Activity Survey*. Adapted recommended intakes used in Figure 2.8 are:

- 2–3 year olds – 2 serves per day
- 4–8 year olds – 2 serves per day
- 9–13 year olds – 3 serves per day
- 14–16 year olds – 4 serves per day.

Figure 2.8 Children meeting guidelines for consumption of vegetables by gender and age, Australia, 2007

Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

Substantially fewer children and young people met the guidelines with respect to vegetables than did for fruit. When potatoes were included, children aged 4–8 years were most likely to meet the guidelines (22% of males and 22% of females). Young people aged 14–16 years were least likely to meet the guidelines with only 11% of males and 1% of females meeting the guidelines when potatoes were included. When potatoes were excluded, 2–3 year olds were most likely to meet the daily requirements (5% of males and 6% of females). Again, 14–16 year olds were least likely to meet the guidelines with less than 1% of females and 2% of males meeting the guidelines.

Sexual knowledge and activity

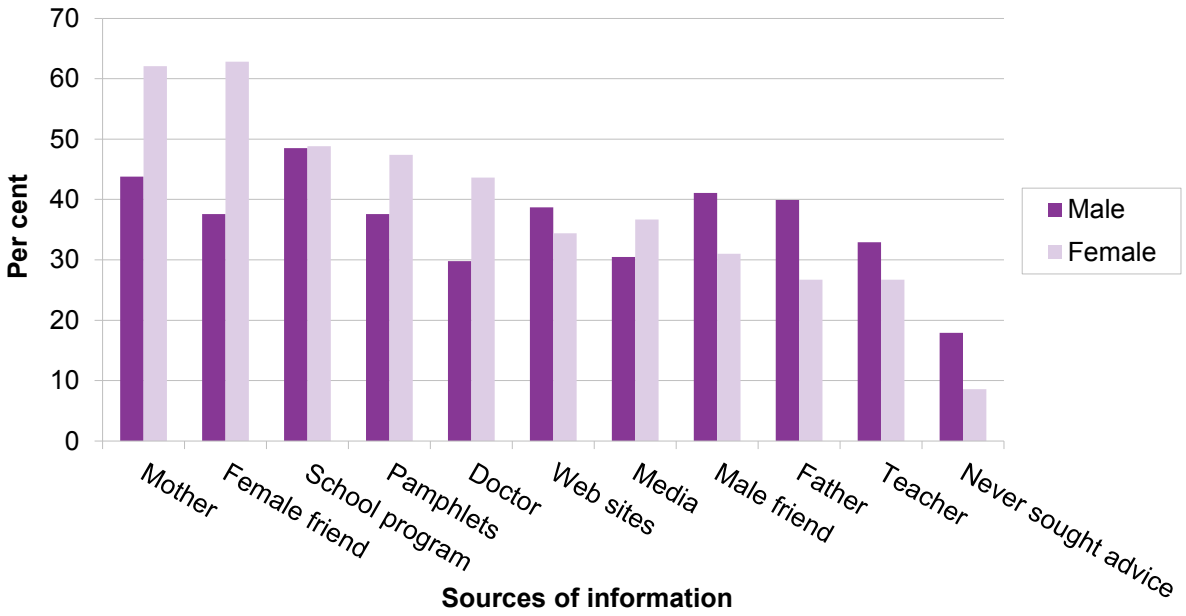
An understanding of sexually transmissible infections (STIs), safe sex practices and contraception is an important protective factor against STIs and unwanted pregnancy for young people and also promotes sexual health. It is also important to understand the sexual practices of young people to understand the sexual health risks young people are exposed to.

The *National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health* explores both of these issues, measuring sources of information that young people draw on to understand issues around sexual health, their knowledge about relevant issues and their sexual practices. The most recent survey was conducted in 2008 and was the fourth since the inaugural survey in 1992. In 2008,

2,926 Year 10 and Year 12 students from 105 schools across the country participated (Smith, Agius, Mitchell, Barrett, & Pitts, 2009).

To explore where young people look for information about sexual health, young people were presented with a list of potential sources of information about sexual health and were asked to indicate whether they had ever used each of the information sources and whether they trusted each information source. The ten information sources most frequently utilised by respondents are presented in Figure 2.9.

Figure 2.9 Most popular sources of information about sexual health amongst young people by gender, Australia, 2008



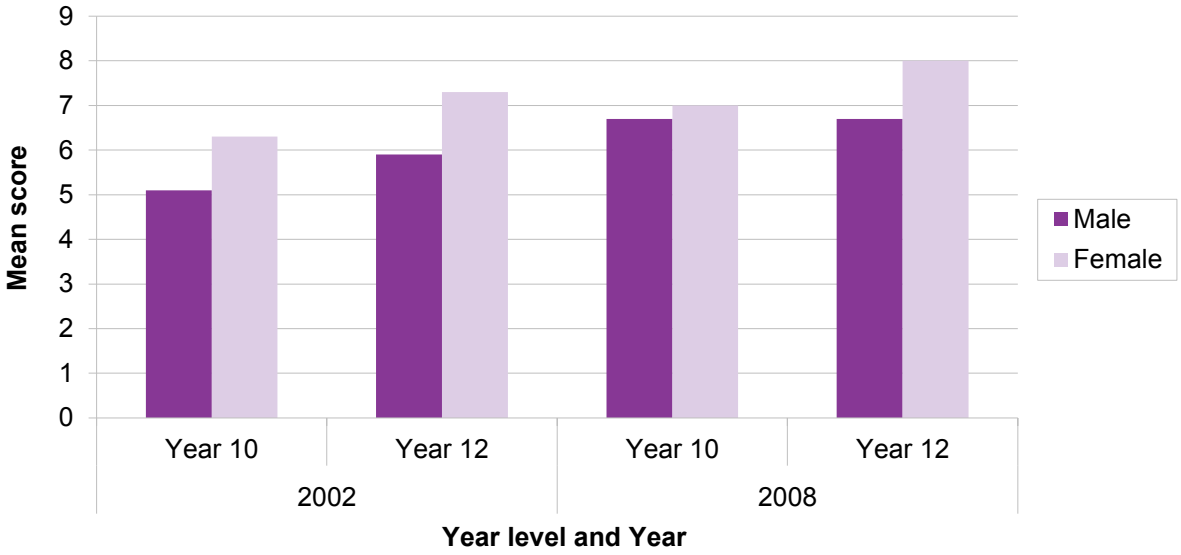
Source: Smith et al., *Secondary Students and Sexual Health 2008*.

Overall, males were less likely to seek information about sexual health than females with 17.9% of males indicating they had never sought advice compared to 8.6% of females. Young people were more likely to access information from friends and family of their own gender, although a considerable proportion of young people reported accessing information from friends and family of the opposing gender. While mothers were the most popular source of information overall (56.0%), the most popular source of information for females was their female peers (62.8%), while males were most likely to access information from school programs (48.5%). Overall, doctors, mothers and female friends were most likely to be rated as a trusted source of information (73.3%, 68.6%, and 56.8% respectively were rated as trusted sources).

The *National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health* also tested knowledge about issues relevant to sexual health. The survey asked participants eleven questions testing general knowledge of STIs including whether obvious symptoms always accompany STIs and the transmissibility and curability of specific STIs (Chlamydia, gonorrhoea, genital warts, HIV and herpes). These questions were also asked in 2002 providing an opportunity for comparison over time. Average success in answering these questions is presented in Figure 2.10. Participants could score between 0 (no correct answers) and 11 (all questions answered correctly). Other sections in the

survey were dedicated to specific knowledge of hepatitis, human papillomaviraus and cervical cancer. Findings from these questions are not included in the analysis below.

Figure 2.10 Young people's mean STI knowledge scores, by year level and gender, Australia, 2002 and 2008

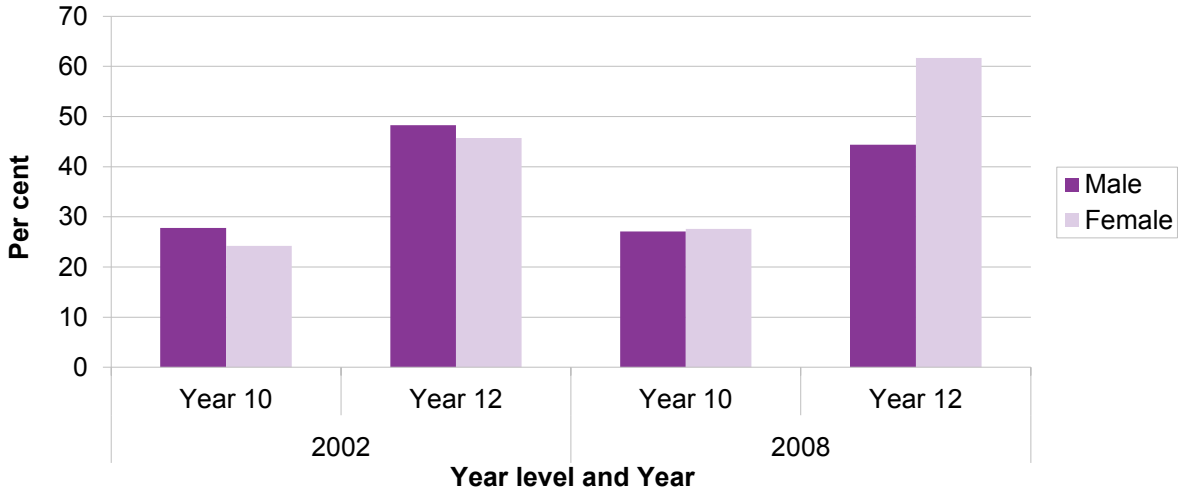


Source: Smith et al., *Secondary Students and Sexual Health 2008*.

On average, females in both Year 10 and Year 12 had better general STI knowledge than their male counterparts. Positively, mean scores for both males and females across both year levels were better in 2008 than in 2002. The vast majority of students were aware that both men (91.0%) and women (90.4%) can have an STI without showing obvious symptoms, however, knowledge about the curability and modes of transmission of specific STIs was somewhat less common.

As in previous years, students were asked about whether they had ever or recently engaged in a variety of sexual activities. Figure 2.11 shows the proportions of students who reported they had ever had sexual intercourse.

Figure 2.11 Young people who have ever had sexual intercourse by year level and gender, Australia, 2002 and 2008

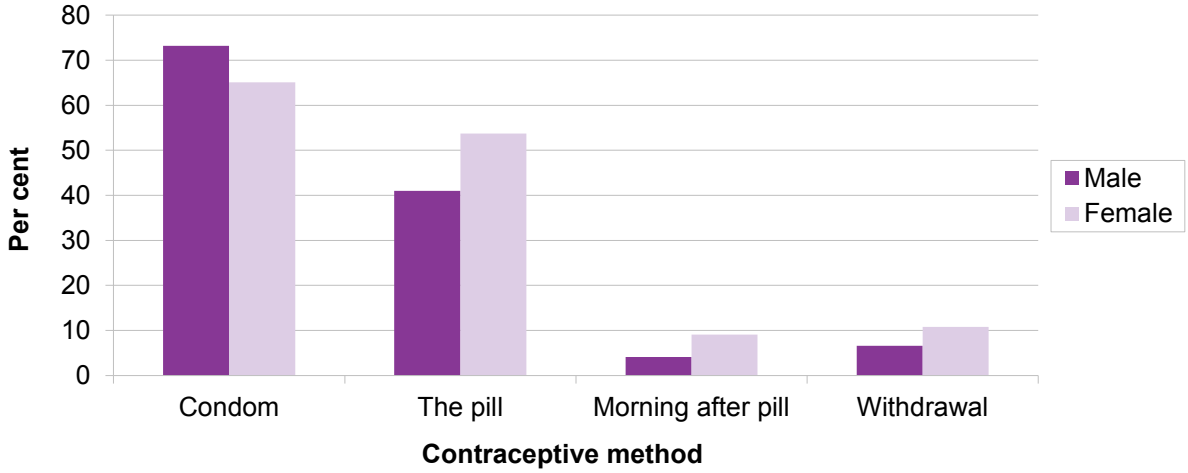


Source: Smith et al., *Secondary Students and Sexual Health 2008*.

With the exception of Year 12 females, the proportions of young people reporting being sexually active were relatively consistent between 2002 and 2008. Across both surveys, younger students were less likely to report being sexually active than older students. In 2002, the proportions reporting being sexually active were comparable for young males and females in both year levels. This remained the case for Year 10 students in 2008 (27.1% of males compared to 27.6% of females); however, a considerable gap was evident amongst Year 12 students (44.4% for males compared to 61.7% for females).

Students who reported being sexually active were asked a number of questions about their most recent sexual encounter including what, if any, contraception they used as a couple. Figure 2.12 shows the proportions of students who reported they had used selected contraceptive methods in their most recent sexual encounter.

Figure 2.12 Selected contraceptive methods used by young people at last sexual encounter by gender, Australia, 2008



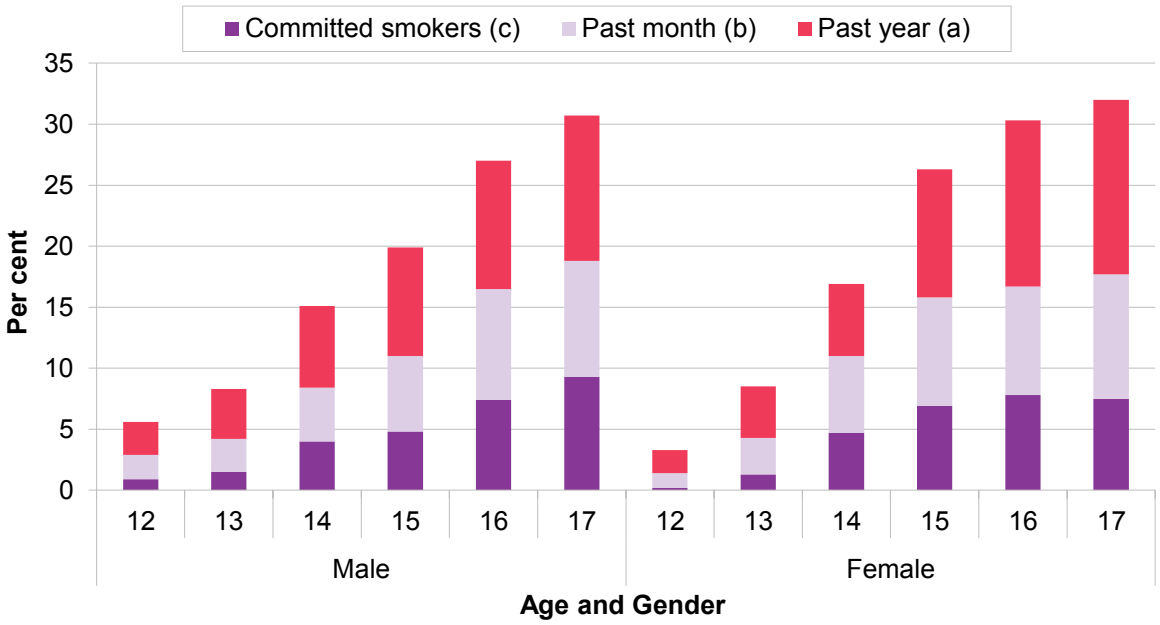
Source: Smith et al., *Secondary Students and Sexual Health 2008*.

Condom and/or the pill were the most frequently reported contraception methods with 73.2% of males and 65.1% of females reporting using condoms and 41.0% of males and 53.7% of females reporting using the pill. Small numbers of respondents reported using IUDs (1.4%), diaphragms (0.2%), rhythm method (0.5%) and other methods (3.1%). Of some concern, 10.8% of females and 6.6% of males reported using withdrawal, although this was slightly less than the proportion reporting doing so in 2002 (13.8% of females and 9.3% of males). In 2008, 0.2% of males and 0.2% of females reported using no contraception at their most recent encounter, which was considerably better than the 8.8% of males and 9.9% of females who reported using no contraception in 2002.

Tobacco use

Cigarette smoking is addictive and causes long-term health conditions. Smoking remains the primary cause of preventable death and ill health in Australia (White and Hayman, 2006). In 2003, tobacco was responsible for about 8% of the burden of disease and around 15,500 deaths in Australia. Most of these deaths were the result of lung cancer or chronic obstructive pulmonary disease (Australian Institute of Health and Welfare, 2007). Figure 2.13 shows the proportions of young people reporting having smoked at different points in time in a preceding 12 month period.

Figure 2.13 Young people who smoked in the previous 12 months by recency of smoking experience, age and gender, Australia, 2008



a. Most recent smoking experience more than 1 month but less than 12 months ago
b. Most recent smoking experience less than one month ago but smoked on less than three of the last seven days
c. Smoked on at least three of the last seven days
Source: White and Smith, *Australian secondary school students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2008*

Overall, 17.6% of young people aged 12–17 years had smoked in the past year. Rates among older respondents were considerably higher than this, with 30.7% of 17 year old males and 32.0% of 17 year old females smoking in the past 12 months. However, proportions of young people who were classified as committed smokers (those who smoked on at least three of the previous seven days) were much lower. For females, rates peaked amongst 16 year olds at 7.8%, while for males rates were highest amongst 17 year olds (9.3%).

Alcohol use

Young people who drink alcohol are at increased risk of injuries, self-harm, violence, risky behaviours (such as riding in cars with intoxicated drivers and using illicit drugs), risky sexual behaviour, and even death (National Health and Medical Research Council, 2009).

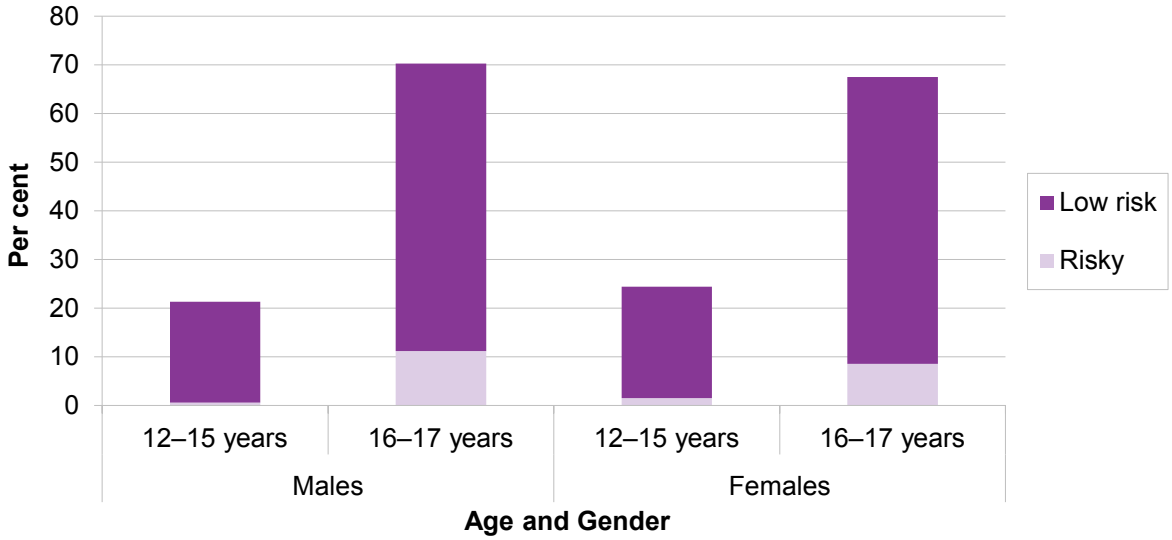
Alcohol consumption is related to significant changes in brain structure in young people, as well as cognitive impairment (including diminished attention and memory retrieval). Among young people, drinking excessively can have detrimental effects on school and work commitments, as well as contributing to longer-term medical and psychological problems (Bonomo, 2005). Rapid consumption of excessive amounts of alcohol can lead to serious short-term harm (such as reckless behaviours, coma or death) and long-term harm (such as impaired organ functioning, stroke or high blood pressure) (National Health and Medical Research Council, 2009).

In March 2009, the National Health and Medical Research Council (NHMRC) released a revised edition of evidence-based Australian Guidelines to Reduce Health Risks from Drinking Alcohol (National Health and Medical Research Council, 2009) which recommends for children and young people under 18 years of age, not drinking alcohol is the safest option and to prolong the initiation of drinking for as long as possible.

The *2010 National Drug Strategy Household Survey* asked 26,648 respondents aged 12 years and over about their alcohol consumption in the previous 12 months. Respondents who reported consuming alcohol were divided into categories according to their long term health risk as defined by the NHMRC's 2009 guidelines for adults. Low risk was defined as an average of no more than two standard drinks per day. Anything in excess of this was defined as risky.

Figure 2.14 shows the proportions of young people consuming alcohol at levels identified as low risk or risky.

Figure 2.14 Young people consuming alcohol by gender, age and lifetime risk level, Australia, 2010



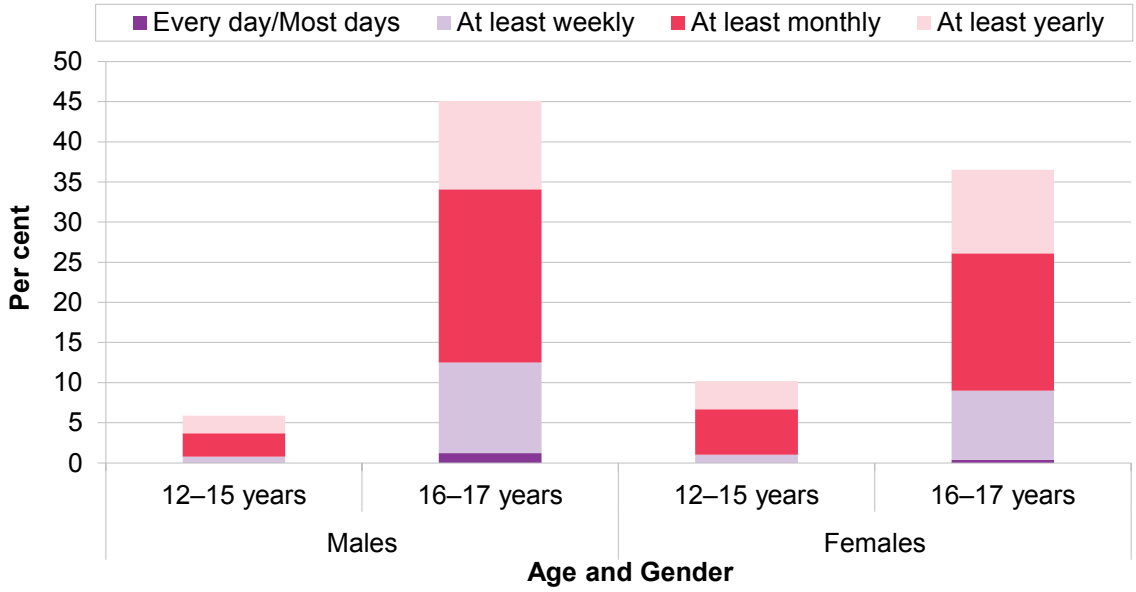
Source: Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*

Around one quarter of young people aged 12–15 years old had consumed alcohol in the previous 12 months. Rates were slightly higher for females (24.4%) compared to males (21.3%). In the older age category, this slight gender imbalance was reversed with a higher proportion of males consuming alcohol (70.3%) compared to females (67.5%).

The vast majority of young people who consumed alcohol in the previous 12 months were categorised as low risk drinkers according to guidelines designed for adults, although a considerable minority were classified as risky. Overall, 11.2% of 16–17 year old males who participated in the survey were classified as risky drinkers. Proportions of females in the same age category were slightly lower with 8.6% considered risky drinkers.

The *2010 National Drug Strategy Household Survey* also categorised respondents by how often their drinking placed them at risk of short-term harm (Figure 2.15). Risk of short-term harm was defined according to the NHMRC's 2009 guidelines as consuming more than four standard drinks on a single occasion.

Figure 2.15 Young people at risk of alcohol related harm on a single occasion by age, gender and frequency of risk, Australia, 2010



Source: Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*

Overall, 5.9% of males aged 12–15 years were at risk of short-term harm at least once in the previous year. Females in the same age group were more likely to drink at risky levels, with 10.2% at risk at least once in the previous year. Small but significant numbers of young people aged 12–15 years were at risk of short-term harm at least monthly (3.7% for males and 6.7% for females), including 0.8% of males and 1% of females who were at risk at least weekly.

Rates in the older 16–17 years age category were significantly higher for both males and females. Of great concern, 0.4% of females and 1.2% of males in this age group were at risk of short-term harm on most days. An additional 11.3% of males and 8.6% of females were at risk at least weekly and a further 21.6% of males and 17.1% of females aged 16–17 years were at risk at least monthly. An additional 11.0% of males and 10.4% of females were at risk less often than monthly but at least yearly. In total, 45.1% of males aged 16 to 17 and 36.5% of females aged 16–17 years were placed at risk of harm at least once per year as a result of their alcohol consumption.

Drug use

Illicit drug use can include use of illegal drugs (such as marijuana/cannabis, heroin, cocaine, ecstasy and amphetamines), but also inappropriate use of other substances (such as prescription drugs, naturally occurring hallucinogens and inhalants).

A range of harms are associated with illicit drug use, for adults and children and young people. Illicit drug users are at increased risk of experiencing physical harm (e.g. cardiovascular disease and strokes), psychiatric disorders (e.g. psychosis, depression and anxiety), cognitive impairment, poor educational attainment, social disengagement and delinquency and crime (National Drug and Alcohol Research Centre, 2007).

The *2010 National Drug Strategy Household Survey* asked 26,648 respondents aged 12 and over about a wide variety of topics related to their drug use. Results from the 2010 survey are compared to the previous five surveys carried out since 1995 in Figure 2.16 below. While 12 and 13 year olds were included in 2010, previous surveys only included young people aged 14 and over. As such, figures below refer to young people aged 14–17 years.

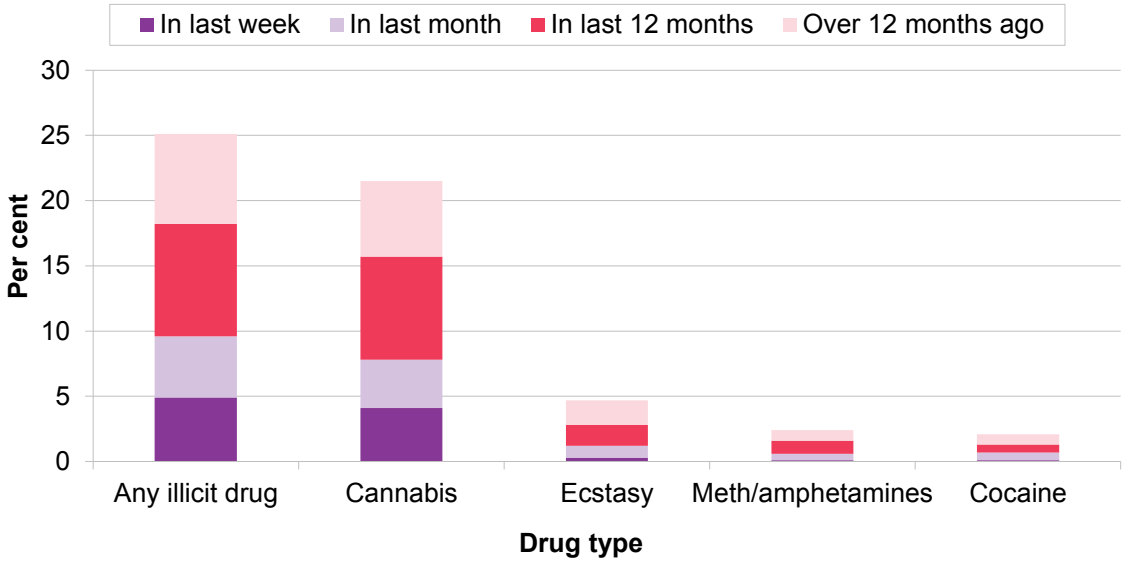
Figure 2.16 Use of any illicit drug in previous 12 months by young people aged 14–17 years by gender, Australia, 1995 to 2010

Source: Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*

Since 1998 when rates of young people aged 14–17 years using drugs in the previous 12 months peaked at 34.5% for males and 33.1% for females, drug usage in this age group has generally declined, although there was a slight increase from 2007 to 2010. At 2010, 13.3% of 14–17 year old males reported using any illicit drug in the previous 12 months as did 15.7% of females.

The 2010 National Drug Strategy Household Survey also asks respondents about their lifetime and recent usage of specific illicit substances (Figure 2.17).

Figure 2.17 Use of illicit drugs by young people aged 14–19 years by drug type and most recent usage, Australia, 2010



Source: Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*

Just over one quarter (25.1%) of 14–19 year olds had used some form of illicit drug in their lifetime, while 18.2% had used an illicit drug in the previous year. Around one in ten (9.6%) of 14–19 year olds had used an illicit drug in the previous month and 4.9% who had used an illicit drug in the previous week.

By far the most common drug used was cannabis with more than one in five (21.5%) 14–19 year olds having used the substance in their lifetime and 4.1% having used cannabis in the previous week. Usage of other drugs were far less common with fewer than 1 in 20 having ever used ecstasy (4.7%), methamphetamines or amphetamines (2.4%) or cocaine (2.1%).

Selected health conditions

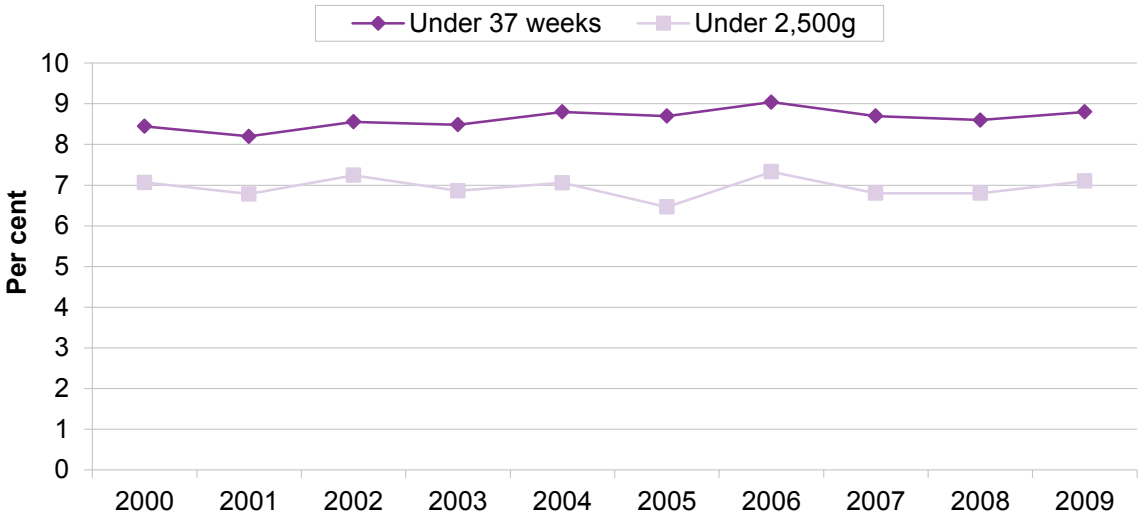
There are a variety of conditions that impact on the overall experience of health and wellbeing of children and young people in Queensland. It is important to monitor the prevalence of these conditions in the population not only to understand the need for and effectiveness of preventative health policies, but also to understand what needs to be done to assist children and young people to manage their conditions. Statistics in relation to a number of health conditions of particular relevance to children and young people are presented below.

Premature birth and low birthweight

Birthweight is key indicator of infant health and a principal determinant of a baby's chance of survival and good health. Babies with low birthweight or shorter gestation have a significantly increased risk of short- and long-term health problems (Al-Yaman, Bryant et al. 2002). Factors contributing to low birthweight or shorter gestation include multiple births, the mother's age (older or younger), cigarette smoking during pregnancy, alcohol consumption and inadequate nutrition.

In Queensland in 2009, 7.1% of babies had a low birthweight (under 2,500g) and 8.8% were born before 37 weeks gestation (Queensland Health – Health Information Centre, 2011). There was very little change in these proportions from previous years (Figure 2.18).

Figure 2.18 Births by birthweight and gestation, Queensland, 2000 to 2009



Source: Queensland Health – Health Information Centre, *Perinatal Statistics, Queensland, 2009*

Babies born to Indigenous mothers were more likely to have a low birthweight and shorter gestation period with 10.2% of babies born to Indigenous mothers recording a birthweight under 2,500g compared to 7.1% of babies overall, and 10.9% born at less than 37 weeks gestation compared to 8.8% overall.

Foetal alcohol syndrome

Foetal alcohol syndrome (FAS) is a developmental condition involving a range of disabilities or abnormalities caused by alcohol consumption by women during pregnancy. Although a variety of physical and developmental symptoms may be present, the key features of FAS are permanent damage to the central nervous system (especially to the brain), prenatal and/or postnatal growth deficiencies and cranio-facial abnormalities.

FAS and Foetal Alcohol Spectrum Disorder (FASD), are associated with a range of preventable secondary disabilities including disrupted school experiences, mental health problems, inappropriate sexual behaviours, alcohol and drug abuse and involvement in the youth justice system (Benz, Rasmussen et al. 2009).

There is limited data on the prevalence of FAS in Queensland, though some recent studies interstate have estimated the prevalence at between 0.01 and 0.2 per 1,000 live births (Allen, Riley et al. 2007). The prevalence rate of children with a diagnosis of FAS in a national prospective study was 0.06 per 1,000 live births, whereas in the same study the prevalence of Indigenous live births was 0.8 per 1,000 live births. Two-thirds (65.2%) of children with FAS were Aboriginal or Torres Strait Islander (Elliott, Payne et al. 2008).

FAS is believed to be poorly recognised and strongly under-diagnosed in Australia. Challenges in diagnosis include obtaining accurate and reliable history of maternal alcohol use and changes in

diagnostic features due to normal child growth and environmental factors (Benz, Rasmussen et al. 2009). Few health professionals correctly identify the essential features of FAS, and there is an underlying reluctance to stigmatise a family by confirming a diagnosis (Elgen, Bruaroy et al. 2007). There is currently no distinct diagnostic test to help practitioners determine FAS in a newborn baby or child.

The NHMRC's Australian Guidelines to Reduce Health Risks from Drinking Alcohol recommends that for women who are pregnant or planning a pregnancy, not drinking is the safest option to prevent harm in the developing foetus (National Health and Medical Research Council, 2009). While heavy drinking poses the greatest risk, there are no established standards which indicate a safe level of consumption.

In 2008, the Commission made a submission to Food Standards Australia New Zealand (FSANZ) that strongly supported the mandatory labelling of alcoholic beverages to warn women of the risks to their developing children of consuming alcohol when planning to become pregnant, during pregnancy or when breastfeeding (Commission for Children and Young People and Child Guardian, 2008). FSANZ is conducting further investigations that could see labelling of alcoholic beverages become mandatory.

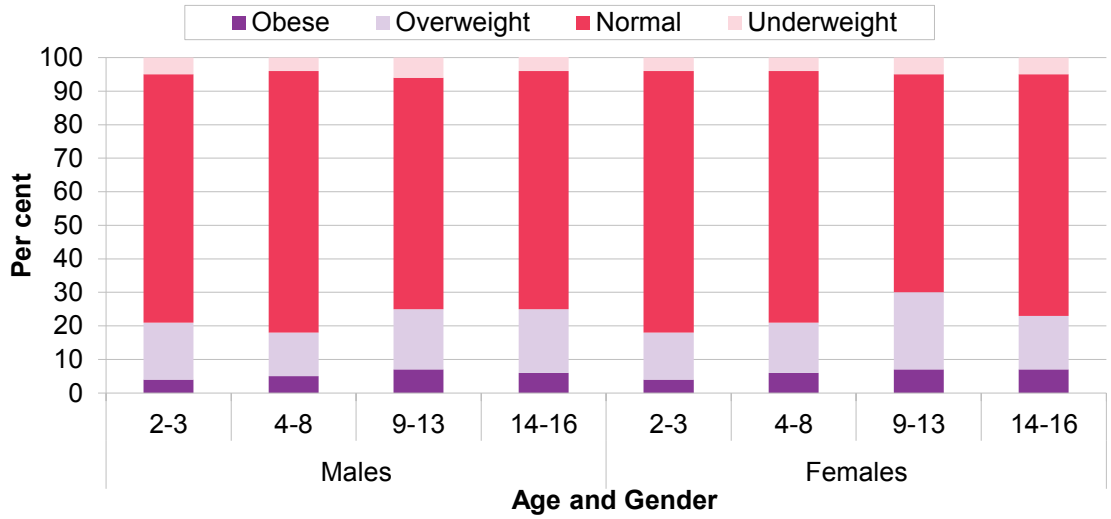
Queensland has implemented a system of universal antenatal screening and referral for mothers who consume alcohol and other drugs.

Overweight/obesity

Physical activity, a healthy diet and maintaining a healthy weight is important for overall health and fitness. A healthy weight range can help reduce the risk of developing conditions including high blood pressure, diabetes type 2, heart disease and certain cancers.

The *2007 National Children's Nutrition and Physical Activity Survey* classified children and young people as underweight, normal, overweight or obese based on their body mass index (BMI) using internationally recognised cut-offs (Figure 2.19).

Figure 2.19 Weight classification of children by gender and age, Australia, 2007



Source: Commonwealth of Australia, *2007 Australian National Children's Nutrition and Physical Activity Survey*

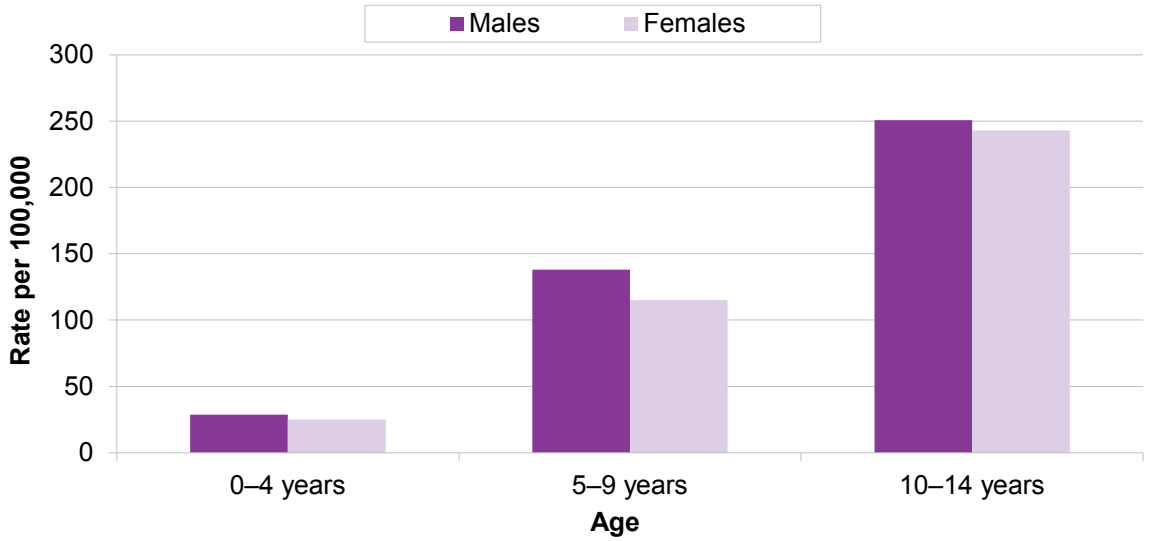
Across all ages and both genders, 17% were classified as overweight and a further 6% were classified as obese. Around three quarters of children and young people (72%) had a normal BMI, while 5% had a BMI that placed them in the underweight category. For both males and females, rates of overweight and obesity were higher in older respondents, with 25% of males aged 9–13 years and 14–16 years overweight or obese compared to 21% of 2–3 year olds and 18% of 4–8 year olds. For females, 18% of those aged 2–3 years were overweight or obese as were 21% aged 4–8 years compared to 30% of females aged 9–13 years and 23% aged 14–16 years.

Type 1 diabetes

Type 1 diabetes is typically diagnosed during childhood. The condition is recognised through a severe insulin deficiency. People with Type 1 diabetes need to administer insulin, normally through injections (or an insulin pump), for survival. Destruction of the insulin producing cells within the pancreas by the body's own immune system is the main cause of Type 1 diabetes (Australian Institute of Health and Welfare, 2010).

The incidence of Type 1 diabetes in Australian children increased significantly over the first part of the decade (2000–2004), but since 2005 there has been little change in the rate of new cases (Australian Institute of Health and Welfare, 2010). In December 2008, the estimated prevalence of Type 1 diabetes was slightly higher for males than for females across all age groups (Figure 2.20). Prevalence increased with age with 251 per 100,000 males and 248 per 100,000 females aged 10–14 years estimated to be living with Type 1 diabetes.

Figure 2.20 Estimated prevalence of Type 1 diabetes in children aged 0–14 years (per 100,000 children), by age and gender, Australia, December 2008



Source: Australian Institute of Health and Welfare, *Incidence of Type 1 diabetes in Australian children 2000-2008*

During 2008, 980 new cases of diabetes were reported to the National Diabetes Register. This was equivalent to the 987 reported for the 2007 period. These new cases represented a rate of 23.2 children per 100,000 population within Queensland and 22.8 per 100,000 within Australia.

The incidence of new cases of Type 1 diabetes increased with age. During the period 2000-2008 (Australian Institute of Health and Welfare, 2010), the average annual rates of new cases for Australian children were:

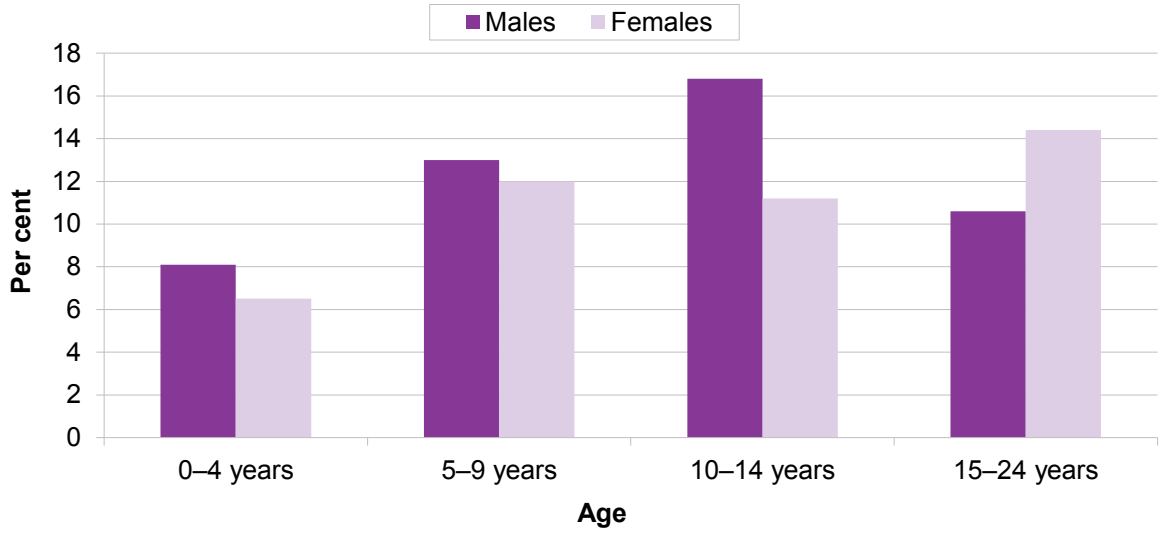
- 14.6 for children aged 0–4 years per 100,000 population
- 24.1 for children aged 5–9 years per 100,000 population, and
- 29.3 for children aged 10–14 years per 100,000 population.

Asthma

Asthma is a common chronic inflammatory condition of the airways which presents as episodes of wheezing, breathlessness and chest tightness due to widespread narrowing of the airways. Among those with the condition, airway narrowing and symptoms can be triggered by viral infections, exercise, air pollutants, tobacco smoke or specific allergens such as house dust mites, pollens and animal danders. The symptoms of asthma are usually reversible, either spontaneously or with treatment (Australian Centre for Asthma Monitoring, Woolcock Institute of Medical Research, 2008)

The *2004-05 National Health Survey* provides the most recent data on the prevalence of asthma in Australia (Figure 2.21).

Figure 2.21 Prevalence of probable asthma, by age and gender, Australia, 2004-05



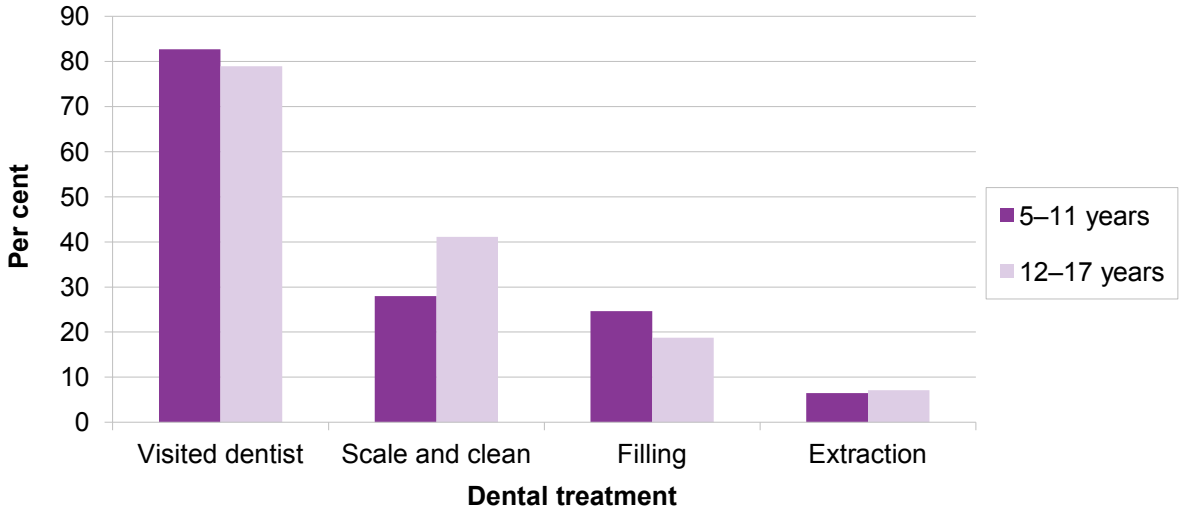
Source: Australian Bureau of Statistics, *2004-05 National Health Survey*

The *National Health Survey* found asthma to be the most common long-term medical condition in children (Australian Bureau of Statistics, 2006). In 2004-05, prevalence among males aged 14 and under was higher than for females (8.1% compared to 6.5% among 0–4 year olds, 13.0% compared to 12.0% among 5–9 year olds and 16.8% compared to 11.2% among 10–14 year olds). Among young people and adults aged 15–24 years, asthma was more common among females (14.4% for females compared to 10.6% for males).

Oral health

The *National Dental Telephone Interview Survey* investigates trends in access to dental care among young Australians. The most recent survey, the fifth since 1994, was carried out in 2005 and included 1,760 children and young people aged 5–17 years from across Australia (Ellershaw & Spencer, 2009). Results from this survey are presented in Figure 2.22.

Figure 2.22 Children and young people receiving selected dental treatment by age, Australia, 2005



Source: Ellershaw & Spencer, *Trends in Access to Dental Care Among Australian Children*

In 2005, 82.7% of 5–11 year olds visited the dentist in the previous year as did 78.9% of 12–17 year olds. A similar proportion of children and young people in each age group had an extraction in the previous 12 months (6.5% of 5–11 year olds and 7.1% of 12–17 year olds). Fillings were more common in younger children (24.6% of 5–11 year olds compared to 18.8% of 12–17 year olds), while older young people were more likely to receive a scale and clean (41.1% of 5–11 year olds compared to 28.0% of 12–17 year olds).

The survey also found that the cost of dental treatment was a barrier for small but significant proportions of children in 2005. One in fourteen (7.1%) 5–11 year olds and one in ten (10.2%) 12–17 year olds avoided or delayed dental treatment because of the cost; however, these proportions have declined from 1994 (12.6% and 16.3% respectively).

Mental health conditions

The complex nature of mental health contributes to the difficulties in adequately defining and determining the scope of the problems, particularly in relation to children and young people. Accordingly, there is very limited information available that comprehensively describes the extent of mental health problems in young people. There is a spectrum of mental difficulties that ranges from mild distress through to clinically diagnosed mental disorders. Mental problems can sit anywhere along that continuum, so it is important to understand that, even if a child or young person has not been clinically diagnosed, they can still experience distress and dysfunction which require attention.

According to the Department of Health and Aged Care (Raphael, 2000), factors that influence the mental health of children and young people include:

- physical health and development
- social and psychological development
- the family and the quality and consistency of nurture and the child's relationship with parents or other adults
- environmental factors, both social and physical
- genetic factors

- social norms and expectations that influence child rearing
- cultural influences on children, young people and families, and
- social advantage or disadvantage, including access to basic resources.

In 2007–08, 14.4% of Australians aged under 15 years were estimated to suffer a diagnosed mental or behavioural problem (Australian Bureau of Statistics, 2009). The most common reported problems were behavioural and emotional problems with usual onset in childhood/adolescence (5.9%), anxiety related problems (5.0%) and problems of psychological development (4.7%). Also, almost one in forty (2.4%) Australians aged 0–14 years experienced mood or affective disorders such as depression.

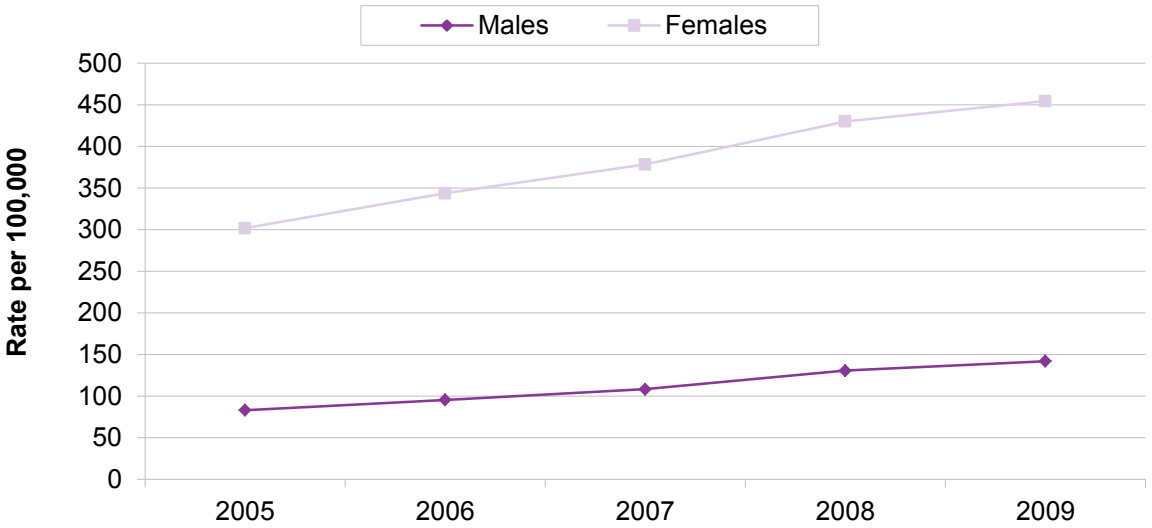
Sexually transmissible infections (STIs)

Data on a variety of sexually transmissible infections (STIs) are collected at a national level, including:

- Chlamydia, a curable bacterial infection that is often asymptomatic but can result in sterility in both men and women, as well as pelvic inflammatory disease and ectopic pregnancy in women (Queensland Health, 2011).
- Gonorrhoea, a curable bacterial infection that can affect the genital area, anus or throat. Symptoms in females can include abdominal cramping, change in vaginal secretions and pain when passing urine and after sex. In males, symptoms can include painful urination and a discharge from the penis. Infection of the throat can be asymptomatic. If left untreated, gonorrhoea can lead to infertility in both men and women, as well as pelvic inflammatory disease and ectopic pregnancy in women (Queensland Health, 2011).
- Human Immunodeficiency Virus (HIV), an incurable blood borne virus that leads, usually after a number of years, to Acquired Immune Deficiency Syndrome (AIDS) (Queensland Health, 2011).
- Syphilis, a curable bacterial infection with initial symptoms of ulcers and rashes on various parts of the body. If left untreated, syphilis can lead to problems with nerves, the brain and large blood vessels near the heart (Queensland Health, 2011).
- Hepatitis B, a viral infection that affects the liver and can lead to cirrhosis, and hepatocellular carcinoma. While hepatitis B is incurable, a vaccine is available (Queensland Health, 2011).

In recent years, there have been a number of improvements in both testing technologies and treatment for STIs (Queensland Health, 2005). Increased testing, increased availability of polymerase chain reaction (PCR) testing technology, non-invasive testing, and targeted screening programs in young people and in Indigenous people in north Queensland, have contributed to increasing chlamydia notification trends. Trends in the rates of diagnoses of Chlamydia, gonorrhoea and hepatitis B in young people are presented in the figures below.

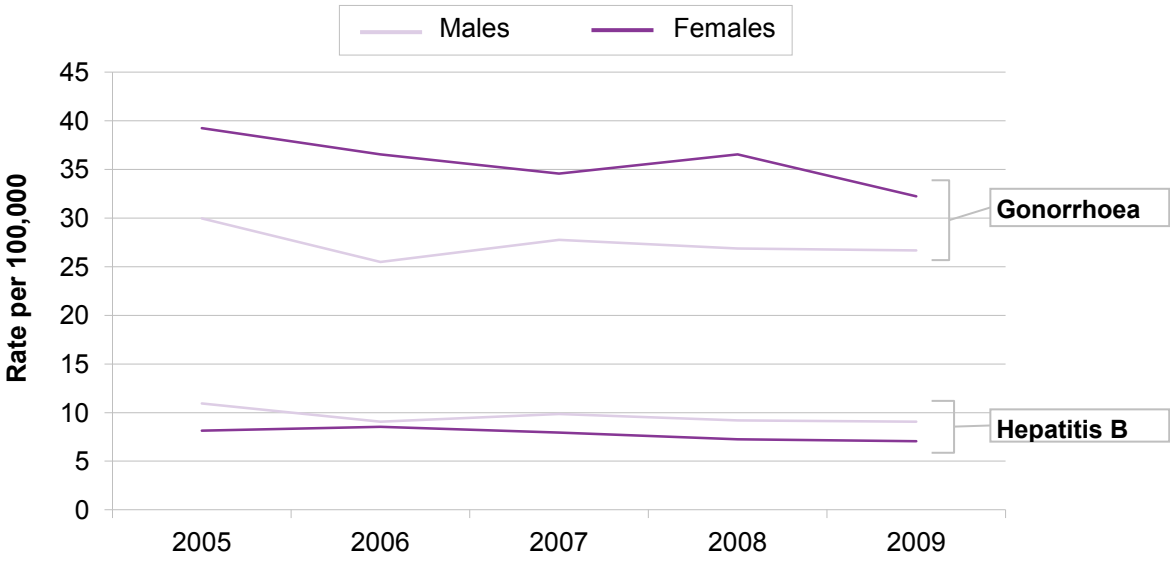
Figure 2.23 Rate of diagnoses of Chlamydia in young people aged 19 and under (per 100,000 young people) by gender, Australia, 2005 to 2009



Source: National Centre in HIV Epidemiology and Clinical Research, *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*

Chlamydia is the most frequently diagnosed notifiable STI in young people. In 2009, 294 diagnoses per 100,000 young people aged under 19 were recorded. Females were considerably more likely to be diagnosed than males (455 per 100,000 young females compared to 142 per 100,000 young males). Rates of diagnosis have steadily climbed over the last five years with diagnoses in young males up by 71.0% (142 per 100,000 in 2005 compared to 83 per 100,000 in 2009) and rates growing by 50.6% for young females (455 per 100,000 in 2005 compared to 302 per 100,000 in 2009).

Figure 2.24 Rates of diagnoses of gonorrhoea and hepatitis B in young people aged 19 and under (per 100,000 young people) by gender, Australia, 2005 to 2009



Source: National Centre in HIV Epidemiology and Clinical Research, *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2010*

The second most frequently diagnosed reportable STI over the last five years was gonorrhoea at 29 diagnoses per 100,000 young people aged 19 and under. Like Chlamydia, females were more likely to be diagnosed than males, although the disparity is less pronounced with young males aged 19 and under diagnosed at a rate of 27 per 100,000 young people compared to 32 per 100,000 for females. There have been small declines in diagnosis of gonorrhoea since 2005 with diagnosis in males down from 30 per 100,000 and diagnosis in females down from 39 per 100,000.

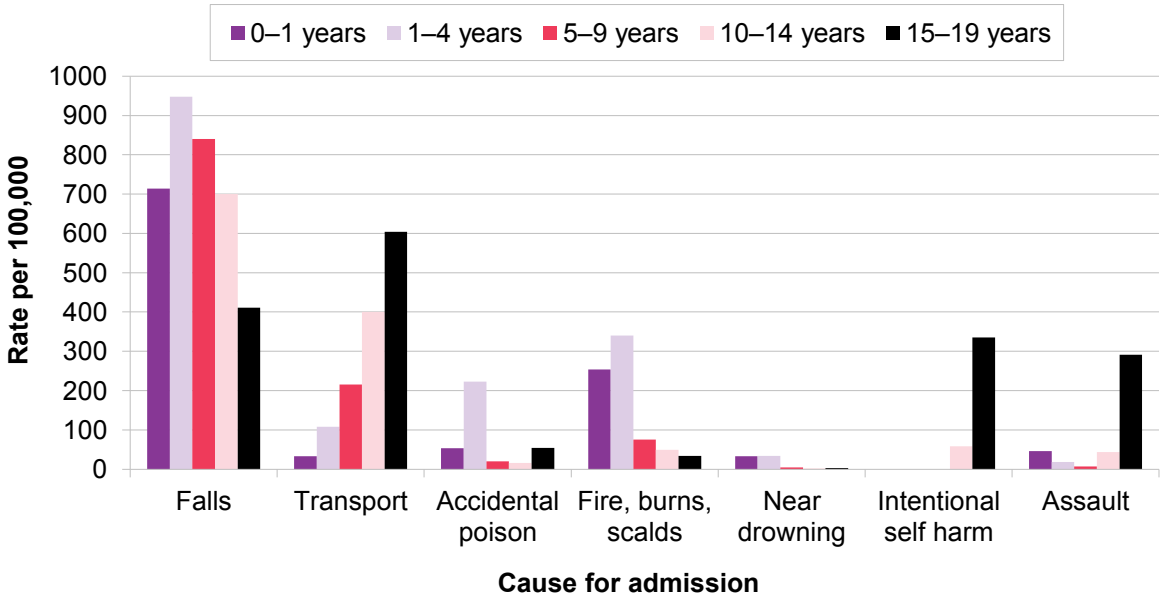
Rates of diagnosis of hepatitis B amongst young people aged 19 and under have also declined from 11 per 100,000 males and 8 per 100,000 females in 2005 to 9 per 100,000 males and 7 per 100,000 females in 2009. Unlike Chlamydia and gonorrhoea, diagnosis of hepatitis B has been consistently more common in males than females.

Each year, small numbers of young people aged 19 and under are diagnosed with HIV. Over the last five years of available data (2005 to 2009) between 17 and 22 young people were diagnosed with HIV each year. Consistent with previous years, 22 HIV diagnoses relating to young people aged 19 or under were reported in 2009. In addition, there were 41 diagnosed cases of syphilis among young people aged 19 and under in 2009, which was considerably lower than the 84 cases reported in 2008 and the 91 cases reported in 2007.

Injuries

Children and young people of all ages experience a variety of injuries ranging in severity. While reliable data are not available to track the breadth of children's and young people's experiences of injury, hospital admission data provide a good measure of more serious injury (Figure 2.25).

Figure 2.25 Injury-related causes of admission to hospitals (rate per 100,000) by cause of admission and age, Queensland, 2009–10



Source: Queensland Health – Health Information Centre

With the exception of the 15–19 year age group, falls were the most common injury-related causes of admission. In the oldest age group, transport incidents took over as the leading causes (604 per 100,000 young people) followed by falls (411 per 100,000).

Accidental poisonings, fires burns and scalds, and near drownings were most prevalent amongst younger children, particularly in the 1–4 year age range. Admissions related to transport accidents, intentional self harm and assault were far more common in older age groups, particularly young people aged 15–19 years.

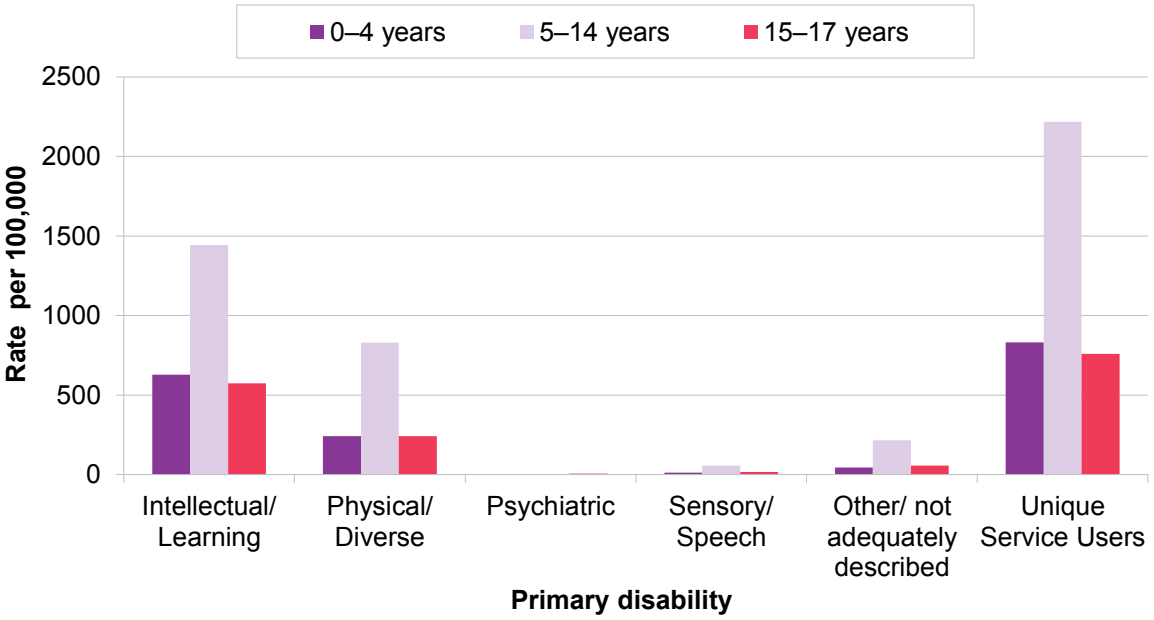
Clear gender patterns are also evident in the data. Males are far more likely to be admitted to hospital for injuries caused by falls (865 admissions per 100,000 young males compared to 544 per 100,000 young females), transport incidents (454 per 100,000 compared to 200 per 100,000) and assaults (138 per 100,000 compared to 48 per 100,000). Females aged 19 years or under were considerably more likely to be hospitalised for intentional self-harm (156 admissions per 100,000 young females compared to 49 per 100,000 young males).

Disability

The Department of Communities (Disability Services and Community Care Services) is responsible for funding and providing specialist disability services to children and young people who have a disability as defined under the *Disability Services Act 2006*. While definitions of disability vary, under this legislation disability is defined as a condition attributable to one or more of the following disabilities: intellectual, physical, neurological, sensory and speech (deaf blind, vision, hearing), psychiatric, developmental delay (0–5 year olds only), autism and acquired brain injury; and results in a substantial reduction of the person's capacity for communication, social interaction, learning, mobility or self care management such that the person requires support. The condition must be permanent or likely to be permanent and may be, but need not be, of a chronic episodic nature.

Figure 2.26 shows the numbers of children and young people receiving support funded and provided directly by the Department of Communities (Disability Services and Community Care Services) for disabilities as defined under the legislation.

Figure 2.26 Users of departmentally funded disability services aged 17 years and under (rate per 100,000 children) by disability group and age, Queensland, 2009-10



Note: Service user data are estimates after use of a statistical linkage key to account for individuals who received more than one service during the collection period. Totals may not be the sum of the components since individuals may have accessed multiple service types and service providers during the collection period.
Disability groups were based on the AIHW's METeOR classification groups. Intellectual/Learning: Intellectual, Specific learning - ADD, Autism and Developmental Delay; Psychiatric: Psychiatric; Sensory/Speech: Deafblind, Vision, Hearing, Speech; Physical/Diverse: Physical, Acquired Brain Injury and Neurological.

Source: Department of Communities (Disability Services)

In 2009-10, there were 7,068 unique users of disability services provided and funded by the Department of Communities (Disability Services and Community Care Services) aged 17 and under. This translates to a rate of 1,269 per 100,000. With the exception of psychiatric conditions, rates of disability were highest amongst children aged 5–14 years across all disability types. The most common forms of disability for all age groups were intellectual or learning disabilities (629 per 100,000 children aged 0–4 years,1,444 per 100,000 children aged 5–14 years and 575 per 100,000 aged 15–17 years). Psychiatric conditions were the least common disability category with just 20 children aged 17 or under in this category in 2009-10 (4 per 100,000 children).

Hospital waiting lists

Throughout Queensland, there are 33 reporting hospitals about which Queensland Health report a variety of performance indicators. In addition, there are a number of smaller hospitals for which data are included in the statewide figures but are not reported on separately, and a number of private hospitals. While most hospitals treat a mix of adults and children, among the 33 reporting hospitals, two treat children exclusively: the Mater Children's Hospital and the Royal Children's Hospital. These hospitals are both located in Brisbane and have 156 beds and 199 beds respectively.

One key performance indicator relates to waiting lists for elective surgery. Elective surgery is surgery that is necessary but can be delayed for at least 24 hours. Patients are placed into one of three categories depending on the urgency of their treatment:

- Category 1 – admission in 30 days is desirable where a condition has potential to deteriorate quickly to the point that it may become and emergency.
- Category 2 – admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, which is unlikely to deteriorate quickly or become an emergency
- Category 3 – admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Table 2.2 shows waiting times for patients requiring elective surgery in Queensland's two children's hospitals.

Table 2.2 Elective surgery waiting lists, Mater Children's Hospital and Royal Children's Hospital, 1 September to 31 December 2010

	Mater Children's Hospital	Royal Children's Hospital
Category 1[a]		
Number treated	141	318
Median waiting time[d]	9 days	7 days
90th percentile waiting time[e]	28 days	28 days
Number "long wait"[f]	0	0
Category 2[b]		
Number treated	341	698
Median waiting time[d]	67 days	36 days
90th percentile waiting time[e]	95 days	104 days
Number "long wait"[f]	13	44
Category 3[c]		
Number treated	370	126
Median waiting time[d]	28 days	126 days
90th percentile waiting time[e]	185 days	351 days
Number "long wait"[f]	0	0
Combined		
Number waiting at 1 January 2011	900	988
Number "long wait"[f]	13	44

a. Category 1 – admission within 30 days desirable for a condition that has the potential to deteriorate quickly, to the point that it may become an emergency.
b. Category 2 – admission within 90 days desirable for a condition causing some pain, dysfunction or disability, which is unlikely to deteriorate quickly or become an emergency.
c. Category 3 – admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.
d. Median waiting time represents the number of days within which half of the patients treated received their surgery.
e. 90th percentile wait shows that 90% of the patients treated received their surgery within the specified number of days.
f. "Long wait" is the number of patients who were waiting longer than clinically recommended at 1 January 2011.
Source: Queensland Health, *Quarterly Public Hospitals Performance Report*

In the December quarter of 2010, all category 1 patients across both children's hospitals were admitted within the clinically recommended time, with at least half being admitted within nine days at the Mater Children's Hospital and half within seven days at the Royal Children's Hospital. While the majority of category 2 patients were admitted within clinically recommended timeframes, a small proportion of patients at each hospital were required to wait longer than clinically recommended (3.8% of category 2 patients at the Mater Children's Hospital and 6.3% of category 2 patients at the Royal Children's Hospital). The majority of category 3 patients at the Mater Children's Hospital were admitted within 28 days compared to 126 days at the Royal Children's Hospital.

Chapter 3:

Early childhood education and care

This chapter describes recent early childhood reforms at the national and Queensland level, including the development of the *National Quality Framework for Early Childhood and Care*. Data from the Australian Bureau of Statistics' Childhood Education and Care Survey are included and cover topics such as parental involvement in informal learning and formal child care arrangements. The Productivity Commission's *Report on Government Services* provides information relating to the extent of use of government approved child care services. The results of the *Australian Early Development Index* are also included in this chapter.

Research and the importance of the early years

Early childhood is a time of critical importance in a child's development. Research has shown that early relationships and experiences influence brain development in ways that have a profound effect on a child's future health, wellbeing and competence (Keating and Hertzman, 1999; Hertzman and Power, 2003; Richardson and Prior, 2005).

Major changes in family structure, support networks and work patterns are also creating significant challenges for families as they negotiate work commitments, caring for young children and family quality of life.

A case exists for strong investment in the quality and availability of early childhood education and care programs, both as an effective approach to supporting vulnerable children and families, and as a way to equip children with the skills they will need for life, for learning and to realise their potential as contributing adults. Research suggests that an investment of this kind generates measurable economic and social benefits for children, their families and the wider community (Heckman, 2000; Isaacs, 2007).

Parental involvement in informal learning

Parents and carers play a vital role in their children's development through active participation in informal learning activities such as talking, playing games and reading. This is important for children of all ages, from before they enter child care or preschool, continuing throughout their formal schooling.

The 2008 Childhood Education and Care Survey reported parental involvement in learning activities in the last week (Australian Bureau of Statistics, 2009). For children aged 0–2 years, parent's self-reported involvement in learning included:

- reading from a book or telling a story (79.8%)
- playing music, singing songs, dancing or doing other musical activities (79.7%)
- playing a game together indoors or outdoors (71.6%)
- watching TV, videos or DVDs (70.6%)
- assisting with drawing, writing or other creative activities (54.0%), and
- taking part in or attending a playgroup (19.1%).

One in eleven (8.8%) parents reported not being involved in any of these activities in the previous week.

Young children in couple families were more likely to have a parent read them a book or tell them a story every day in comparison with children from single-parent families (50.9% and 36.0% respectively). About one in five children in couple and single-parent families did not have a parent read to them or tell them a story in the week prior to the survey (19.8% and 23.0% respectively).

For children aged 3–8 years, informal learning activities included:

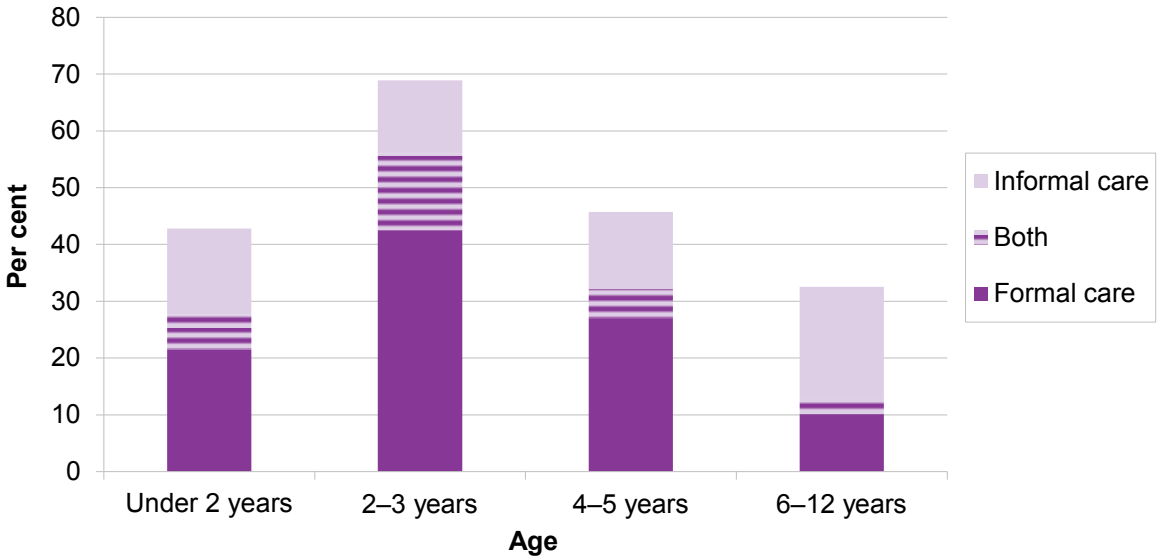
- telling stories, reading or listening to the child read (95.2%)
- watching TV, videos or DVDs (93.4%)
- playing sport, outdoor games or board games (86.5%)
- assisting with homework or other educational activities (77.1%)
- being involved in music, art or other creative activities (75.2%), and
- using computers or the internet (44.3%).

In the week prior to the survey, almost one-half (46.6%) of parents of children aged 3–8 years told stories, read to their child or listened to their child read every day of the week. One in twenty (4.8%) parents did not read or listen to their child at all in the week prior to the survey.

Child care

Formal child care comprises regulated and/or accredited government funded services offered outside the child's home, such as long day-care, family day-care, occasional care and kindergarten. Informal child care is any care that is unregulated – for example from family members, friends, neighbours, paid babysitters and nannies.

Figure 3.1 Children usually accessing child care by type of care and age, Queensland, 2008



Source: Australian Bureau of Statistics, *Childhood Education and Care 2008*, cat. no. 4402.0

The *Childhood Education and Care Survey* conducted by the Australian Bureau of Statistics revealed that an estimated 303,200 children in Queensland aged 0–12 years usually had child care arrangements in 2008 (41.6% of children aged 0–12 years). Parents used child care arrangements for most children aged under 5 years, particularly children in the 2–3 years age bracket. For these children, care arrangements were more likely to be formal than informal. Older children were less likely overall to have child care arrangements but for those that did, they were more likely to be informal arrangements than formal care.

Government approved child care

To be approved by the Australian Government, child care services must meet certain requirements for parents to be eligible for the Child Care Benefit and Child Care Rebate. These include having a license to operate, qualified and trained staff, being open certain hours, and meeting a range of health, safety and other quality standards. The Australian Government approves a variety of service types, including:

- long day-care provided in centres which may also be called occasional care services, child care centres or early learning centres
- family day-care provided in an approved carer's home
- outside school hours care, which is usually provided in schools or community halls to primary school aged children before and after school and on school holidays, and
- occasional care, which is usually provided in small centres on a flexible basis.

The Australian Government also approves in-home care provided by an approved carer in the child's home where no existing services meet the child's needs, for example in remote areas and for children who have an illness or disability not catered for in local services; although, these services are not required to be licensed.

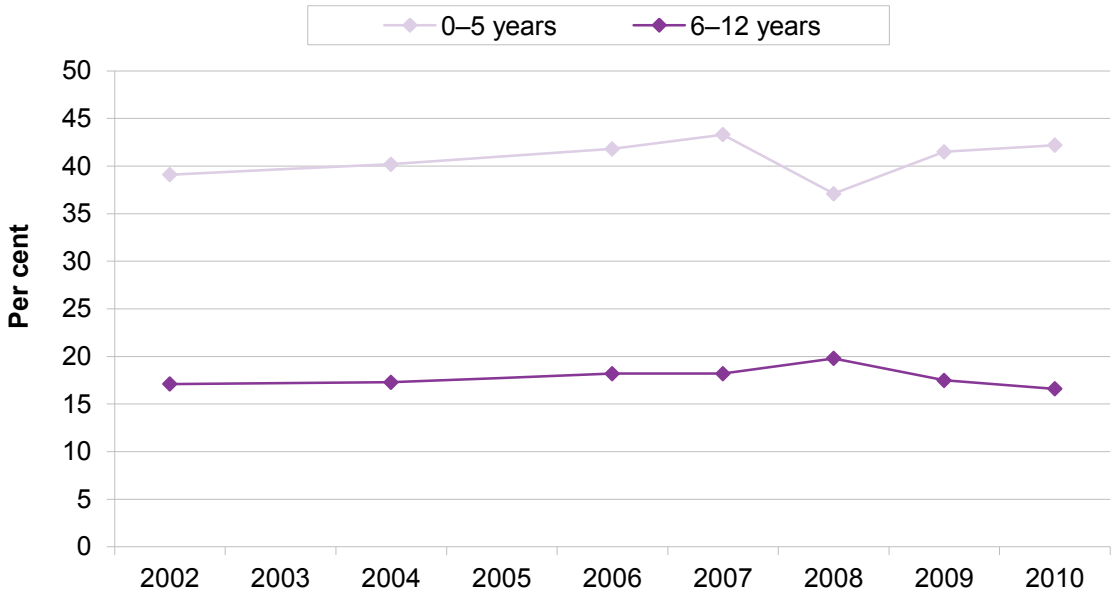
From 2012, the new *National Quality Framework for Early Childhood Education and Care* ('National Quality Framework') will apply to services commonly referred to as long day-care, kindergartens, family day-care and outside school hours care services. The National Quality Framework aims to increase consistency in education and care services and school age care through:

- the Education and Care Services Law and the Education and Care Services National Regulations
- the National Quality Standard for Early Childhood Education and Care and School Age Care consisting of seven Quality Areas
- a national quality rating and assessment process through which services are assessed against the National Quality Standard and provided with a rating from one of the five rating levels
- streamlined regulatory arrangements, and
- a new national body jointly governed by the Australian Government and state and territory governments – the Australian Children's Education and Care Quality Authority – to oversee the system.

All education and care services will need to provide a program that is based on an approved learning framework, which considers the developmental needs, interests and experiences of each child. The approved learning frameworks are:

- Belonging, Being and Becoming: The Early Years Learning Framework for Australia, and
- My Time, Our Place: Framework for School Age Care in Australia.

Figure 3.2 Children accessing government approved child care by age, Queensland, 2002 to 2010



Note: Comparable data for 2003 and 2005 are not available.
Source: Productivity Commission, *Report on Government Services 2011*

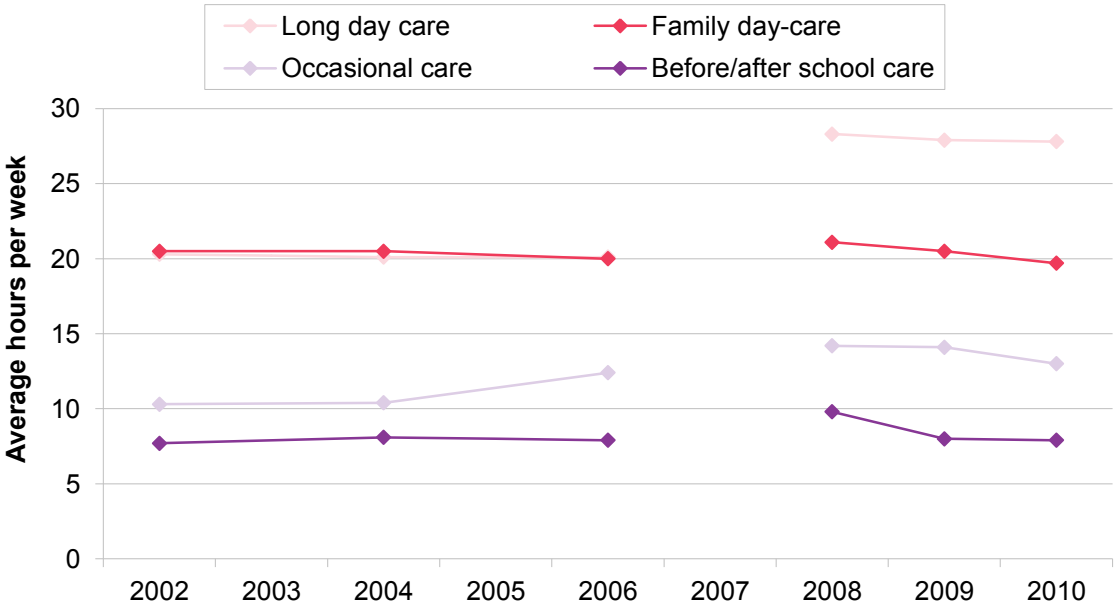
In 2010, there were 223,457 children aged 0–12 years attending Australian Government approved child care services in Queensland (Productivity Commission, 2011). This represented more than one-quarter (28.8%) of 0–12 year old children in the state. The proportion of 0–5 year olds attending government approved child care rose from 41.5% in 2009 to 42.2% in 2010. Conversely, the proportion of older children (6–12 years) utilising government approved child care services dropped slightly from 17.5% in 2009 to 16.6% in 2010.

According to the Productivity Commission (2011), government approved child care was less likely to be accessed by a number of demographic groups including:

- children with a disability (who account for 2.0% of children in child care compared to 7.6% in the population)
- children from non-English speaking backgrounds (6.5% of children in child care compared to 11.9% in the population)
- Indigenous children (2.9% of children in child care compared to 6.2% in the population)
- children from regional areas (32.4% of children in child care compared to 45.6% in the population), and
- children from remote areas (1.2% in child care compared to 4.4% in the population).

Parental employment is also an important factor influencing child care usage with employment being reported in more than two-thirds of cases (69.2%) as the main reason for attending formal child care in Queensland in 2008 (Australian Bureau of Statistics, 2009).

Figure 3.3 Average weekly attendance hours for children 0–12[a] years attending government approved child care services by child care type, Queensland, 2002 to 2010



Note: Comparable data for 2003, 2005 and 2007 are not available.
Data for 2008, 2009 and 2010 are not directly comparable to previous years due to a change in the source for data collection
a: Average attendance hours exclude allowable absences.
Source: Productivity Commission, *Report on Government Services 2011*

Children accessing government approved child care spent, on average, slightly less time per week in those services in 2010, compared to 2008 (the earliest year for which comparable data are available). This decline was most pronounced for before and after school care which declined from 9.8 hours per week in 2008 to 7.9 hours per week in 2010. The smallest change was observed in long day-care (28.3 hours per week in 2008 compared to 27.8 hours per week in 2010). Average hours spent in family day-care and occasional care also saw moderate declines (from 21.1 to 19.7 and 14.2 to 13.0 respectively).

Kindergarten

Kindergarten programs approved by the Department of Education and Training are available for children prior to the year they attend Prep (meaning children must be at least 4 years old by 30 June in the year they participate). In Queensland, approved kindergarten programs provide early learning to children for at least 15 hours per week for at least 40 weeks per year, and are delivered by a four year qualified early childhood education teacher or a registered teacher with early childhood qualifications. To be approved, programs must align with the Queensland Kindergarten Learning Guideline which is based on the Early Years Learning Framework (which is part of the National Quality Framework).

In Queensland, kindergarten programs can be delivered in kindergarten services affiliated with:

- Creche and Kindergarten Association of Queensland (C&K)
- Independent Schools Queensland
- Queensland Catholic Education Commission
- Queensland Lutheran Early Childhood Services, or
- The Gowrie (Qld) Inc.

A number of long day-care services have also been approved to provide kindergarten programs in Queensland.

In co-operation with the Federal government, Queensland is investing almost $900 million dollars to enable universal access to kindergarten for every child in Queensland. The Queensland Government aims to offer up to an extra 240 kindergarten services in areas of need by 2014, including 108 services co-located with a school to open by the end of 2012.

Preparatory Year of schooling

The statewide roll-out of the Preparatory Year of schooling (Prep) commenced in 2007. Prep is a non-compulsory early education program and is offered to all Queensland children of eligible age in all Queensland state schools and most non-state schools where there is a primary program. Children attend Prep full-time from Monday to Friday during school hours. Prep was introduced to enhance early learning and assist the smooth transition to Year 1 and ultimately to assist children in their journey to Grade 12 by:

- developing a positive approach to learning
- helping to develop independence and build confidence
- assist in developing problem solving skills
- assist in numeracy and literacy skills, and
- improving health and physical development.

In 2010, there were an estimated 58,359 Prep students enrolled in government and non-government schools across Queensland (Australian Bureau of Statistics, 2011).

Early childhood education and care for Aboriginal and Torres Strait Islander children

The *National Partnership Agreement on Indigenous Early Childhood Development* between the Australian Government and states and territories commenced in 2009. A key element of this National Partnership Agreement is the establishment of ten Children and Family Centres in Queensland by the end of 2012. The centres will provide Indigenous families residing in areas where services are needed most with access to integrated early childhood education and care, parenting and family support and child and maternal health services.

A range of other early childhood education and care and family support programs provide services for Indigenous children and families living in the Cape York, Gulf of Carpentaria and Torres Strait regions, including the *Remote Area Aboriginal and Torres Strait Islander Child Care* (RAATSICC) program's provision of playgroups, children's activity centres, family support workers and centre-based child care in 22 Indigenous communities and two regional centres.

In addition, under the Queensland Government's *Bound for Success pre-Prep in Indigenous Communities* initiative, enhancements have been made to the quality of early childhood education programs across 35 Aboriginal and Torres Strait Islander communities to provide Indigenous children with the foundation for a successful transition into Prep and Year 1. The pre-Prep program is delivered in different settings, including community kindergartens, child care centres and schools. As at

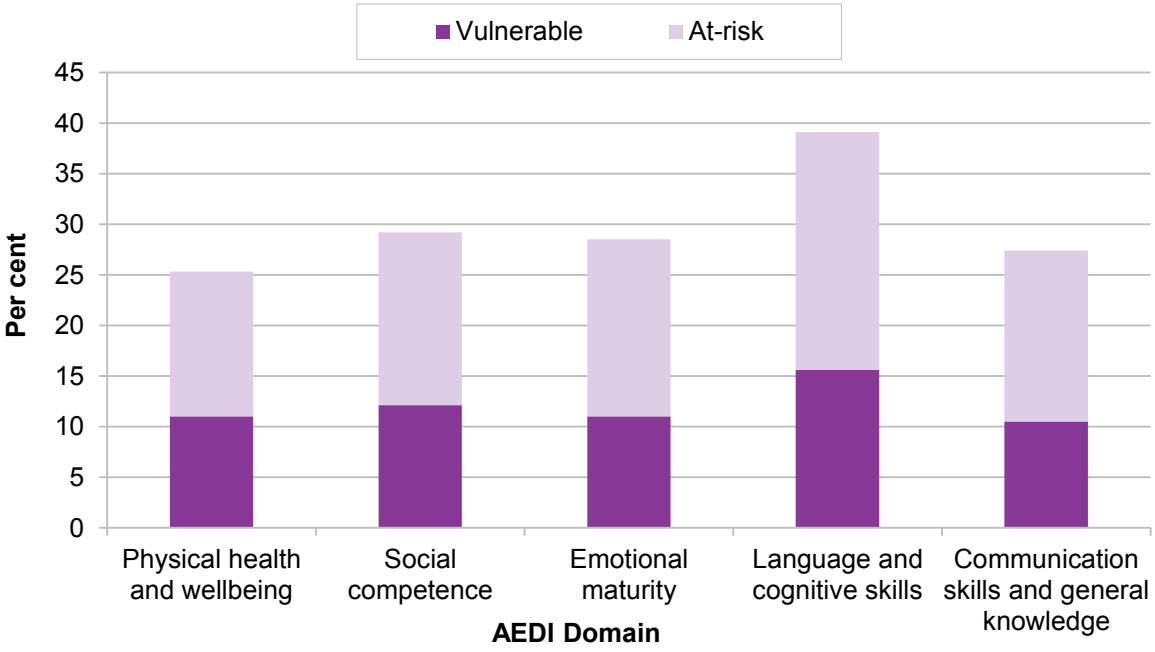
February 2010, there were 519 children participating in pre-Prep programs at 29 state schools in Aboriginal and Torres Strait Island communities.

Australian Early Development Index

The Australian Early Development Index (AEDI) has been endorsed by the Council of Australian Governments (COAG) as a national measure of progress in early childhood development. The AEDI is a population based measure of child development that enables communities to assess how children are developing by the time they reach school age. Additionally, the results from the AEDI will assist governments and policy-makers identify the services and support required to optimise child development.

The first national rollout of the AEDI took place in 2009, with 261,147 children in their first year of formal schooling (Centre for Community Child Health and Telethon Institute for Child Health Research, 2011). In Queensland, 55,448 children participated which represented 99.1% of the estimated 5 year old population. One in ten (10.0%) Queensland children had a language background other than English and 6.7% were Indigenous.

Figure 3.4 Children classified as developmentally vulnerable[a] or developmentally at risk[b] by AEDI domain, Queensland, 2009



a. Performance below the national 10th percentile
b. Performance between the national 10th percentile and the 25th percentile.
Source: Centre for Community Child Health and Telethon Institute for Child Health Research, *A Snapshot of Early Childhood Development in Australia – National Report 2009*

The results indicated that while most children in Queensland are making good progress in adapting to school, 29.6% were developmentally vulnerable (performance below the national 10th percentile) in at least one domain and 15.8% were vulnerable in at least two domains as they entered school. Children in Queensland were most likely to fall below national cut-offs in the language and cognitive skills domain, with 15.6% classified as developmentally vulnerable and 23.5% as developmentally at risk. Smaller proportions were classified as vulnerable in other domains (11.0% in the physical health and

wellbeing domain, 12.1% in the social competence domain, 11.0% in the emotional maturity domain and 10.5% in the communication and general knowledge domain).

The AEDI Indigenous Adaptation Study was undertaken in 2007 to revise the tool to ensure that it is relevant and sensitive to the needs of Indigenous children (Silburn, Brinkman et al. 2009). As a result of this study, a number of recommendations were adopted for national implementation in 2009.

Chapter 4:

Education

This chapter provides an overview of recent education and training reforms, including the introduction of the *National Curriculum* for all school students and the *Smarter Schools National Partnerships*. Data featured in this chapter include statistics on enrolments, participation and retention to Year 12, completion of Year 12, vocational education and training and disciplinary absences from school due to suspensions and exclusion. This information is derived from several sources including the Australian Bureau of Statistics' *Schools Australia* and Queensland Studies Authority's *Summary of Year 12 Enrolment and Certification*. Test scores from the third National Assessment Program – Literacy and Numeracy show the proportion of children in Years 3, 5, 7 and 9 in Queensland meeting the national minimum standards for literacy and numeracy. This chapter also features data from the *Australian Covert Bullying Prevalence Study* which provide a picture of bullying behaviour and exposure to bullying in young people.

School

Significant changes have occurred in schooling in Queensland over recent years including:

- the introduction of a full-time Preparatory Year (Prep) in 2007
- the increase in 2008 of the school entry age so that children will have to turn 6 on or before 30 June to enrol in Year 1, and
- the legal school leaving age in Queensland has increased, so that it is now compulsory for young people to stay at school until they complete Year 10, or turn 16, whichever comes first. Young people still have an obligation to earn or learn beyond these milestones.

In addition, a new *National Curriculum* for all school students is being phased in. The content of the national curriculum for Prep to Year 10 has been endorsed for English, mathematics, science and history. In 2011, Queensland teachers will have the opportunity to become familiar with the new English, mathematics and science curricula, before teaching and assessing against these curricula commences in 2012. The new history curriculum will commence in 2013. Course content for senior secondary courses (Years 11 and 12) is currently being drafted through consultation, and is not expected to be implemented before 2014 in Queensland.

The *Smarter Schools National Partnerships,* which is also operating at a national level, was introduced by the Queensland and Federal Governments in 2009. It is designed to:

- improve teacher quality
- develop literacy and numeracy for young people, and
- provide specific support for students from disadvantaged areas.

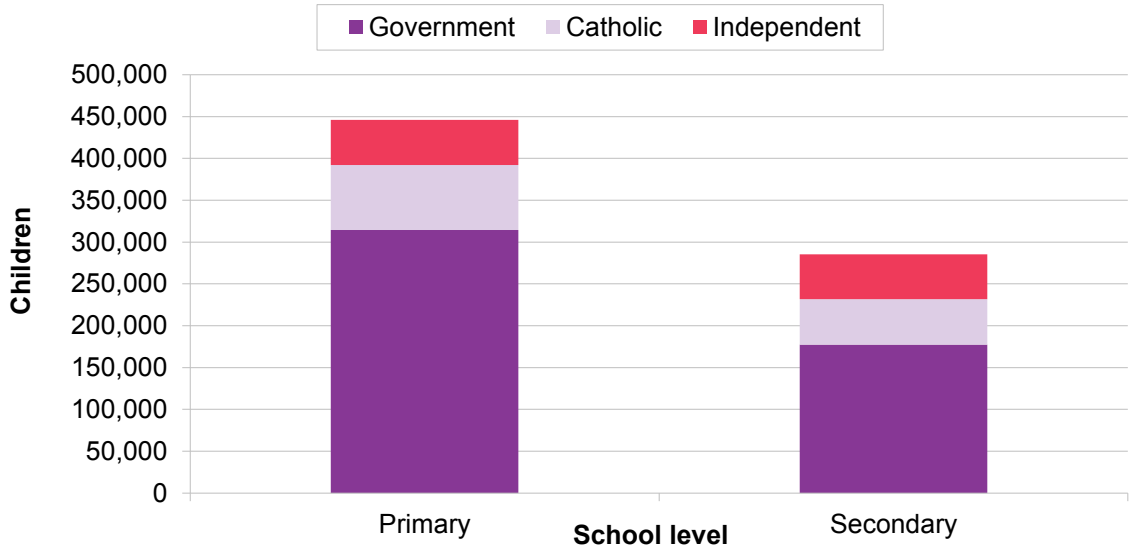
In 2010, the Department of Education and Training released the *Flying Start for Queensland Children* Green Paper, outlining proposed significant changes to the education system with the changes falling under three banners:

- getting ready for school
- getting ready for secondary school, and
- boost performance for all schools.

Following this consultation process, the Queensland Government announced that Year 7 would be moved into the secondary school system by 2015. This move was supported by the state, Catholic and independent school sectors.

Attendance

Figure 4.1 Children enrolled in schools by school level and sector, Queensland, 2010

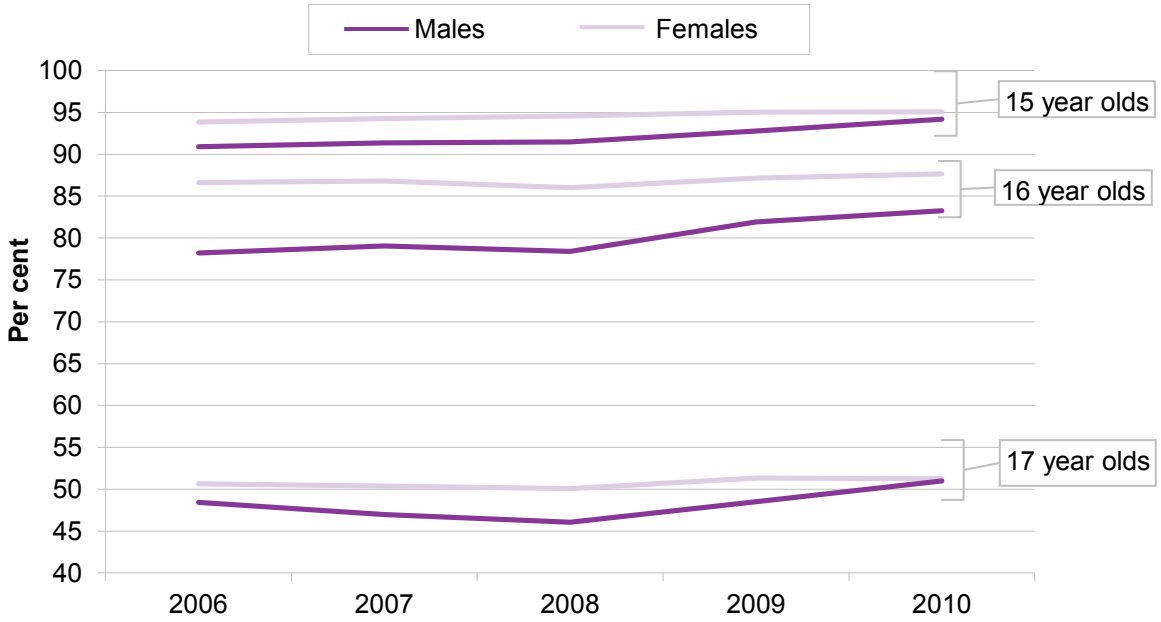


Source: Australian Bureau of Statistics, *Schools Australia 2010*, cat. no. 4221.0

In 2010, there were 731,617 full-time and part-time students enrolled in 1,702 schools across Queensland. This consisted of 492,114 enrolled in government schools, 131,867 enrolled in Catholic schools and 107,636 enrolled in independent schools (Australian Bureau of Statistics, 2011). There were 446,188 students enrolled in primary schools in Queensland in 2010 and 285,429 enrolled in secondary schools.

The school age participation rate indicates the proportion of the resident population enrolled at school on a full-time basis (based on data collected each year in August). With school enrolment compulsory for younger children in Queensland, participation rates for children aged 7–14 years are at around 100%. School enrolment is not compulsory for children who have completed Year 10 (which most students do at the age of 15) or who have turned 16 so participation rates begin to decline at this age. The participation rate is considerably lower for children aged 17 at the time of the August data collection with many already completing Year 12 in the previous year.

Figure 4.2 Participation rate of young people aged 15–17 by age and gender, Queensland, 2006 to 2010



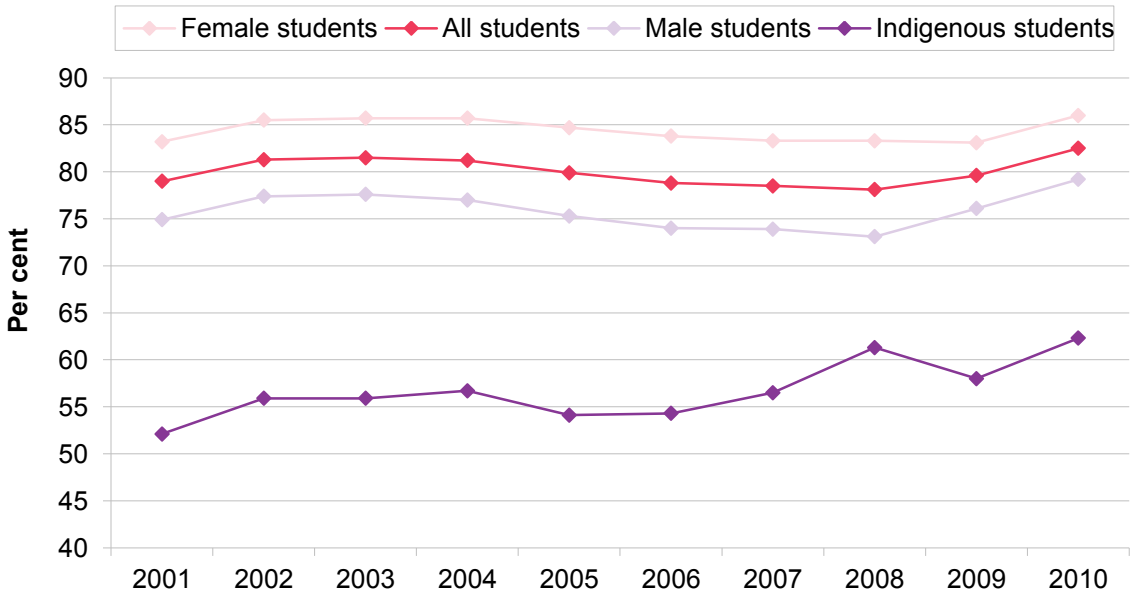
Source: Australian Bureau of Statistics, *Schools Australia 2010*, cat. no. 4221.0

In 2010, 94.6% of Queensland 15 year olds, 85.4% of 16 year olds and 51.1% of 17 year olds were attending school (Australian Bureau of Statistics, 2011). The participation rate for females has generally been higher than for males across all age categories, although in 2010 the male participation rate increased across all three age categories with the disparity all but disappearing for both 15 and 17 year olds. The participation rate for 16 year old males increased to 83.2% but still remains below the female rate of 87.6%.

Attendance rates for Indigenous children are lower than those of their non-Indigenous peers. For Semester 1 in 2010, attendance rates at discrete Indigenous community schools ranged from 74.2% to 77.8% in the primary school years (Prep to Year 7) (Queensland Government, 2010). Attendance rates are considerably lower in high school with attendance rates at 55.2% in Year 10.

Apparent retention rates provide a measure of the proportion of young people who continue formal education to Year 12 by comparing the current number of Year 12 students to the number of young people enrolled in Year 8 four years earlier. It should be noted that apparent retention rates are influenced by factors such as interstate and overseas migration, as well as students repeating or skipping years of schooling. It is also important to note that retention rates are based on enrolments and are therefore not an indication of successful completion of Year 12. Further discussion of Year 12 completion is made below.

Figure 4.3 Apparent retention rate by gender and Indigenous status, Queensland, 2001 to 2010



Note: Apparent retention rates are calculated as the number of full-time Year 12 students divided by the number of Year 8 students four years before. Factors such as migration and students skipping or repeating year levels will affect rates.

Source: Australian Bureau of Statistics, *Schools, Australia*, cat. no. 4221.0

Year 8 to Year 12 apparent retention rates in Queensland in 2010 were the highest recorded over the past decade. As with participation rates, the retention rate was higher for females, with 86.0% retention to Year 12 compared with 79.2% for males.

Indigenous students are much less likely to continue schooling to Year 12 than non-Indigenous students. The Indigenous apparent retention rate has improved considerably over the past decade (from 52.1% in 2001 to 62.3% in 2010); however, there is still a substantial gap between Indigenous and all-student retention rates (62.3% and 82.5% respectively).

The Year 7/8–Year 12 apparent retention rate continues to be higher in Queensland than the national average, both for the whole school cohort (82.5% and 78.0% respectively) and for Indigenous students (62.3% and 47.2% respectively). Factors such as jurisdictional differences in schooling systems, students repeating years and those joining or leaving the school system will affect the estimates.

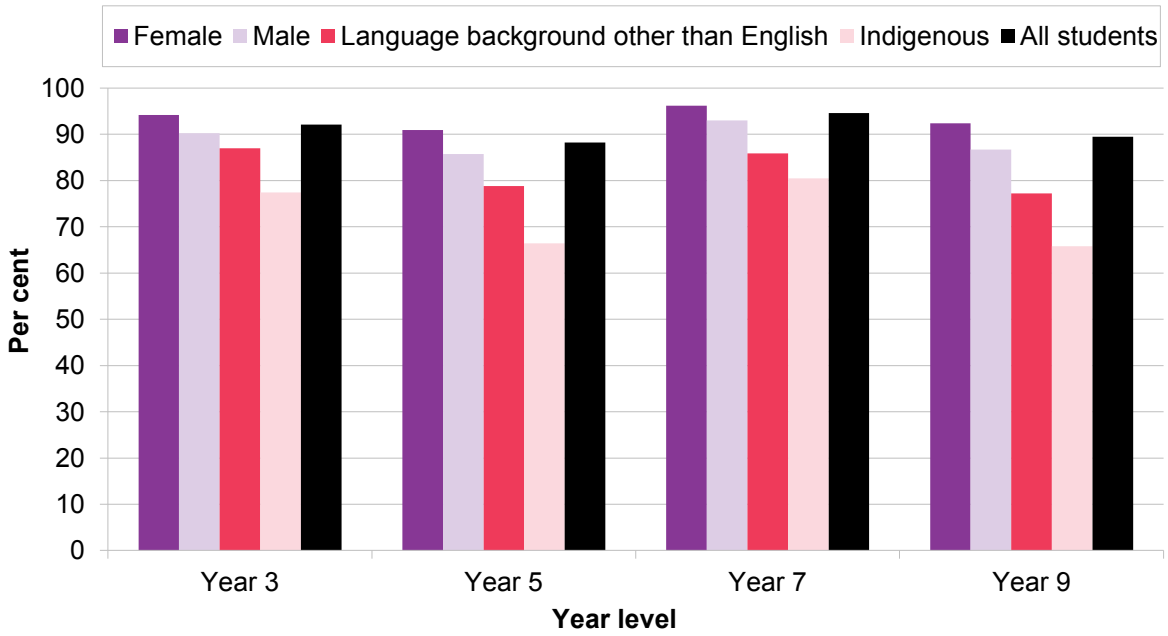
Achievement of minimum benchmarks

In May 2008, Year 3, 5, 7 and 9 students at all government and non-government schools in Australia sat the National Assessment Program – Literacy and Numeracy (NAPLAN) tests for the first time. Reading, writing, language conventions (spelling, grammar and punctuation) and numeracy were all assessed for each cohort. Before 2008, each state and territory administered independent tests, which prevented reliable comparisons across jurisdictions.

Student performances in literacy and numeracy tests have shown that there are wide ranges in abilities in each year level, and the student performances from different year levels overlap. For example, higher-performing students in Year 3 performed at least as well as the lower-performing students in Year 7.

Each year in September, individual student reports are delivered to parents of all students who sat the tests, with schools receiving whole-of-school reports. Figures 4.4 and 4.5 show Queensland students' achievements in reading and numeracy in 2010 (Australian Curriculum, Assessment and Reporting Authority, 2011).

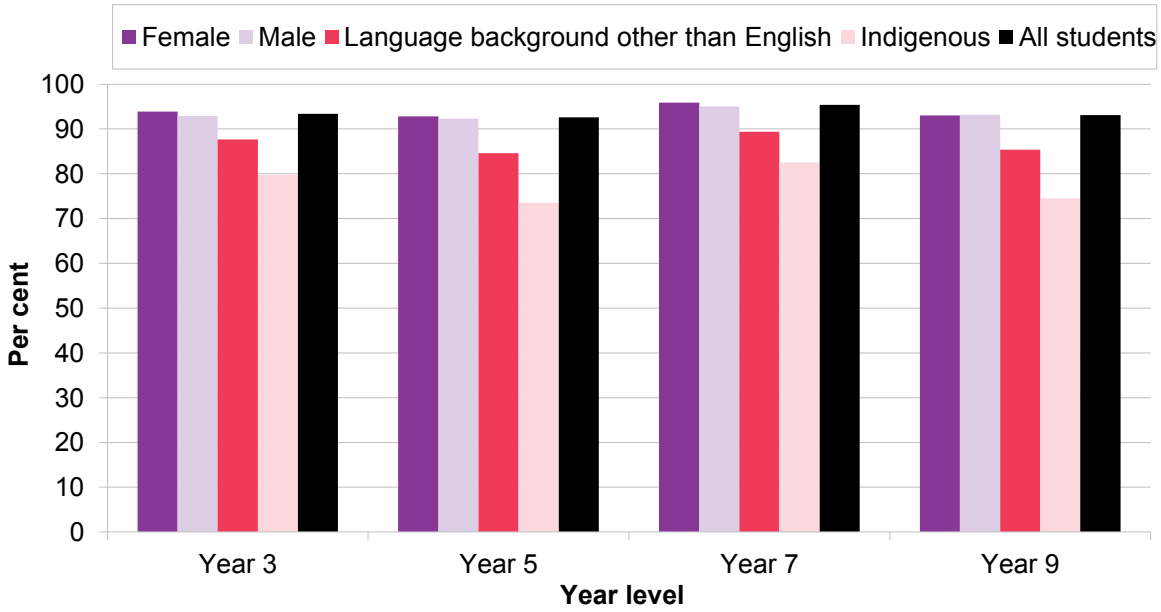
Figure 4.4 Students achieving national minimum standards for reading by selected groups, Queensland, 2010



Source: Australian Curriculum, Assessment and Reporting Authority, *National Assessment Program – Literacy and Numeracy Achievement in Reading, Writing, Language Conventions and Numeracy: National Report for 2010*

Overall, most students reached the minimum benchmarks in reading (92.1% of Year 3 students, 88.2% of Year 5 students, 94.6% of Year 7 students and 89.5% of Year 9 students). Females across all four year levels were more likely to reach the minimum benchmark than males with the gap between 3.2 and 5.7 percentage points across the four year levels. Students with a language background other than English were less likely to meet minimum benchmarks, particularly in Year 9 (77.2% of students with a language background other than English compared to 92.4% overall). A considerably smaller proportion of Aboriginal and Torres Strait Islander students met minimum benchmarks in reading and this was consistent across all four year levels. Again, this disparity was most apparent in Year 9 with only 65.8% of Indigenous students meeting the benchmark. Students in more remote areas were also consistently less likely to achieve the minimum benchmark for reading across all four year levels.

Figure 4.5 Students achieving national minimum standards for numeracy by selected groups, Queensland, 2010



Source: Australian Curriculum, Assessment and Reporting Authority, *National Assessment Program – Literacy and Numeracy Achievement in Reading, Writing, Language Conventions and Numeracy: National Report for 2010*

As with reading, the vast majority of Queensland students across all four year levels met minimum benchmarks in numeracy (93.4% of Year 3 students, 92.6% of Year 5 students, 95.4% of Year 7 students and 93.1% of Year 9 students). Unlike reading results, gender differences in reaching numeracy benchmarks were minor. Students with a language background other than English were less likely to reach minimum benchmarks; however, this disparity was generally less pronounced than in the reading results. Likewise, the gap between Indigenous and other students was evident but somewhat less pronounced than for reading, ranging between 12.9 and 19.1 percentage points across the four year levels. As with reading, students from more remote areas were less likely to reach minimum benchmarks.

There are a variety of programs throughout the state designed to improve literacy and numeracy amongst students working below the minimum academic benchmarks. For example, the *Literacy and Numeracy National Partnership* funds reforms to enhance literacy and numeracy outcomes for all students, especially Aboriginal and Torres Strait Islander students. In addition, the Queensland Government, in partnership with key stakeholders, has established several initiatives to improve literacy and numeracy outcomes. These include:

- the appointment of 91 full-time equivalent Literacy and Numeracy Coaches to support 175 state schools
- *Let's Stay Put for Literacy and Numeracy Learning*, a pilot project which focuses on addressing student mobility as a major factor influencing low student achievement in literacy and numeracy; this project will target 11 low socio-economic status schools across central, north and south east Queensland
- the *Summer Schools Initiative*, which was piloted in September 2009 and January 2010, engages students to develop and build on fundamental literacy and numeracy skills
- the *Bound for Success Consistent Curriculum* (also known as Scope and Sequence), which was developed specifically for discrete Aboriginal and Torres Strait Islander communities in

Cape York and the Torres Strait and reflects local, regional and systemic priorities across all learning areas for Years 1–9, and

- the *Remote Area Teacher Education Program*, which provides flexible, community-based training to Indigenous peoples in remote, rural and urban sites across Queensland to access tertiary education and train as teachers in their home communities.

Disciplinary absences

A number of strategies are used by schools to manage student behaviour. State schools in Queensland use school disciplinary absences – suspension, exclusion and cancellation of enrolment – as options of last resort to deal with serious behaviour difficulties after other strategies have been considered inappropriate (Department of Education and Training, 2010).

The Queensland Government has announced stronger powers for principals and higher behaviour standards for students. Since 2010, principals have had the authority to exclude a student without seeking approval from their supervisor when a student engages in serious misbehaviour and support strategies, or other less severe disciplinary measures, have not been sufficient to address the behaviour.

In the four terms from Term 3, 2009 to Term 2, 2010, there were:

- 27.8 short (1–5 day) suspensions per 1,000 students per term (54,616 suspensions)
- 3.6 long (6–20 day) suspensions per 1,000 students per term (7079 suspensions)
- 0.5 exclusions per 1,000 students per term (981 exclusions), and
- 0.3 cancellations per 1,000 students per term (681 cancellations).

The numbers and rates of 1–5 and 6–20 day suspensions continue to increase over time. In 2009–10, there was an increase of 7.1% in the number of short suspensions and 14.2% in long suspensions. Reasons for the 1–5 day suspensions in the four terms in 2009–10 (Department of Education and Training, 2010) were:

- 32.8% for physical misconduct
- 23.2% for verbal or non-verbal misconduct
- 14.2% for other conduct prejudicial to the good order and management of the school
- 9.2% for persistently disruptive behaviour adversely affecting others
- 6.5% for refusal to participate in the program of instruction
- 6.5% for property misconduct
- 5.1% for substance misconduct involving tobacco and other legal substances
- 2.0% for absences, and
- 0.4% for substance misconduct involving an illicit substance.

The main reasons for long suspensions were physical misconduct (35.3%), other conduct prejudicial to the good order and management of the school (18.9%), verbal or non-verbal misconduct (16.4%), and persistently disruptive behaviour adversely affecting others (8.8%).

Over one-third of exclusions were for physical misconduct (38.0%), with nearly one-quarter (24.0%) for other conduct prejudicial to the good order and management of the school, 12.3% due to substance misconduct involving illicit substances and 8.8% for verbal or non-verbal misconduct.

All cancellations were due to students' refusal to participate in the program of instruction.

Year 12 completion

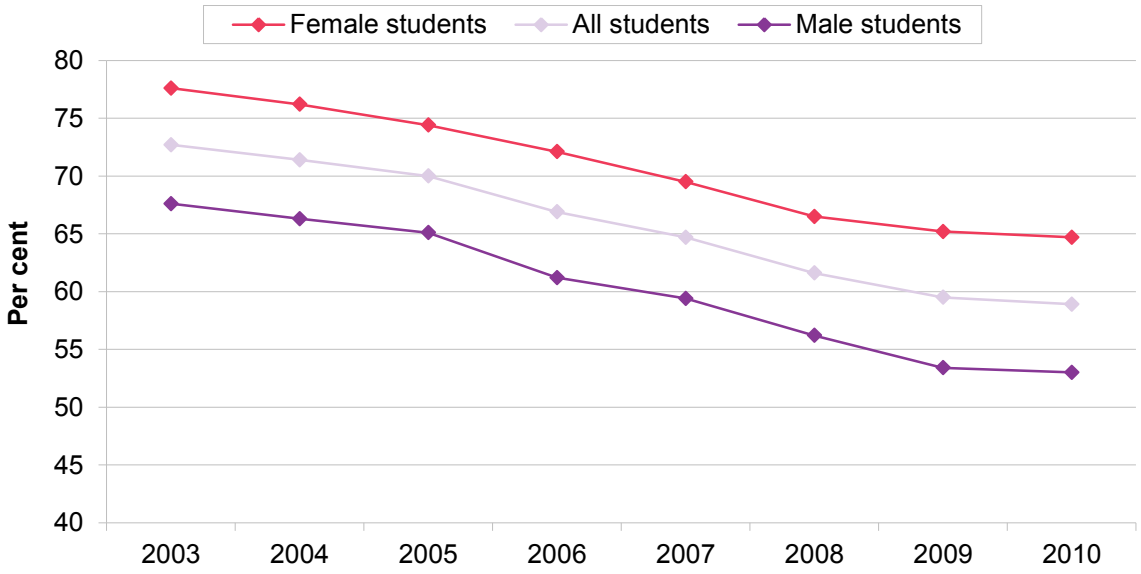
Upon completion of Year 12, students receive a Senior Education Profile (SEP), which includes the statements and certificates the student is eligible to receive. All Senior Education Profiles include a Senior Statement, which includes a transcript of studies undertaken and results achieved.

In addition, students may also be eligible for a Queensland Certificate of Education (QCE), which replaced the Senior Certificate in 2008. The QCE is Queensland's senior school qualification and recognises broad learning options including senior school subjects, vocational education and training, workplace and community learning and even university subjects undertaken while the student is at school. To be eligible for the QCE, students must complete a minimum number of semesters of approved subjects and meet literacy and numeracy requirements.

Students may additionally receive a Tertiary Entrance Statement, which shows a student's Overall Position (OP) and Field Positions (FPs), which are rankings used to determine entrance into tertiary courses. To be eligible for a Tertiary Entrance Statement students must complete minimum semesters of approved subjects including at least three subjects for four semesters each and sit the Queensland Core Skills (QCS) test.

Students who have impairments or difficulties not primarily due to socioeconomic, cultural or linguistic factors may receive a Certificate of Individual Achievement reflecting the completion of an individualised learning program. The certificates provide students with a summary of their skills and knowledge that they can present to employers and training providers.

Figure 4.6 Students eligible to receive OP scores by gender, Queensland, 2003 to 2010



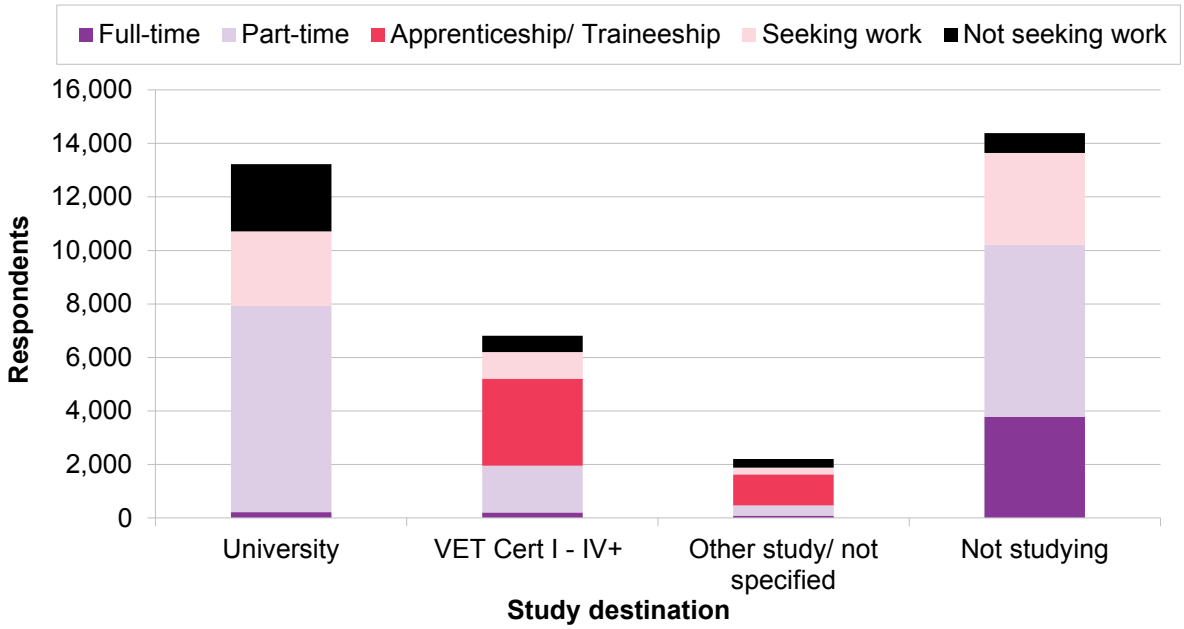
Source: Queensland Studies Authority, *2010 Summary of Year 12 Enrolment and Certification*

In 2010, Senior Education Profiles were issued to 44,997 students. Of these, just under three-fifths (58%) were eligible for a Tertiary Entrance Statement and OP score (Queensland Studies Authority, 2011). The proportion of students eligible for an OP continues to decrease, from 72.7% in 2003 to 58.9% in 2010, suggesting that more young people are taking up training or vocational qualifications after reforms to senior schooling policy in recent years. Males have been consistently less likely to be

eligible for an OP, with only 53.0% of graduating males receiving an OP compared to 64.7% of females.

Each year, the Department of Education and Training conducts a survey to investigate the study and work destinations of young people who have completed Year 12 the previous year. In 2010, 36,638 young people who completed Year 12 in 2009 participated in the survey which represented a response rate of 82.3%. The survey was conducted between 30 March and 12 May 2010, approximately six months after the young people had left school.

Figure 4.7 Study and employment destinations for Year 12 completers, Queensland, 2010



Source: Department of Education and Training, *Next Step 2010: A report on the destinations of Year 12 completers from 2009 in Queensland*

The majority (60.7%) of Year 12 completers reported being engaged in some form of study six months after leaving school. A university degree was the most common form of study (36.1% of completers) followed by VET Certificate III (9.3%) and VET Certificate IV+ (7.5%). A small number of completers were undertaking VET at Certificate I or II level (1.8%).

Including those undertaking traineeships and apprenticeships, over two-thirds (69.2%) of completers were employed. Overall, completers were more likely to be working part-time than full-time (11.8% compared to 44.4% of those surveyed) and this was particularly the case for those engaged in some form of study, with only 1.4% of completers choosing to work full-time and study. Of those Year 12 completers not studying and not working, more than eight in ten were seeking work (82.3%). There was a small number of young people (2% of all Year 12 completers) who were not studying, not working and not looking for work.

Gender differences were also apparent with females more likely to be undertaking a university degree (40.3% compared to 31.5% of males). Males were more likely to be undertaking VET study or training (29.2% compared to 20.4% of females) and apprenticeships (14.5% compared to 2.1% of females). Indigenous completers were less likely to be engaged in further education and training, with only 44.5% reporting doing so compared to 61.2% of non-Indigenous completers. While the proportion of

Indigenous completers indicating they were undertaking VET (including traineeships and apprenticeships) was slightly higher than non-Indigenous completers (29.5% compared to 24.5%), Indigenous completers were less likely to be undertaking a university degree (14.9% compared to 36.7%). In addition, Indigenous completers were more than twice as likely as non-Indigenous completers to be not studying and seeking work (22.6% compared to 9.0%) and were also more likely to be not studying, not working and not seeking work (4.3% compared to 1.9%).

Vocational education and training

Vocational education and training is a national system designed to train workers to work in specific industries. VET helps young people move from school to work through the provision of hands-on courses that encourage learning in the workplace as well as the classroom.

VET includes School-based Apprenticeships and Traineeships (SATs), which are becoming more prevalent throughout Queensland. SATs allow Years 11 and 12 high school students to participate in paid employment, receiving structured training on and off the job while continuing with their school studies. That is, they divide their time between school, work and training. The skills they acquire are part of nationally recognised vocational qualifications, and it is possible for young people to complete up to one-third of an apprenticeship while still at school.

There are more than 700 different apprenticeships and traineeships available through SATs in various fields (for example retail, hospitality, construction and automotive). At 30 June 2010, 8,883 Queensland students had commenced a school-based apprenticeship or traineeship (Department of Education and Training, 2010 - annual report). One in eight (13.3%) Year 12 completers in 2009 undertook SATs while at school (Department of Education and Training, 2010b).

In 2009–10, an estimated 14,700 15–17 year olds commenced apprenticeships or traineeships in Queensland (Department of Education and Training, 2010a). Furthermore, there were about 49,000 15–17 year old VET students in industries such as construction, hospitality, automotive and tourism.

According to the *Next Step 2010* report, 9,027 Year 12 completers from 2009 were enrolled in VET in 2010 (Department of Education and Training, 2010b). More than one-half (54.3%) of Year 12 completers in 2009 left school with a VET qualification.

Bullying and cyber bullying

There are a variety of ways that bullying and cyber bullying are understood. The *Queensland Schools Alliance Against Violence* (QSAAV), a cross-sectoral body including representatives from all three schooling sectors, parent and principal associations, unions and the Commission, was established in 2010 to provide independent advice to the Minister for Education and Training on best practice in dealing with bullying and violence in schools. QSAAV has adopted the definition proposed by Dr Ken Rigby (2010) in his *Enhancing Responses to Bullying Queensland Schools* report, but has also developed a number of resources, including *Working Together: A toolkit for effective school based action against bullying*, to support schools to develop their own definition of bullying.

QSAAV suggests that the core elements of bullying are that it:

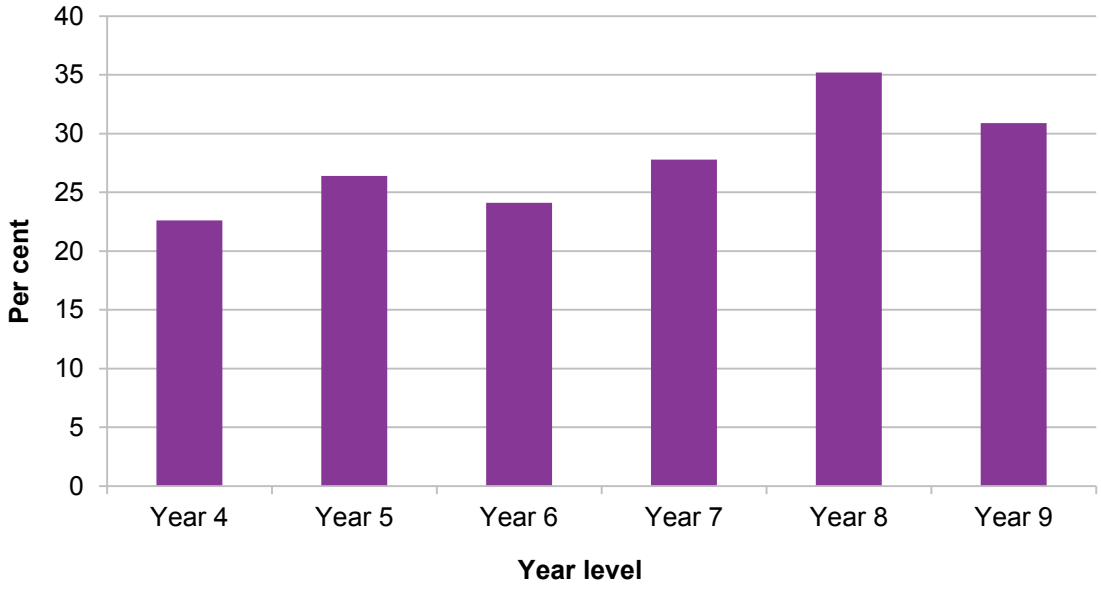
- is repeated behaviour
- involves a power imbalance, and
- can take many forms.

A variety of forms of bullying fit within this broad definition, including:

- physical bullying
- verbal bullying
- covert bullying
- psychological bullying, and
- cyber bullying.

Depending on the definitions, focus and methodology of research, estimated prevalence of bullying victimisation and perpetration vary considerably. The *Australian Covert Bullying Prevalence Study* used national data from several different surveys to determine whether students across a range of year levels from 4–9 had been repeatedly exposed to bullying type behaviours. The report notes that these behaviours did not necessarily constitute bullying because they were unable to determine whether the respondent was powerless to prevent recurrence of the behaviour, a necessary element of bullying as defined for this study.

Figure 4.8 Students reporting experiencing bullying by others by year level, Queensland, 2007



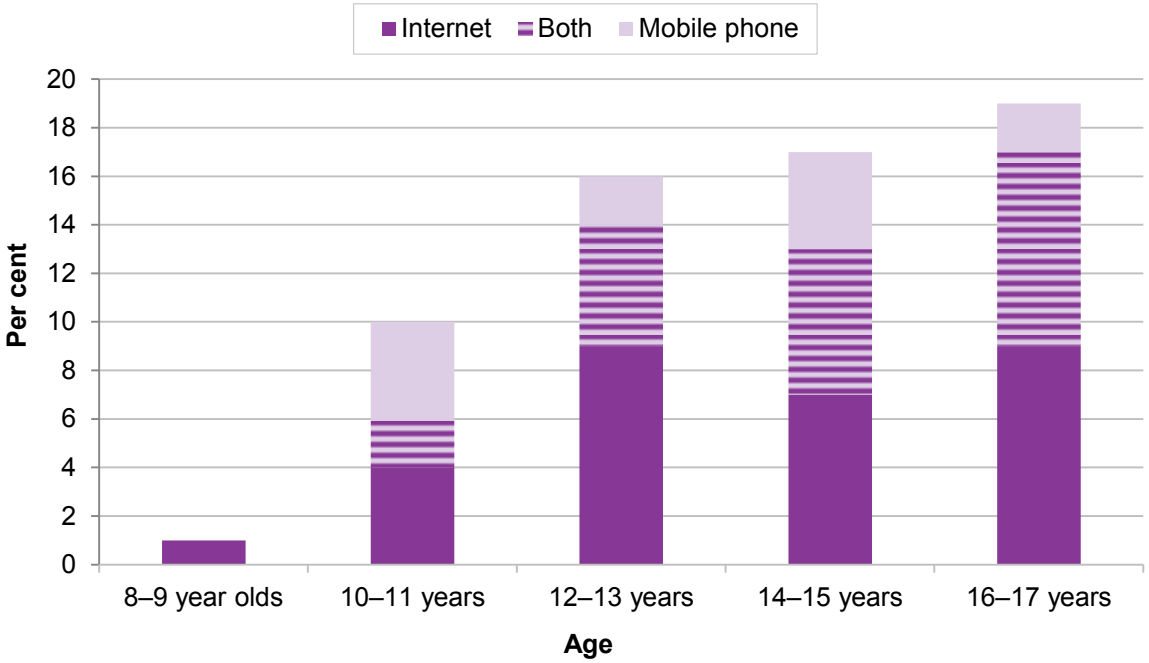
Source: Cross et al. *Australian Covert Bullying Prevalence Study*

Bullying behaviour was more common among older pupils than younger pupils, with 35.2% of Year 8 students and 30.9% of Year 9 students reporting that they had been bullied compared to 22.6% of students in Year 4.

The Australian Communications and Media Authority (2009) conducted a survey of 819 children and young people to investigate their use of electronic communications including mobile phones and the internet. Respondents were told that "cyberbullying is when someone repeatedly uses the internet or a mobile phone to deliberately upset or embarrass somebody else. It is intended to harm others and can

include sending mean or nasty words or pictures to someone over the internet or by mobile phone." Respondents were then asked whether they had experienced cyber bullying over the internet and/or by mobile phone.

Figure 4.9 Children and young people reporting ever experiencing cyber bullying[a] by age and medium, Australia, 2008



a. Cyber bullying was defined as "when someone repeatedly uses the internet or a mobile phone to deliberately upset or embarrass somebody else. It is intended to harm others and can include sending mean or nasty words or pictures to someone over the internet or by mobile phone"

Source: Australian Communication and Media Authority, *Click and connect: Young Australians' use of online social media*

Overall, only 1% of children aged 8–9 years reported experiencing cyber bullying, compared to 10% of 10–11 year olds, 16% of 12–13 year olds, 17% of 14–15 year olds and 19% of 16–17 year olds. Respondents across all age categories were more likely to report experiencing cyber bullying over the internet than by mobile phone, except for 10–11 year olds who were equally likely to report being bullied via each medium.

Improving outcomes for Aboriginal and Torres Strait Islander students

A substantial disparity continues between the educational outcomes of Aboriginal and Torres Strait Islander students and non-Indigenous students. The sustained disadvantage in educational outcomes has driven the *Closing the Gap* reform, introduced by the Council of Australian Governments (COAG) in 2009.

Two specific COAG targets pertaining to improving educational outcomes for Aboriginal and Torres Strait Islander students are to:

- halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade, and
- halve the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020.

In order to meet the COAG targets, the Department of Education and Training has developed the *Closing the Gap Education Strategy* which is the overarching strategy to improve the education outcomes of Aboriginal and Torres Strait Islander students in Queensland state schools. It sets three intermediary targets for state schools which are to:

- halve the gap in Year 3 reading, writing and numeracy by 2012
- eliminate the gap in student attendance by 2013, and
- eliminate the gap in Year 12 retention by 2013.

The second *Queensland Closing the Gap Report 2008–09* (Queensland Government, 2009) revealed that:

- Aboriginal and Torres Strait Islander students in Year 7 and 9 generally achieved literacy and numeracy test scores equivalent to, or lower than, their non-Indigenous peers two grades lower (that is, in Year 5 and 7 respectively)
- average scale scores for reading for Indigenous (and non-Indigenous) Year 3 students increased significantly in 2009, which was the only significant increase in performance by Indigenous students
- the gap between Aboriginal and Torres Strait Islander and non-Indigenous student attendance rates tended to increase over Years 8–10, most markedly in remote regions, and
- Indigenous Year 12 completing students were significantly less likely to be awarded a QCE than their non-Indigenous peers in 2008 (41.2% and 77.9% respectively).

The *Indigenous Education Support Structures* (IESS) pilot is a cross-sectoral initiative aimed at boosting educational outcomes for Indigenous students. The four-year (2008 to mid-2011) pilot has focussed on working with Aboriginal and Torres Strait Islander students, their teachers and families to improve student attendance, achievement and school completions. Teams were established in selected schools within five cluster sites – Mt Isa, Cairns, Rockhampton, Ipswich and Cunnamulla-Charleville. Each of these clusters used local information to identify specific targets and strategies to provide a locally based approach to improving educational outcomes and fostering Indigenous leadership.

Chapter 5:

Deaths

This chapter uses the Commission's own data on child deaths contained in the *Child Death Register* and summarises issues explored in more detail in the *Annual Report: Deaths of Children and Young People in Queensland* series. Data are also sourced from several Australian Bureau of Statistics publications, including *Deaths Collection*, *Births Australia* and *Population by Age and Sex*. This chapter considers trends in mortality rates by age and Indigenous status, and the leading causes of death in children and young people, particularly from external causes such as drowning, transport accidents and suicide.

The Commission's Child Death Review functions

Since 1 August 2004, the Commission has been required, under Chapter 6 – Child deaths – of the *Commission for Children and Young People and Child Guardian Act 2000*, to:

- maintain a register of the deaths of all children and young people in Queensland (starting from 1 January 2001)
- review the causes and patterns of deaths of children and young people
- conduct broad research in relation to child deaths
- make recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child death, and
- prepare an annual report to Parliament and the public regarding child deaths.

Detailed analyses of the deaths of all Queensland children and young people since 1 January 2004 are contained in the Commission's *Annual Report: Deaths of Children and Young People Queensland* series.

The Commission's seventh annual report analysing deaths in the period 2010–11 is scheduled for release in late 2011.

Methodology and data limitations

The number of deaths of children and young people in Queensland each year is relatively small. As a result, year-to-year variations in numbers can cause large changes in mortality rates, which means that these rates are not necessarily a good indication of changing trends. For this reason, mortality rates reported in this chapter are rolling averages – that is, they are based on annual rates averaged over three years. For example, mortality rates for 2008–2010 are average rates from the years 2008, 2009 and 2010.

Data regarding the number of live births in Queensland in 2010 had not been released at the time of publication of this report. As a result, all infant mortality rates (including neonatal, post-neonatal and SIDS deaths) are reported up to and including 2009. Deaths of children over the age of 1 are reported up to and including 2010.

Information on cause of death included in this report is obtained from two main sources. Analyses of longer-term trends are based on the Australian Bureau of Statistics' Deaths Collection, as provided by the Office of Economic and Statistical Research (OESR). Information on deaths from 2004 onwards is based on the Queensland Child Death Register maintained by the Commission.

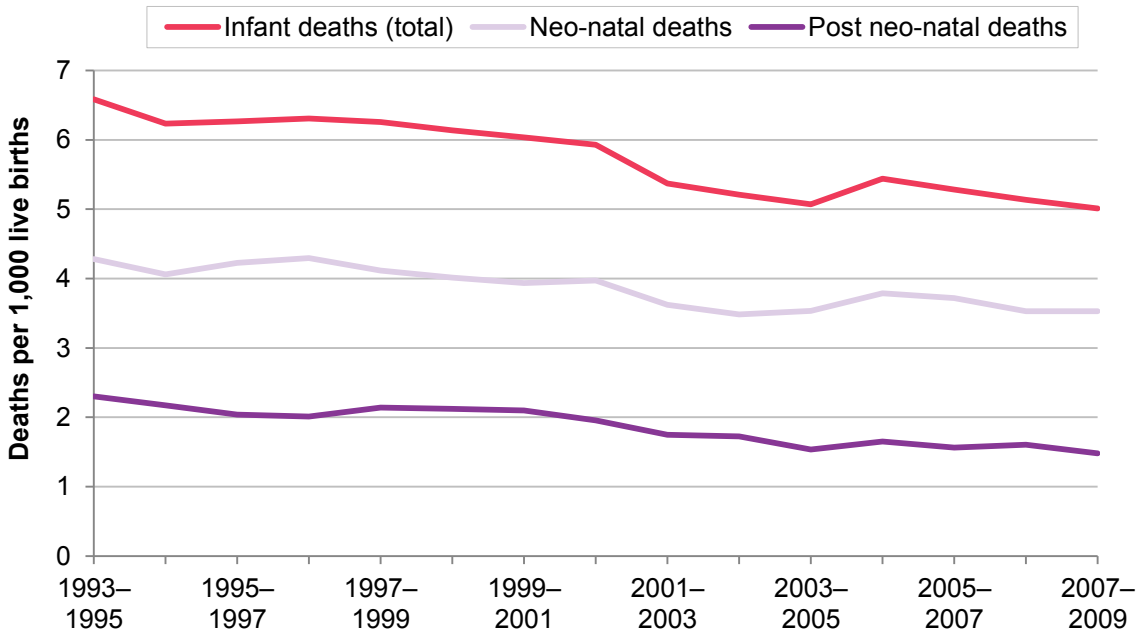
The Commission's child death data differ in some significant respects from the ABS Deaths Collection data. Although both collections use the International Classification of Diseases, tenth revision (ICD-10) to classify cause of death, differences can be found in the classification of cause of death because of differences in the amount of information available to each agency at the time of reporting. To help overcome the limitations of ICD-10, the Commission also classifies deaths according to their circumstances, based on the information contained in the Police Report of Death to a Coroner. Further information in respect to ICD-10 and the Commission's calculations can be found in the *Annual Report: Deaths of children and young people in Queensland 2009-10.*

Mortality by age

Infant mortality

The infant mortality rate (the rate of death within the first year of life) has been generally declining in Queensland (Figure 5.1), falling from 6.6 deaths per 1,000 live births in 1993–1995 to 5.0 deaths per 1,000 in 2007–2009. This decline was also apparent in neonatal mortality rates (referring to babies under 4 weeks of age), which declined from 4.3 to 3.5 deaths per 1,000 live births and in post-neonatal mortality rates (referring to babies between 4 weeks and 1 year of age), which declined from 2.3 to 1.4 deaths per 1,000 live births.

Figure 5.1 Neonatal[a], post-neonatal[b] and infant[c] mortality rate[d] Queensland, 1993–1995 to 2007–2009



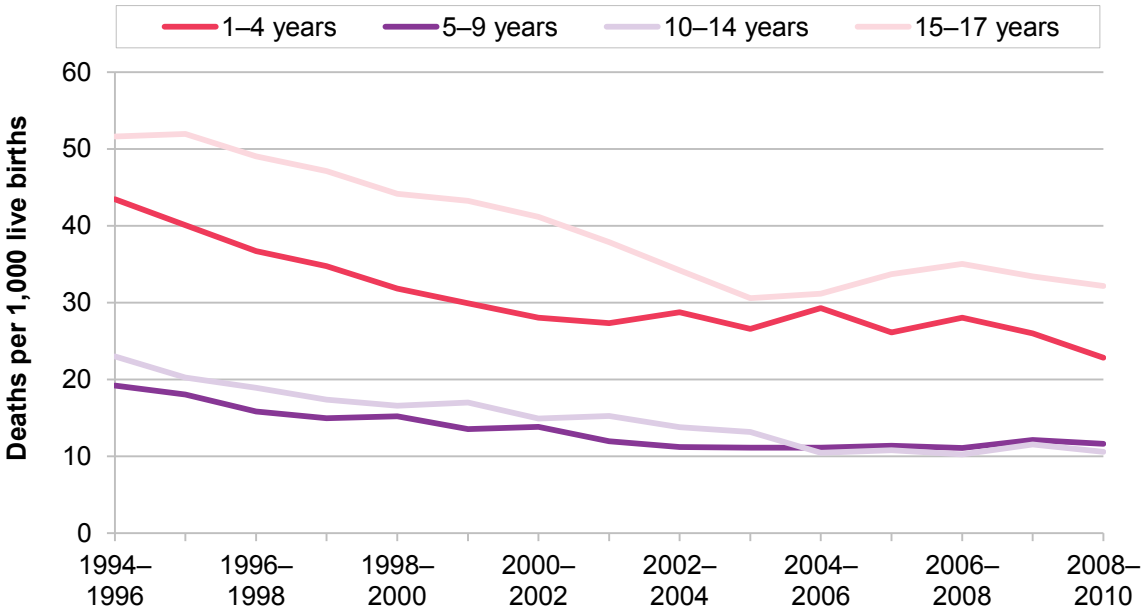
Note: Rates calculated over three year periods.
a. Under 4 weeks of age.
b. Between 4 weeks and under one year of age.
c. Under one year of age (i.e. neonatal and post-neonatal combined).
d. Per 1,000 live births.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in the years after 2003); ABS, *Births, Australia*, cat. no. 3301.0

Mortality for 1–17 year olds

Mortality rates for children and young people have generally decreased in the last 17 years (Figure 5.2). Mortality rates were highest for 15–17 year olds (32.2 deaths per 100,000 per year) and 1–4 year olds (22.8 per 100,000) in 2008-2010, compared with children aged 5–9 years (11.6 per 100,000) and 10–14 years (10.6 per 100,000).

Mortality rates for 15–17 year olds and 1–4 year olds in Queensland declined in 2008–2010 for the second three-year period in a row. Death rates for 5–9 year olds and 10–14 year olds have been stable in recent years.

Figure 5.2 Mortality rate[a] by age, Queensland, 1994–1996 to 2008–2010



Note: Three-year rolling averages.
a. Deaths per 100,000 population in age group.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex*, cat. no. 3201.0

Mortality for Aboriginal and Torres Strait Islander children and young people

Information on Indigenous status on birth and death registrations was introduced in Queensland in 1996. Although the identification of the deaths of Aboriginal and Torres Strait Islander people on registration forms has improved considerably in recent years, figures based on registration are still expected to undercount Indigenous deaths. Given this, it is necessary to draw upon additional sources of data to accurately gauge Indigenous mortality.

Of the 496 children who died in the 2009-10 financial year, 61 were identified as Aboriginal or Torres Strait Islander (Commission for Children and Young People and Child Guardian, 2010). The mortality rate for Indigenous infants for 2007-2009 was 6.8 per 1,000 live births compared to the general Queensland rate of 5.0. The mortality rate for Indigenous children aged 1–17 years was also considerably higher with a rate of 31.9 per 100,000 for 2008-2010 compared to a state wide rate of 17.7 per 100,000.

As discussed in further detail below, Indigenous children and young people are particularly overrepresented in deaths caused by SIDS and undetermined causes, and suicides.

Causes of death

Table 5.1 shows the leading causes of death for each age group between 2008 and 2010. Deaths of younger children aged up to1 year were most often caused by peri-natal and congenital conditions and SIDS and undetermined causes. In older age groups, external causes of death, particularly

drowning, transport incidents and suicide become more relevant, although neoplasms remain the leading cause of deaths for children aged 5–9 years and 10–14 years.

Table 5.1 Leading causes of death by age, Queensland, 2008–2010

	Under 4 weeks	Between 4 weeks and 1 year	1–4 years	5–9 years	10–14 years	15–17 years
1	Certain conditions originating in the perinatal period (*n* = 421)	SIDS and undetermined (*n* = 80)	Drowning (*n* = 30)	Neoplasms (*n* = 26)	Neoplasms (*n* = 25)	Transport (*n* = 54)
2	Congenital malformations, deformations and chromosomal abnormalities (*n* = 210)	Congenital malformations, deformations and chromosomal abnormalities (*n* = 55)	Transport (*n* = 25)	Transport (*n* = 23)	Transport (*n* = 19)	Suicide (*n* = 49)
3	Diseases of the nervous system (*n* = 15)	Certain conditions originating in the perinatal period (*n* = 44)	Diseases of the nervous system (*n* = 16)	Congenital malformations, deformations and chromosomal abnormalities (*n* = 11)	Diseases of the nervous system (*n* = 10)	Neoplasms (*n* = 21)
4	SIDS and undetermined (*n* = 6) Endocrine, nutritional and metabolic diseases (*n* = 6)	Diseases of the respiratory system (*n* = 12)	Congenital malformations, deformations and chromosomal abnormalities (*n* = 15)	Drowning (*n* = 9)	Suicide (*n* = 5)	Congenital malformations, deformations and chromosomal abnormalities (*n* = 11)
5	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (*n* = 3) Other non-intentional injury-related deaths [a] (*n* = 3)	Diseases of the nervous system (*n* = 11)	Diseases of the respiratory system (*n* = 11)	Diseases of the nervous system (*n* = 6)	Congenital malformations, deformations and chromosomal abnormalities (*n* = 4) Diseases of the respiratory system (*n* = 4) Endocrine, nutritional and metabolic diseases (*n* = 4) Diseases of the circulatory system (*n* = 4)	Diseases of the nervous system (*n* = 7) Other non-intentional injury-related deaths [a] (*n* = 3)

a. This category includes falls; non-intentional strangulation, suffocation and choking; poisoning; electrocution and other non-intentional injury-related deaths.

Source: CCYPCG, *Queensland Child Death Register*

Sudden and unexpected deaths in infancy

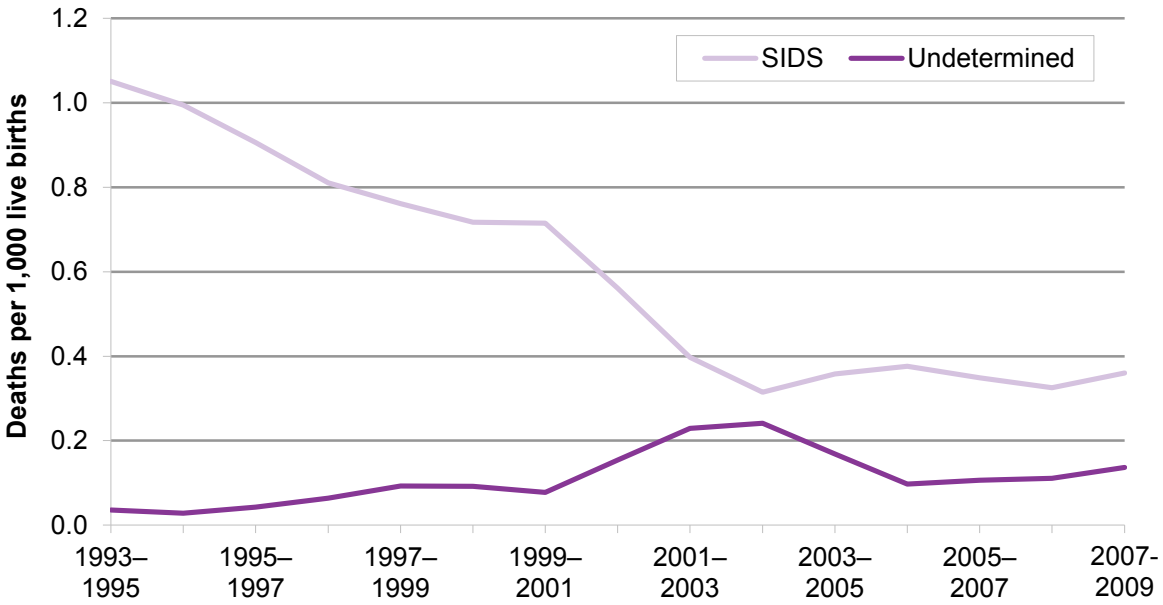
In this section, the information available relates to registered infant deaths (aged under 1 year) classified as SIDS (ICD-10 code R95) or of undetermined causes (other sudden deaths – cause unknown, ICD-10 codes R96–R99).

Figure 5.3 shows the steady decline of SIDS deaths, decreasing from 1.05 deaths per 1,000 live births in 1993–1995 to 0.37 deaths in 2007–2009. Recorded deaths from SIDS made up 7.1% of all infant deaths in 2007–2009 in Queensland.

A number of factors may have contributed to the recorded decrease, including improved access to preventative health care, increased public awareness of SIDS risk factors and increased use of autopsies in suspected SIDS cases leading to identification of non-SIDS causes (Commission for Children and Young People and Child Guardian, 2009).

The classification of infant deaths as being due to undetermined causes since 1996 reflects ambiguities in definitions of SIDS. Detailed death scene examinations for apparent SIDS deaths were introduced in December 2003 by the Queensland Police Service to improve information available for investigation by coroners.

Figure 5.3 SIDS and undetermined[a] infant mortality rate[b] Queensland, 1993–1995 to 2007–2009



Note: Years stated refer to three-year rolling averages at year's end.
a. Infant deaths, cause undetermined (ICD-10 codes R96–R99).
b. Deaths in the first year of life per 1,000 live births.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in years after 2003); ABS, *Births, Australia*, cat. no. 3301.0

The Commission's *Deaths of Children and Young People Queensland* annual reports reveal that Indigenous infants are over-represented in deaths from SIDS and undetermined causes, with mortality rates significantly higher than for non-Indigenous infants. In 2009–10, Aboriginal and Torres Strait

Islander infants died from SIDS or undetermined causes at 6.8 times the rate of non-Indigenous infants (Commission for Children and Young People and Child Guardian, 2010).

Risk factors identified in the *Deaths of Children and Young People Queensland* series include:

- infant factors – prematurity and low birth weight; twins or triplets; neonatal health problems; male gender and recent history of viral respiratory infections and/or gastrointestinal illness
- parental factors – cigarette smoking; alcohol and drug abuse; young maternal age; single marital status; high number of births and short inter-pregnancy intervals and poor or delayed prenatal care
- environmental risk factors – social disadvantage and poverty; sleeping on soft surfaces and loose bedding; prone (stomach) or side sleeping position; winter months; over-wrapping/overheating and some forms of shared sleeping.

The reports also identified concerns in relation to unsafe sleeping practices such as smoking parents who share a sleep surface with their infant, or leaving young infants unattended on adult beds.

A suite of resources are available for parents and health professionals to improve understanding of the importance of supine sleep and to support infant care practices that reduce the risk of sudden and unexpected infant death.

Two projects have directly targeted the needs of Aboriginal and Torres Strait Islander families:

- the Keeping Bubba Safe resources for health services, which include a flip chart, pamphlet and poster, and
- Baby Help – an infant illness assessment tool based on the original Baby Check tool, which has been adapted for use by Indigenous Health Workers and parents.

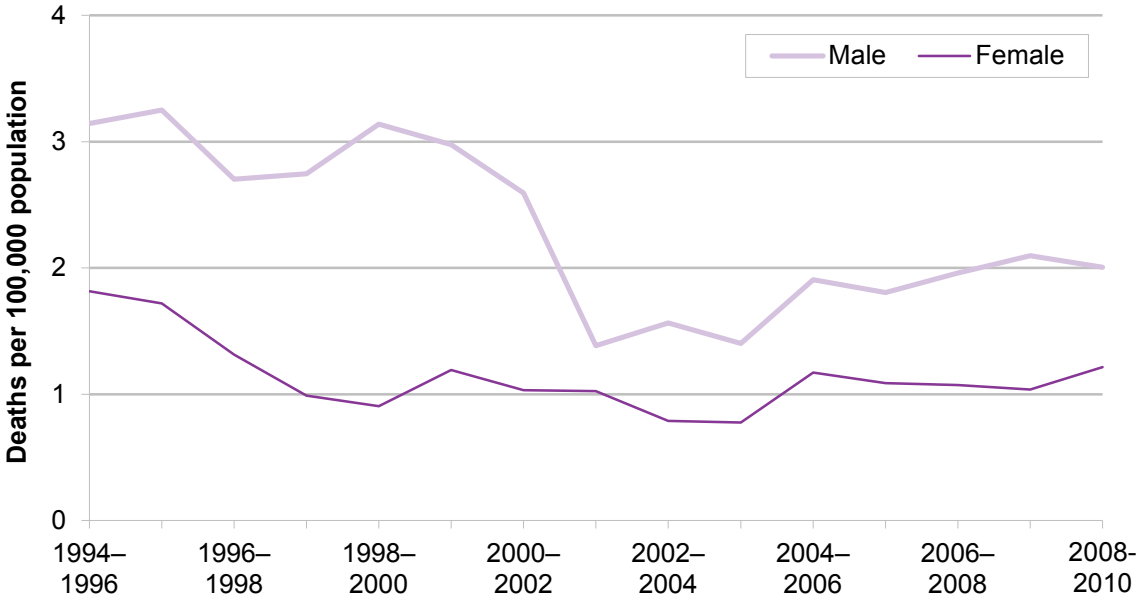
Drowning

There has been a general decrease in the rate of drowning deaths of 0–17 year olds over the past 15 years, with rates dropping from 2.50 per 100,000 in 1994–1996 to 1.62 per 100,000 in 2008–2010 (Figure 5.4). There is considerable fluctuation in the drowning mortality rate, due to the relatively low number of deaths by drowning each year (between 6 and 24 annually since 1994).

Over the last 15 years, there was a consistently higher number of male children and young people drowning in Queensland then females. During the period 1998–2000, males aged 0–17 years were 3.5 times more likely to drown then females of the same age.

During 2008–2010, 65.4% of drowning deaths were of children aged 0–4 years. Of the 52 deaths of 0–17 year olds, 42.3% were in swimming pools, with 77.3% of pool incidents involving children under 5 years.

Figure 5.4 Drowning mortality rate[a] by gender, 0–17 year olds, Queensland, 1994–1996 to 2008–2010



Note: Years stated refer to three-year rolling averages at year's end.
a. Deaths per 100,000 population aged 0–17 years.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex*, cat. no. 3201.0

Uniform pool fencing legislation was introduced in Queensland in 1992 and has been shown to be effective in reducing pool drownings of young children (Cunningham, Hockey et al. 2002). A pool safety review in 2009 has culminated in the release of new laws and guidelines. A two-stage pool safety improvement strategy was implemented in December 2009 with stage one targeting new pools and the various standards required to improve safety.

Stage two commenced on 1 December 2010 and targeted existing swimming pools. After an extension was granted due to the impact of the Queensland floods during the summer of 2010–2011, pool owners now have until 30 November 2015 to comply with the new pool safety standards, or earlier if their property is sold or leased before then.

Key achievements of the Queensland Government's *Swimming Pool Safety Improvement Strategy* include:

- the introduction of uniform fencing standards for all residential pools regardless of their date of construction
- extension of fencing laws to include hotels, motels, caravan parks and indoor pools
- removal of local government exemptions for pool fencing, except in the case of disability
- mandatory reporting of all immersion incidents of young children by hospitals and ambulance staff
- provisions for alerting home buyers and lessees to the compliance or otherwise of the pool fence with legislation, and
- increased government spending on awareness-raising campaigns.

Transport

Deaths of children and young people caused by transport incidents have generally decreased, but there have been several increases for females only in the most recent periods (Figure 5.5). Transport incidents were the leading cause of death among 15–17 year olds, and the second leading cause among 1–4 year olds, 5–9 year olds and 10–14 year olds in 2008-2010.

In the period 1994–2010:

- twice as many males as females died because of transport-related incidents (66.6% were males and 33.3% females)
- the vast majority (93.2%) of motorcycle deaths were among males as were the majority (80%) of bicycle deaths

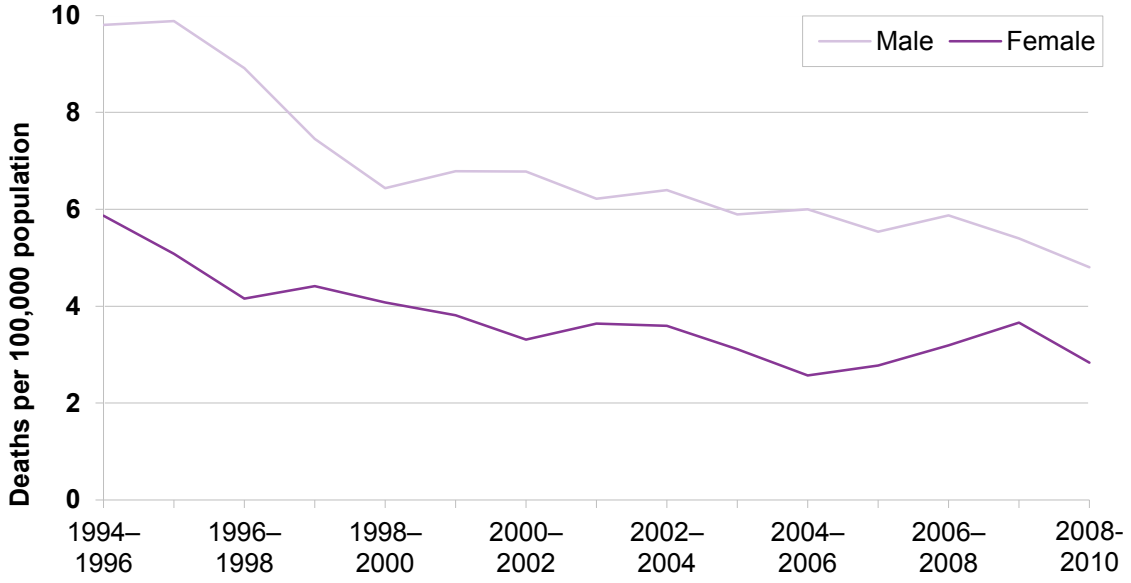
New legislation introduced in Queensland in March 2010 requires all children in motor vehicles up to the age of 7 years be seated in an appropriate child restraint for their age and size.

In response to the high incidence of transport-related deaths of young people, additional requirements for learner drivers in Queensland under the age of 25 years were introduced in 2007 which stipulate:

- that learner licences must be held for a minimum of 12 months
- that learners must gain 100 hours of supervised on-road driving, including 10 hours of night driving
- various provisional licence stages and the number of passengers that can be carried
- hours that a provisional driver may use a vehicle, and
- that vehicles driven must not be high powered (8-cylinder or turbocharged engines are not permitted, and there are additional restrictions regarding engine capacity, power and modifications).

As reported in the Commission's *Annual Report: Deaths of Children and Young People Queensland 2009–10*, the rate of child deaths from transport incidents is the lowest recorded since the Commission's Child Death Review reporting began on 1 January 2004. This decline in child deaths caused by transport incidents coincided with a general decline in road fatalities in 2010.

Figure 5.5 Transport mortality rate[a] by gender, 0–17 year olds, Queensland, 1994–1996 to 2008–2010



Note: Years stated refer to three-year rolling averages at year's end.
a. Deaths per 100,000 population aged 0–17 years.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex*, cat. no. 3201.0

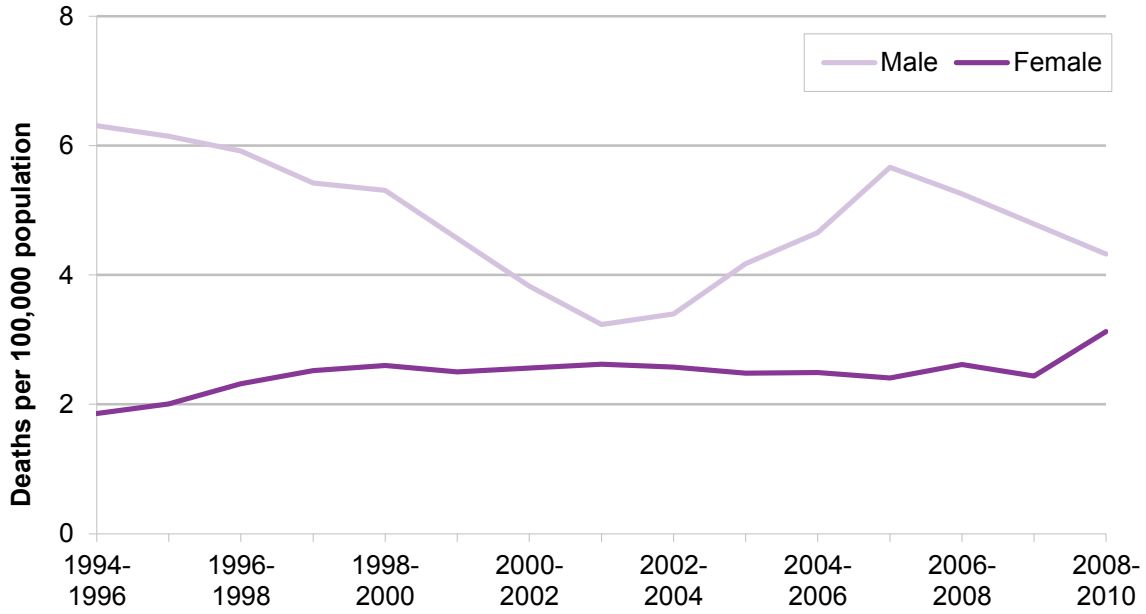
Suicide

The male suicide mortality rate has been greater than the female rate for the entire period between 1994 and 2010, with the differences between the genders often being twofold or greater.

In this period, suicides only occurred in children and young people between 10 and 17 years of age, with 15–17 years being the most common age bracket for young people to take their own life (0.56 per 100,000 population for 10–14 years in 2008–2010 and 8.85 per 100,000 population for 15–17 years).

Figure 5.6 outlines the suicide mortality trends for 10–17 year olds from 1994 to 2010 reported by the Commission for Children and Young People and Child Guardian. Fluctuations in rates from period to period may be the result of changes in suicidal behaviour but may also be the result of changes in the identification of suicide (Commission for Children and Young People and Child Guardian, 2009).

Figure 5.6 Suicide mortality rate[a] by gender, 10–17 year olds, Queensland, 1994–1996 to 2008–2010



Note: Years stated refer to three-year rolling averages at year's end.
a. Deaths per 100,000 population aged 10–17 years.
Source: OESR, *Deaths Collection* (for deaths in the years up to 2003); CCYPCG, *Child Death Register* (for deaths in the years after 2003); ABS, *Population by Age and Sex*, cat. no. 3201.0

As reported in the Commission's *Annual Report: Deaths of Children and Young People Queensland 2009–10*, the rate of suicide among Indigenous children and young people aged 10–17 years was over 5 times greater than for non-Indigenous young people (15.3 and 2.9 per 100,000 respectively).

A range of precipitating incidents and other stressful life events have been identified among young people who have suicided (Commission for Children and Young People and Child Guardian, 2010). These include:

- arguments with parents, partner or other family or community member
- relationship breakdown
- offence-related contact with police or the youth/criminal justice system
- bereavement of a close friend
- health-related concerns
- recent unemployment
- homelessness
- school problems
- possible pregnancy, and
- placement transition for those living in alternative care.

The Commission's *Reducing Youth Suicide in Queensland* initiative reviewed the lives and deaths of 65 children and young people who died from suicide in Queensland between 2004 and 2007 (Commission for Children and Young People and Child Guardian, 2009). The Commission is using this information to work with key stakeholders to inform youth suicide prevention strategies.

Chapter 6:

Child protection system

This chapter summarises the child protection concerns arising in Queensland, and the State and Commonwealth Governments' responses, including the *National Framework for Protecting Australia's Children* and the introduction and evaluation of the *Helping Out Families* initiative and *Referral for Active Intervention* services in Queensland to address risk and reduce the need for children to enter the child protection system. Statistics for this chapter predominantly come from data from the Department of Communities' (Child Safety Services) administrative data collection, *Our Performance*. Information contained in this chapter includes investigations and substantiations of harm and neglect, characteristics of children and families within the child protection system, as well as the use of protective orders and out-of-home care, and a range of outcomes for children in the child protection system. Results from the Commission's latest *Views of Children and Young People in Foster Care* and *Views of Young People in Residential Care* surveys, which provide valuable insights into children and young people's experiences in foster and residential care, are also featured.

Child abuse and neglect

Official definitions of child abuse and neglect vary across jurisdictions and time. In Queensland, the threshold for state intervention is set by the *Child Protection Act 1999* and is operationalised by the Department of Communities (Child Safety Services). Legislation authorises the department to intervene where a child has suffered harm, is suffering harm or is at unacceptable risk of suffering harm and there is no parent able and willing to protect the child from this harm (*Child Protection Act 1999*, s10).

Harm is defined in s9 of the *Child Protection Act 1999* as "any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing". Harm can result from a discrete action or episode but can also result from a series of circumstances and events that individually would have a minor impact on a child, but taken collectively result in significant detriment to the child. This may be referred to as "cumulative harm". What constitutes unacceptable risk is determined on a case-by-case basis by Child Safety Officers (CSOs) guided by Structured Decision Making (SDM) tools designed to support and provide consistency in decision making.

Government response to child abuse and neglect

In recognition of the shared responsibility across a range of government agencies that engage with children and young people, Queensland has adopted a whole-of-government model of child protection. This model involves all government agencies that have a major role in the promotion of child safety including the Department of Communities (Child Safety Services; Housing; Disability Services), the Queensland Police Service, Queensland Health, the Department of Education and Training and the Department of Justice and Attorney-General.

Queensland's Department of Communities (Child Safety Services) and the Queensland Police Service (QPS) have statutory authority to respond to reports of child abuse and neglect. Child Safety Services administers the *Child Protection Act 1999* which gives it authority to intervene where a child suffers harm or is at unacceptable risk of suffering harm and does not have a parent willing and able to protect them. Suspected abuse by others, including strangers, is dealt with by the QPS.

The Commission has a legislated responsibility to monitor the child protection system, including the services provided by Child Safety Services. To this end, the Commission audits and reviews legislation, policy and practice, investigates specific complaints about service delivery, supports the Child Death Case Review Committee and coordinates the Community Visitor Program. The Commission reports on agencies' performance in relation to outcomes for children and young people in the annual *Child Guardian Report*.

In April 2009, COAG announced a national approach for protecting children in Australia, *The National Child Protection Framework*.

Six supporting outcomes have been identified:

1. children live in safe and supportive families and communities
2. children and families access adequate support to promote safety and intervene early
3. risk factors for child abuse and neglect are addressed
4. children who have been abused or neglected receive the support and care they need for their safety and wellbeing
5. Indigenous children are supported and safe in their families and communities, and
6. child sexual abuse and exploitation are prevented and survivors receive adequate support.

Support outside the statutory system

Families who are not subject to intervention from Child Safety Services may access support services on a voluntary basis. There are a number of situations where families may engage with these support services, including where:

- some risk factors exist, but they are considered unlikely to pose an immediate safety risk
- more serious or escalating risk factors are observed, but there is at least one parent able and willing to protect the child, and
- families are able to benefit from additional support as they transition from the statutory system after a period of ongoing departmental intervention.

These non-statutory services are sometimes broadly referred to as “prevention and early intervention”, although they are also accessed by families who have already had substantial involvement in the statutory system and in cases where it is considered unlikely that the observed risk factors will escalate to abusive or neglectful behaviour.

Referral for Active Intervention

Referral for Active Intervention (RAI) services are funded by the Department of Communities to provide intensive family support for children, young people and their families where:

- there is a child aged 0–18 years in the family
- the family is assessed as having medium to high complex needs
- the child and family have been in, or are at risk of progressing into, the statutory child protection system, and
- the child is not assessed as being in need of protection.

Families are usually referred by Child Safety Services, the Department of Education and Training and Queensland Health, although referrals can be made by other government and non-government agencies. Families can also engage without a referral where service capacity allows.

The three-year evaluation of RAI, released in October 2010, found that

- in 2008-09, 69% of families referred to the service engaged, equating to 1,428 families receiving support
- average engagement duration was five and a half months
- across each of the 11 RAI locations, frequency of contact with the child protection system was reduced for engaged families, and
- presenting factors and family functioning challenges with the highest proportions at entry to RAI showed the greatest improvements.

Helping Out Families

The *Helping Out Families* (HOF) initiative is designed to provide support to children and families who have been referred to Child Safety Services, where the department identifies some need but where the child is not in need of protection.

Under this initiative, currently being piloted in Beenleigh-Eagleby-Nerang, Logan and South Gold Coast, Child Safety Services refers families, with their consent, to the Alliance, which is comprised of two distinct sets of services. Family Support Alliance Services make contact with and engage families, assess their needs and then refer them on to Intensive Family Support Services. The Intensive Family

Support Services undertake a needs assessment of families, provide case management and practical assistance around parenting, home management, budgeting, meal preparation and life management skills, as well as individual and family counselling. Intensive Family Support Services may also refer families on to specialist support services with the family's consent.

The first two locations in Beenleigh-Eagleby-Nerang and Logan opened in October 2010 with the third location, South Gold Coast, commencing operations in January 2011. An evaluation of the trial is due in late 2014.

Statutory child protection system

The section refers to the statutory child protection system administered by the Department of Communities (Child Safety Services). It is important to recognise that, for a number of reasons, the data presented here do not reflect the actual incidence of child abuse and neglect in the community. Some reasons are that:

- the data include children who have not been harmed but are assessed by the department to be at risk of being abused or neglected
- the data exclude extra-familial abuse unless a parent is assessed by the department to be unable or unwilling to protect the child from this harm
- much abuse and neglect is never reported to child protection authorities, and
- the data are extremely sensitive to changes in legislation, policy, practice, definitions, organisational capacity, data management systems and community awareness.

It is therefore not appropriate to draw conclusions about the actual incidence of child abuse and neglect from these data. However, they do provide important insights into the operation and decisions of the government services involved and the effects these activities have on children, young people and their families.

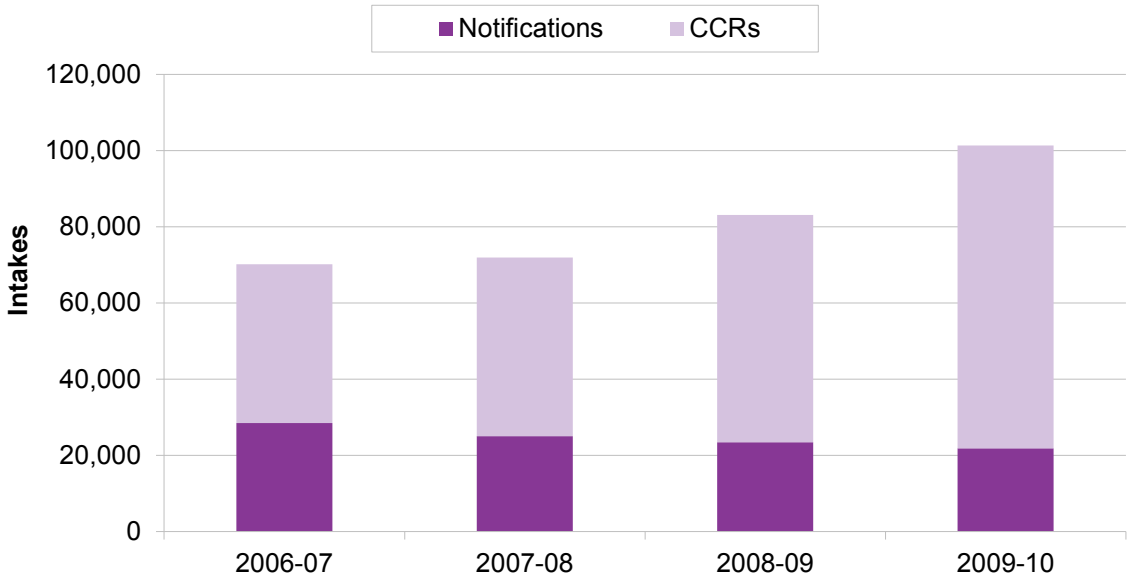
Intakes

When a report is received by Child Safety Services, it is assessed against the department's screening criteria to determine if what is being alleged would constitute harm or unacceptable risk of harm under the *Child Protection Act 1999*. Where the report does not meet the department's screening criteria, a Child Concern Report (CCR) is recorded. There are several possible responses to a CCR:

- general information can be provided to assist with the child's and family's needs (such as information about local services)
- a referral to an appropriate service can be provided
- a referral can be made to the QPS about a possible criminal matter, or an interstate child protection agency can be contacted as appropriate, or
- the case may be closed with no further action being taken.

A notification is recorded where a CSO has a reasonable suspicion that a child is in need of protection – that is, where the child has suffered harm, is suffering harm or is at unacceptable risk of suffering harm and there is no parent able and willing to protect the child (*Child Protection Act 1999*, s10). The CSO recommends a response timeframe for investigation and assessment (24 hours, 5 days or 10 days) based on the child's immediate level of safety, and an investigation is carried out.

Figure 6.1 Intakes (child concern reports and notifications) received, Queensland, 2006-07 to 2009-10



Note: Where a report relates to more than one child, an intake is counted for each child. If a child was subject to more than one report during the reference period, an intake is counted for each instance.

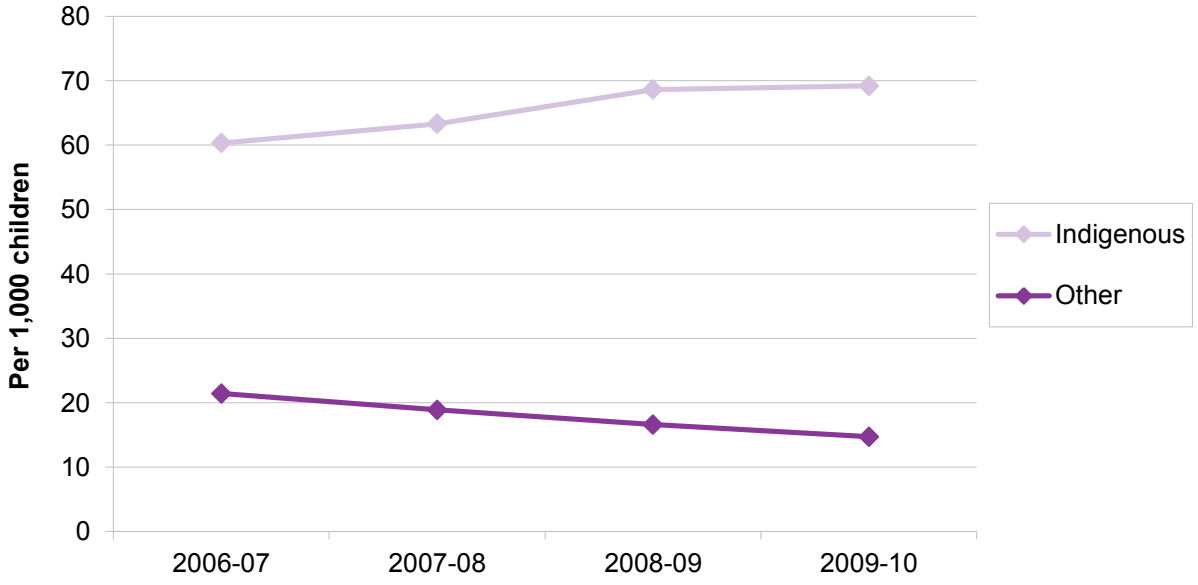
Source: Department of Communities, *Our Performance*

Over the past four years, the overall numbers of intakes have steadily risen. In 2006-07, there were 70,126 intakes (including 28,511 notifications and 41,615 CCRs) compared to 101,356 in 2009-10 (including 21,885 notifications and 79,471 CCRs). Overall, this represents a 45% increase.

It is important to note, however, that the growth in intakes relates exclusively to CCRs with notifications falling 23% between 2006-07 and 2009-10. Over that same time, the number of CCRs recorded grew by 91%. This shift towards CCRs meant that in 2009-10, 22% of intakes were screened as notifications compared to 41% in 2006-07.

From 2007-08 (the earliest year that data are available) through to 2009-10, QPS was by far the most common source of intakes, accounting for 30.5% of intakes over this period and was also the most rapidly growing source of intakes, increasing by 77.4% over this time. Consistent with the overall trend, growth in referrals from QPS related largely to CCRs, meaning that the number of notifications declined from 6,404 in 2007-08 to 6,290 in 2009-10.

Figure 6.2 Children subject to notifications (rate per 1,000 children) by Indigenous status, Queensland, 2006-07 to 2009-10



Note: Where a child was subject to more than one notification during the period, the child is counted only once.
Other includes non-Indigenous, unknown and not stated.

Source: Department of Communities, *Our Performance*

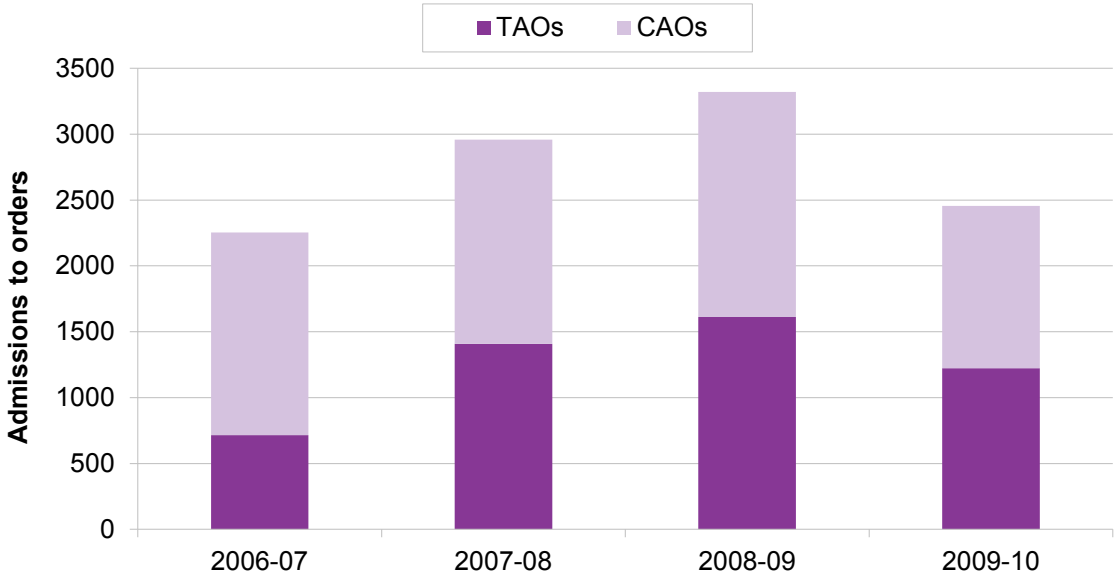
The reduction in notifications over time was not consistent for all children and young people. In 2006-07, 21.4 children per 1,000 non-Indigenous children were subject to notifications compared to 14.7 children per 1,000 in 2009-10. This represents a real drop of 31%. Over the same period, the already disproportionately high rates of Aboriginal and Torres Strait Islander children subject to notifications grew by 15%. In 2009-10, Aboriginal and Torres Strait Islander children were 4.7 times more likely to be the subject of a child protection notification and therefore be subject to an investigation and assessment.

Investigations and assessments

Intakes classified through the screening process as notifications are investigated by departmental officers. The department prefers to conduct investigations with the cooperation of parents; however, where parents refuse to consent to actions essential to the investigation or to ensure the safety of the child during the investigation, the department may apply to the court or a magistrate for assessment orders.

Assessment orders can provide authority for the department to have contact with a child, take a child into the custody of the chief executive, enter premises, authorise medical examinations or treatment or direct parents about contact with a child. Temporary Assessment Orders (TAOs) are sought directly from a Magistrate and can last for no longer than three days. Court Assessment Orders (CAOs) are sought from the court and can last for up to 28 days initially with the possibility of extension for an additional 28 days at the court's discretion.

Figure 6.3 Admissions to Temporary Assessment Orders (TAOs) and Court Assessment Orders (CAOs), Queensland, 2006-07 to 2009-10



Note: Where a child is the subject of more than one admission to a TAO and/or CAO during the period, an admission is counted for each instance.

Source: Department of Communities, *Our Performance*

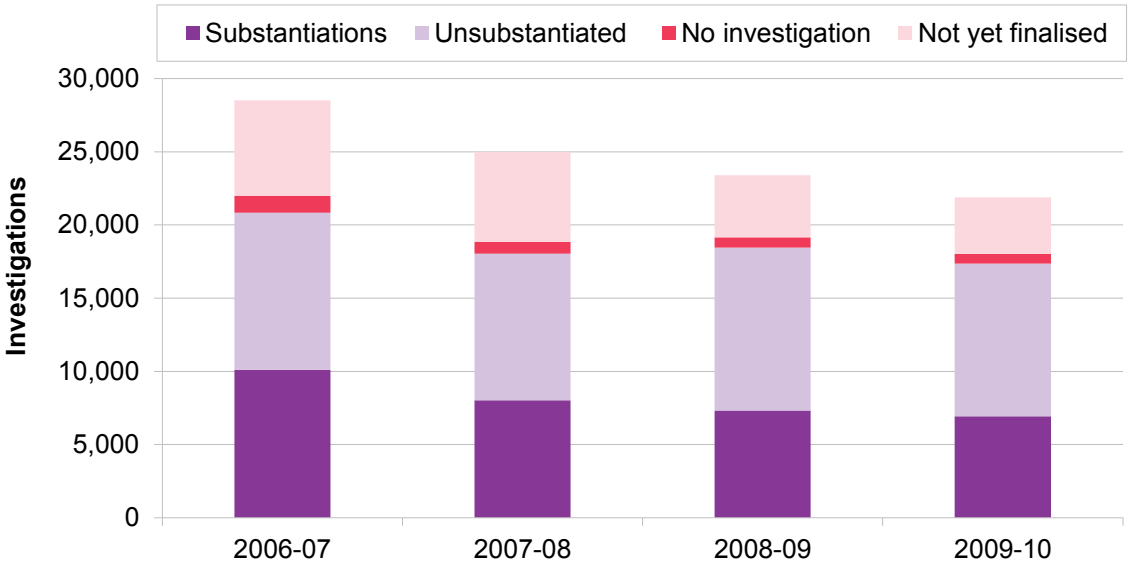
In 2009-10 a trend of increasing use of both TAOs and CAOs was reversed with a drop in the number of admissions to both CAOs and TAOs. In 2009-10, there were 1,232 admissions to CAOs, which was 28% down on 2008-09 and even lower than 2006-07 when 1,537 admissions were recorded. TAOs also fell by 24% from 1,612 in 2008-09 to 1,223 in 2009-10 but in spite of this drop, admissions to TAOs remained substantially higher than they were in 2006-07 when only 716 admissions to TAOs were recorded. While these data do not reveal exactly how many investigations proceeded with or without some form of assessment order, it is clear that the vast majority of the more than 20,000 investigations carried out each year are able proceed without court intervention.

After gathering all relevant information, including sighting and interviewing children subject to the investigation, one of the following four investigation and assessment outcomes is recorded:

- substantiated – child in need of protection (child is at risk of being harmed in the future and there is no parent able and willing to protect the child)
- substantiated – child not in need of protection (child has been harmed but there is a parent able and willing to protect the child from future harm)
- unsubstantiated (child has not suffered harm and there is a parent able and willing to protect the child from future harm), or
- no investigation and assessment outcome (where there is insufficient information to decide on an outcome, efforts to locate the child and family have been unsuccessful).

The department intervenes in all cases where a child is assessed as being in need of protection. Cases where a child is assessed as not in need of protection (whether substantiated or unsubstantiated) are treated in much the same way as a CCR. In these cases, a support service case may be opened, a referral to other support services can be made or the case can be closed with no further action taken.

Figure 6.4 Investigations and assessments by outcome, Queensland, 2006-07 to 2009-10

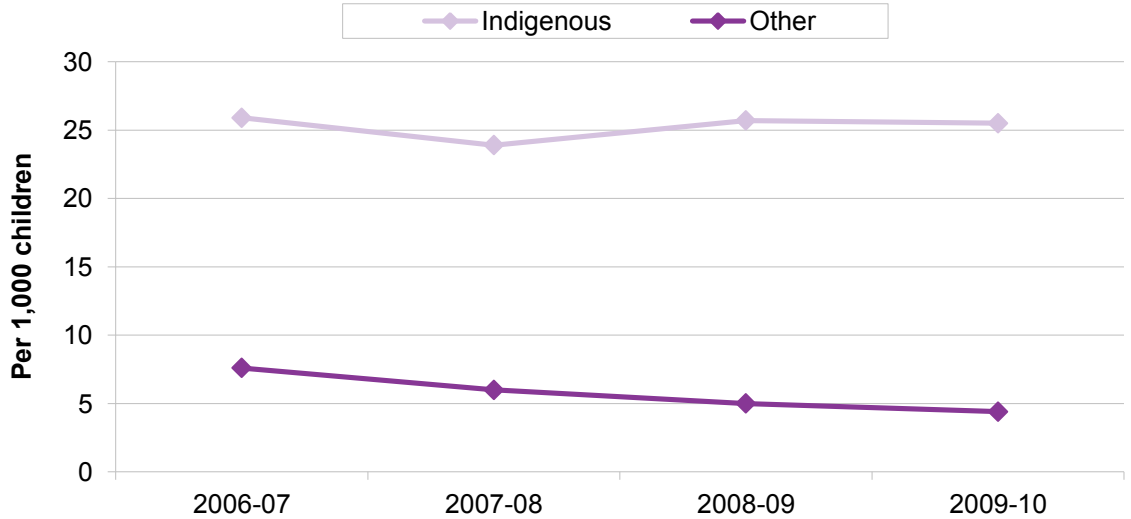


Note: Investigations not yet finalised refers to notifications where the investigation was not finalised and approved within 2 months of the end of the reference period.

Source: Department of Communities, *Our Performance*

The number of recorded substantiations has declined, dropping 32% between 2006-07 and 2009-10. With the reduction in investigations being undertaken each year, the proportion of investigations started during the financial year that are yet to be finalised two months after the end of the financial year has steadily declined from 22.9% in 2006-07 to 17.6% in 2009-10.

Figure 6.5 Children subject to substantiated notifications (rate per 1,000 children) by Indigenous status, Queensland, 2006-07 to 2009-10

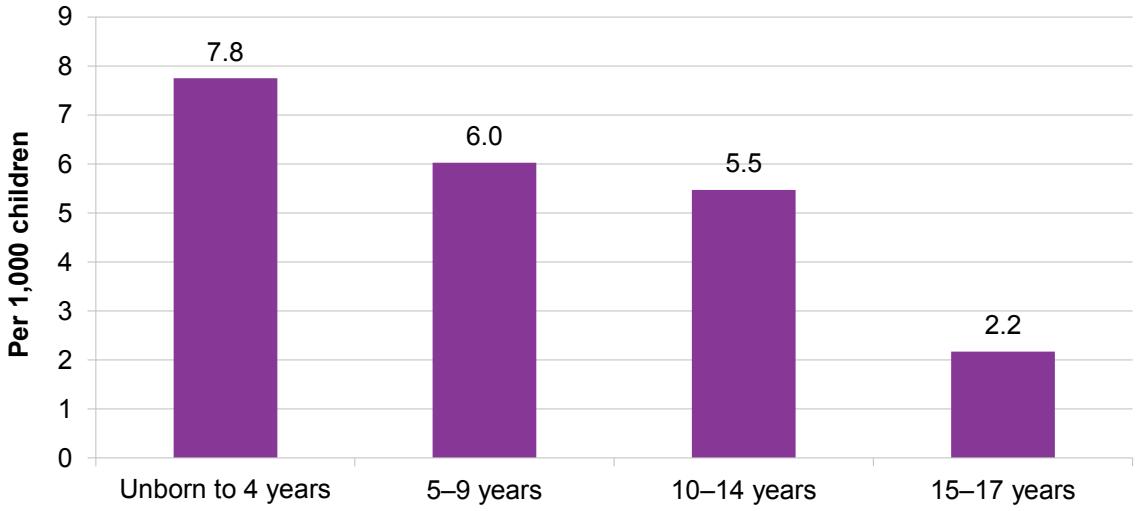


Note: Counts notifications recorded during the reference period, where an assessment has been finalised and the investigation outcome was recorded as substantiated within two months after the end of the reference period. If a child is subject to more than one substantiation in the period, the child is counted only once. Other includes non-Indigenous, unknown and not stated.

Source: Department of Communities, *Our Performance*

Given the disproportionate number of investigations and assessments conducted on Aboriginal and Torres Strait Islander children and young people, it is not surprising that Indigenous children are also more likely to be subject to substantiations than other children. However, it is important to note that the gap between Indigenous and non-Indigenous children is further widened at the investigation and assessment stage. Indigenous children are 4.7 times more likely to be subject to a notification but 5.8 times more likely to be subject to a substantiation. This gap in substantiations is also widening over time, with the rate of Indigenous children subject to substantiations consistently around 25 per 1,000 (25.9 in 2006-07 and 25.5 in 2009-10) while the rate for other children has dropped 42% from 7.6 per 1,000 to 4.4 per 1,000.

Figure 6.6 Children subject to substantiated notifications by age, Queensland, 2009-10

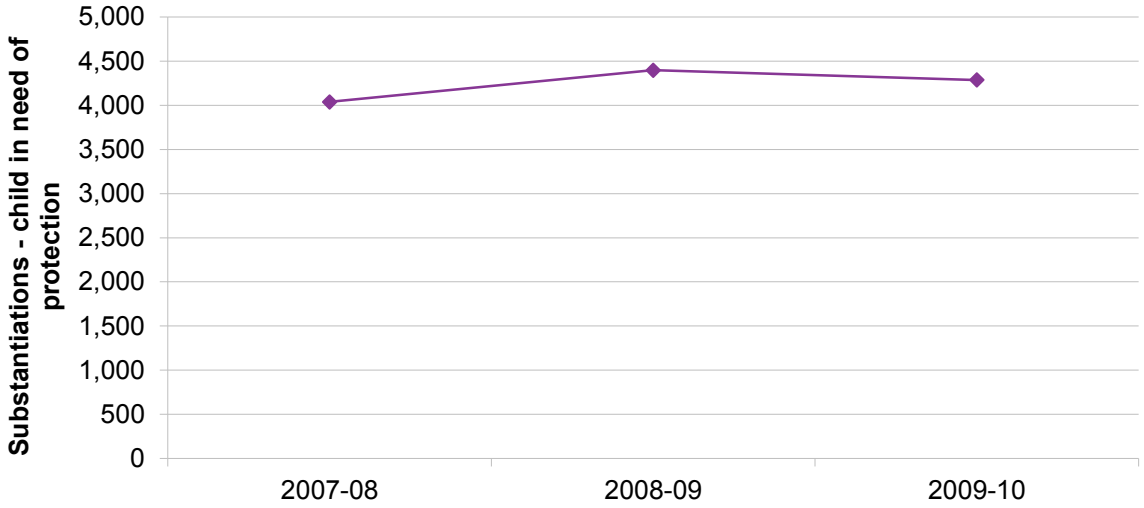


Note: Counts notifications recorded during the reference period, where an assessment has been finalised and the investigation outcome was recorded as substantiated within two months after the end of the reference period. If a child is subject to more than one substantiation in the period, the child is counted only once.

Source: Analysis based on data from Department of Communities, *Our Performance* and estimated resident population (ABS cat. no. 3201.0)

Younger children, who are more likely to be regarded as vulnerable, are more likely to be subject to a substantiation. Children aged four years and under were subject to substantiations at a rate of 7.8 per 1,000 in 2009-10 compared to 15–17 year olds who were subject to substantiations at a rate of 2.2 per 1,000. Since 2006-07, the numbers of substantiations in each age group have declined in line with the overall decline in substantiations.

Figure 6.7 Investigations and assessments with outcome of Substantiated – child in need of protection, Queensland, 2007-08 to 2009-10



Note: Counts notifications recorded during the reference period, where an assessment has been finalised and the investigation outcome was recorded as substantiated – child in need of protection within two months after the end of the reference period.

Source: Department of Communities, *Our Performance*

While figures relating to intakes, investigations and substantiations have undergone considerable change in recent years, the numbers of cases where children are assessed to be in need of protection, and therefore must be engaged in ongoing intervention, have remained comparatively stable, at least over the three years for which data are available. The number of children in need of protection increased from 4,038 in 2007-08 to 4,397 in 2008-09 before easing to 4,287 in 2009-10.

Ongoing interventions

Where a child is assessed to be in need of protection through an investigation and assessment, the department is required to engage the family in ongoing intervention. Preference is given to less invasive interventions beginning with intervention with parental agreement (IPA).

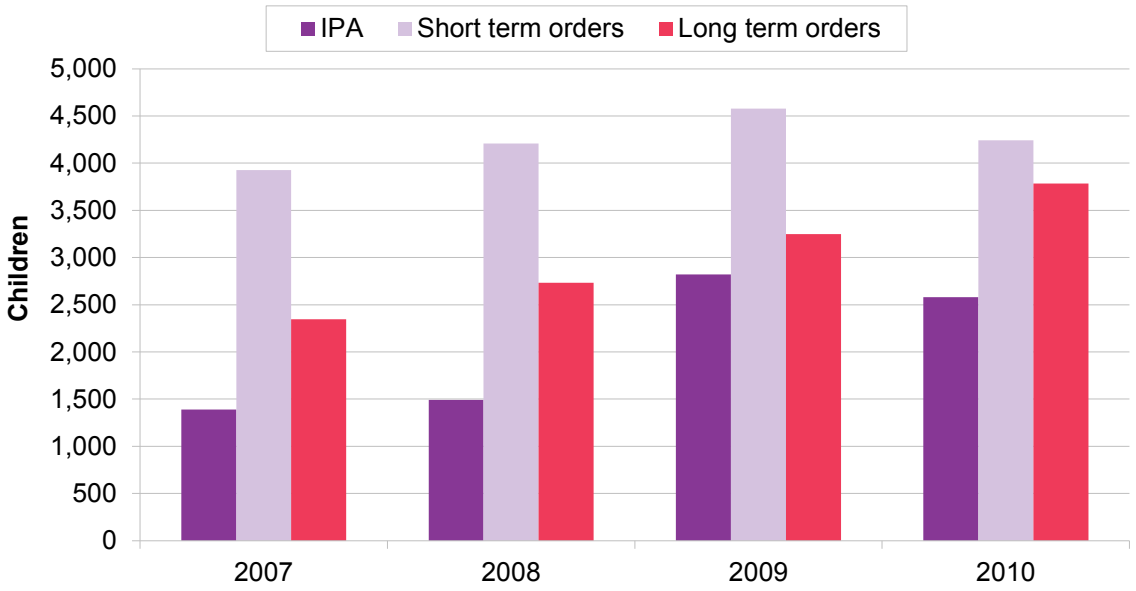
IPAs are designed to provide intensive support to families over a relatively short period (six months to one year) and children usually remain living in the home for most or all of the intervention period. No court orders are required as parents agree to the conditions of the IPA; however, where parents are unwilling to enter into an agreement, the department will seek court orders as officers are required to initiate ongoing intervention in all cases where children are assessed to be in need of protection (Practice Manual 4.1). As such, parents involved in IPAs have the ability to negotiate the nature of the intervention; however, engagement with the department remains compulsory.

Where an IPA is not appropriate, the department can seek a court order to undertake intervention. The court may grant directive or supervision orders where the child remains living at home while the family is supported, or the court may transfer custody or guardianship to the department to allow the child to be placed in out-of-home care.

When children and young people are placed in out-of-home care, reunification with family is the initial goal. In some cases, reunification will not be possible so a permanent out-of-home care solution is planned in parallel. If it becomes clear that reunification will not be possible, long-term orders that

remain in effect until the child turns 18 may be sought from the court. In some cases, guardianship may be retained by the chief executive and, in others, guardianship is transferred to a suitable carer. This is usually a family member, although guardianship can be transferred to a biologically unrelated carer with the support of the department.

Figure 6.8 Children subject to ongoing intervention at 30 June by intervention type, Queensland, 2007 to 2010

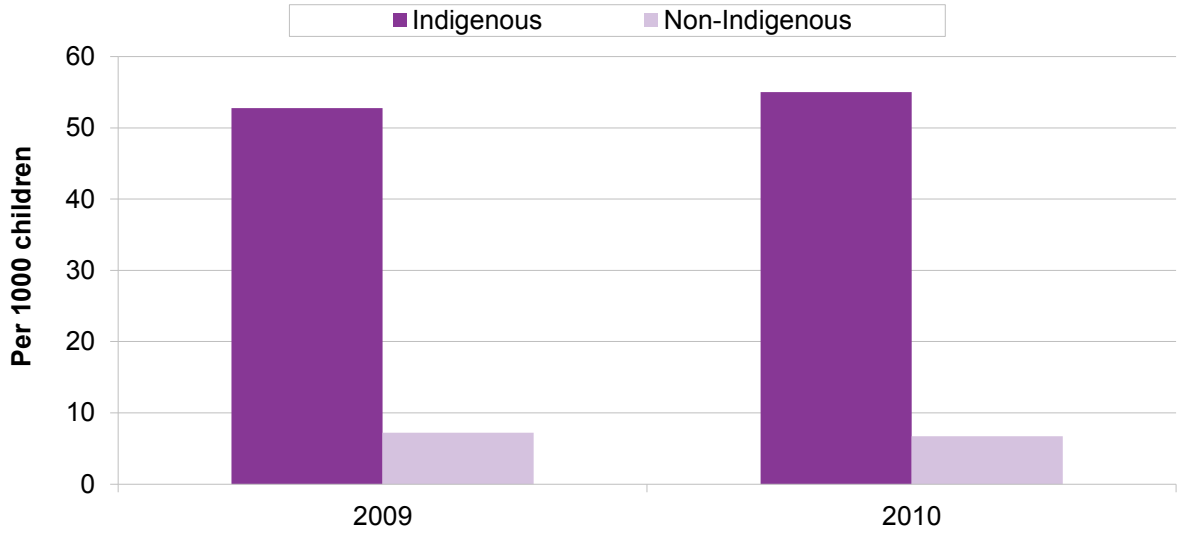


Note: For figures relating to 2007 and 2008 children subject to an IPA and a short or long term order are counted in both categories. From 2009, children are counted once as being subject to a short or long term order.

Source: Department of Communities, *Our Performance*

At 30 June 2010, 10,606 children and young people were engaged in ongoing intervention with the department which was roughly consistent with 2009 when 10,647 children and young people were engaged in ongoing intervention. Among all intervention types between 2007 and 2010, however, the strongest growth was in IPAs, increasing 85.7% from 1,389 in 2007 to 2,580 in 2010 and long-term orders up 61.3% from 2,346 in 2007 to 3,783 in 2010.

Figure 6.9 Children subject to ongoing intervention at 30 June, by Indigenous status, Queensland, 2009 to 2010



Source: Department of Communities, *Our Performance*

As at earlier stages of the child protection system, there is a considerable over-representation of Indigenous children engaged in ongoing intervention. The rate of Indigenous children engaged in ongoing intervention was 55.0 per 1,000 at 30 June 2010. The rate of non-Indigenous children engaged in ongoing intervention was considerably lower at 6.7 per 1,000 in 2010. At 30 June 2010 Indigenous children were 8.2 times more likely to be engaged in some form of ongoing intervention with the department than non-Indigenous children. This over-representation is more pronounced than at earlier stages of the child protection system (Indigenous children are 4.7 times more likely to be subject to a notification and 5.8 times more likely to be subject to a substantiation than other children).

Out-of-home care

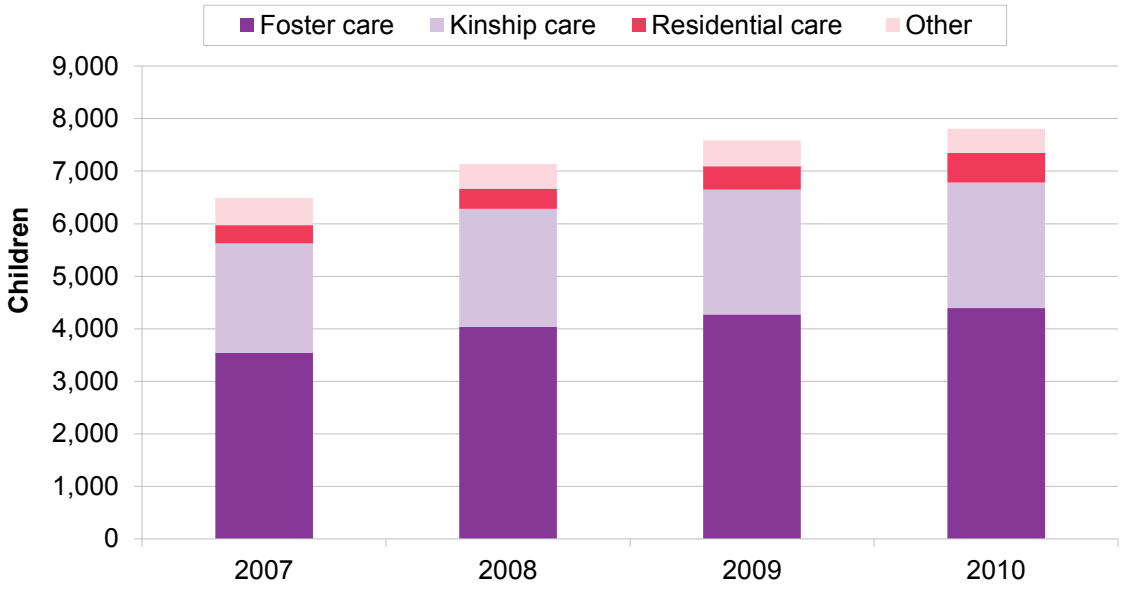
As described above, the department may take custody or guardianship of children, either by agreement or court order, and place the child in out-of-home care. This may be for a short period during the investigation and assessment stage, although is more likely in the ongoing intervention stage.

Children can be placed in a number of different care situations. Home-based care includes foster care, where children are placed with an unrelated family, and kinship care where children are placed with extended family. In both cases, carers must be approved by the department and receive some financial assistance to contribute towards costs of caring for the child.

Alternatively, children may be placed in a number of different residential care placements where children are cared for by paid support staff rather than in a carer's home. Residential placements are usually considered appropriate for young people aged 12 or older with complex or extreme needs or for sibling groups.

In addition, children in the care of the department may reside in other locations such as hospitals and youth detention for periods.

Figure 6.10 Children living away from home at 30 June by care type, Queensland, 2007 to 2010



Source: Department of Communities, *Our Performance*

The population of children in the department's care living away from home has grown over recent years. At 30 June 2007, 6,493 children were living away from home. Three years later, 20% more children were living away from home with a total of 7,809 on 30 June 2010. This growth, while considerable, was more modest than the growth in children engaged in ongoing intervention overall, which was up 38% over the same period. The most rapid growth was in children living in residential care, which increased 64% from 345 children at 30 June 2007 to 567 children in 2010.

Figure 6.11 Children living away from home at 30 June by Indigenous status, Queensland, 2007 to 2010

Source: Department of Communities, *Our Performance*

As described above, Indigenous children are more likely to be engaged in ongoing intervention than other children and they are even more likely to be living away from home. At 30 June 2010, 41.5

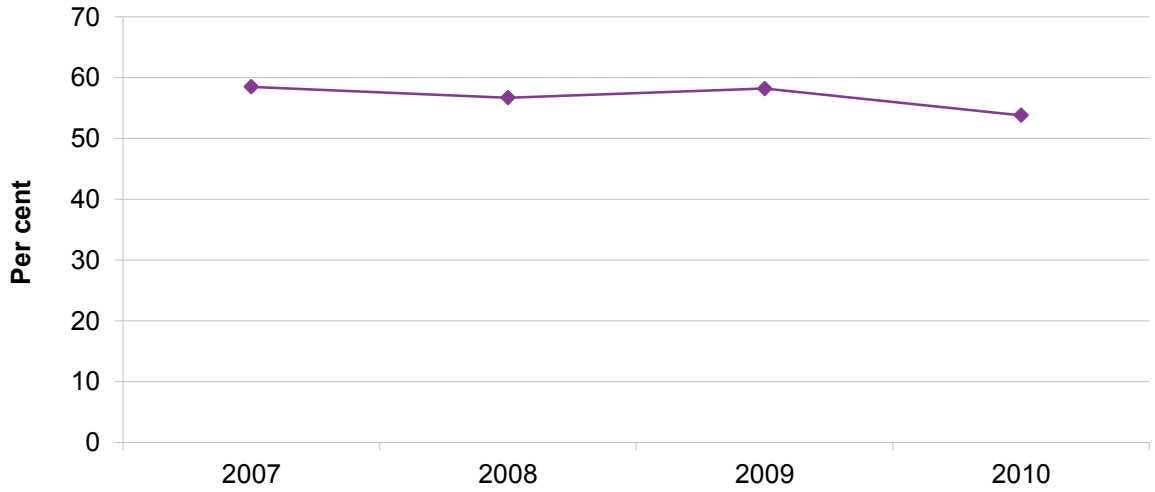
Indigenous children per 1,000 were living away from home compared to 4.9 per 1,000 non-Indigenous children. This equates to Indigenous children being 8.5 times more likely to be living away from home than non-Indigenous children. As with earlier stages of the child protection system, the over-representation of Indigenous children is steadily increasing over time. Since 2007, the rate of Indigenous children living away from home has risen by 44% while the rate for non-Indigenous children has remained stable.

In recognition of the importance of Indigenous children being able to remain connected to their culture, both for them as individuals and to support the transmission of Aboriginal and Torres Strait Islander culture and language, the *Child Protection Act 1999* operationalises the Indigenous Child Placement Principle through s83. Under this section, the department must give proper consideration to placing Indigenous children in the following order of priority. With:

- a member of the child's family
- a member of the child's community or language group
- another Aboriginal or Torres Strait Islander person who is compatible with the child's community or language group
- another Aboriginal or Torres Strait Islander person
- a non-Indigenous person who is willing and able to facilitate the child's ongoing connection to their community.

In addition, Recognised Entities, designed to provide input from the child's Aboriginal or Torres Strait Islander community, are to be consulted in placement decisions relating to Indigenous children.

Figure 6.12 Proportion of Indigenous children placed with kin, Indigenous carer or Indigenous residential care service at 30 June, Queensland, 2007 to 2010



Source: Department of Communities, *Our Performance*

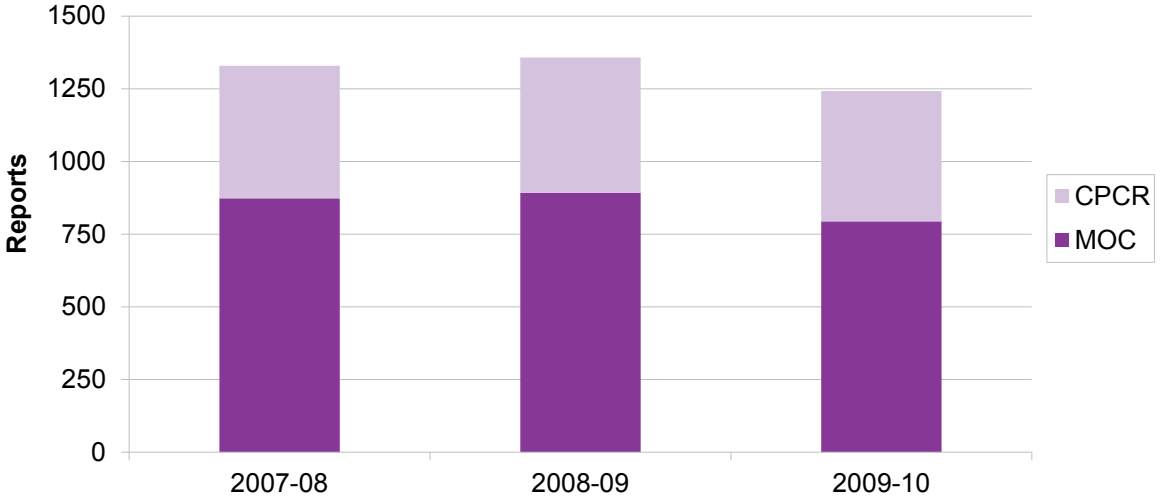
Figure 6.12 shows the proportion of Indigenous children in the types of placements generally preferred by the Act. These data reflect the outcomes of the ICPP rather than department's compliance with the mandated process. In 2010, 53.8% of Indigenous children were placed with kin, an Indigenous carer or Indigenous residential care service compared to 58.2% in 2009. The Commission's *Indigenous Child Placement Principle Audit 2010* will be released in late 2011. This audit aims to report on the department's compliance with s83 as well as identify, and make recommendations where necessary, to address areas for improvement to ensure maintained connection of Aboriginal and Torres Strait Islander children and young people in care to their family, community and culture.

Wellbeing of children in out-of-home care

The *Child Protection Act 1999* outlines standards of care, as well as a charter of rights that must be met for all children in the custody or guardianship of the department. These standards place a greater burden of responsibility on the department than simply ensuring that children are not subjected to or placed at risk of abuse and neglect. As such, the department has an investigation and assessment process specifically for children in care that allows the department to assess both allegations of suspected harm but also breaches of these standards. This process is separate and distinct from the process for investigating allegations of abuse and neglect in the general public.

Where concerns raised indicate that a child has been harmed or is at risk of harm under s10 of the Act (described above in more detail), and it is suspected the approved carer has provided inadequate care, a Matter of Concern (MoC) Notification is recorded. Where concerns suggest a breach of the standards of care without harming the child or placing the child at risk of harm as defined by s10, a Child Placement Concern Report (CPCR) is recorded.

Figure 6.13 Matters of Concern Notifications (MoCs) and Child Placement Concern Reports (CPCRs) received, Queensland, 2007-08 to 2009-10



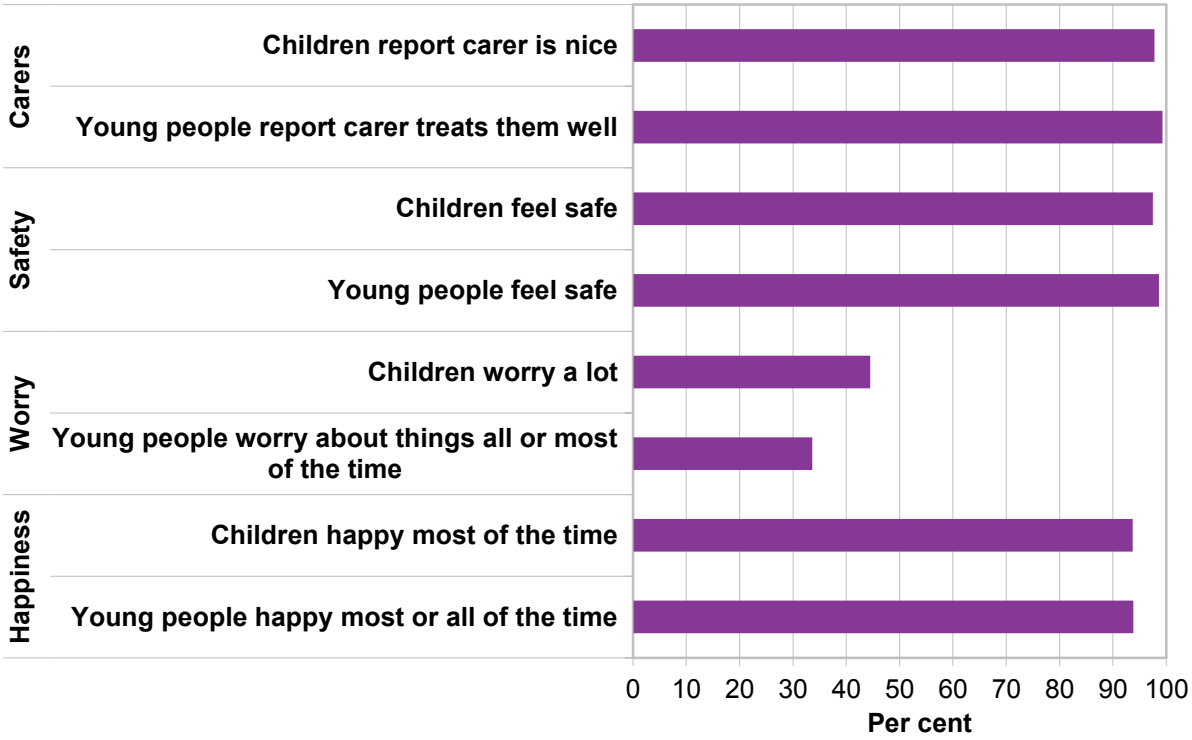
Source: Department of Communities, *Our Performance*

In 2009-10, there were 448 CPCRs relating to 425 children in out-of-home care, which was consistent with 2007-08 and 2008-09 when there were 456 and 466 CPCRs recorded respectively. MoCs, which made up the bulk of reports relating to children and young people in care, were down compared to the previous two years, with 794 MoCs in 2009-10 compared to the peak of 892 in 2008-09. This 11.0% drop is especially significant given the growth in the out-of-home care population over recent years.

Total numbers of MoCs substantiated are available from the department, however, data about the outcomes of CPCRs are not available. In 2009-10, 233 MoC Substantiations relating to 228 children were recorded which was consistent with the previous year when 238 MoC Substantiations relating to 230 children were recorded.

The Commission's *Views of Children and Young People in Foster Care 2010* and *Views of Young People in Residential Care 2009* also provide an important perspective on the wellbeing of children and young people in care. The most recent survey gathered the views of 2,727 children and young people living in foster care, while the survey of residential care included the views of an additional 169 young people.

Figure 6.14 Selected measures of subjective wellbeing for children and young people in foster care, Queensland, 2009



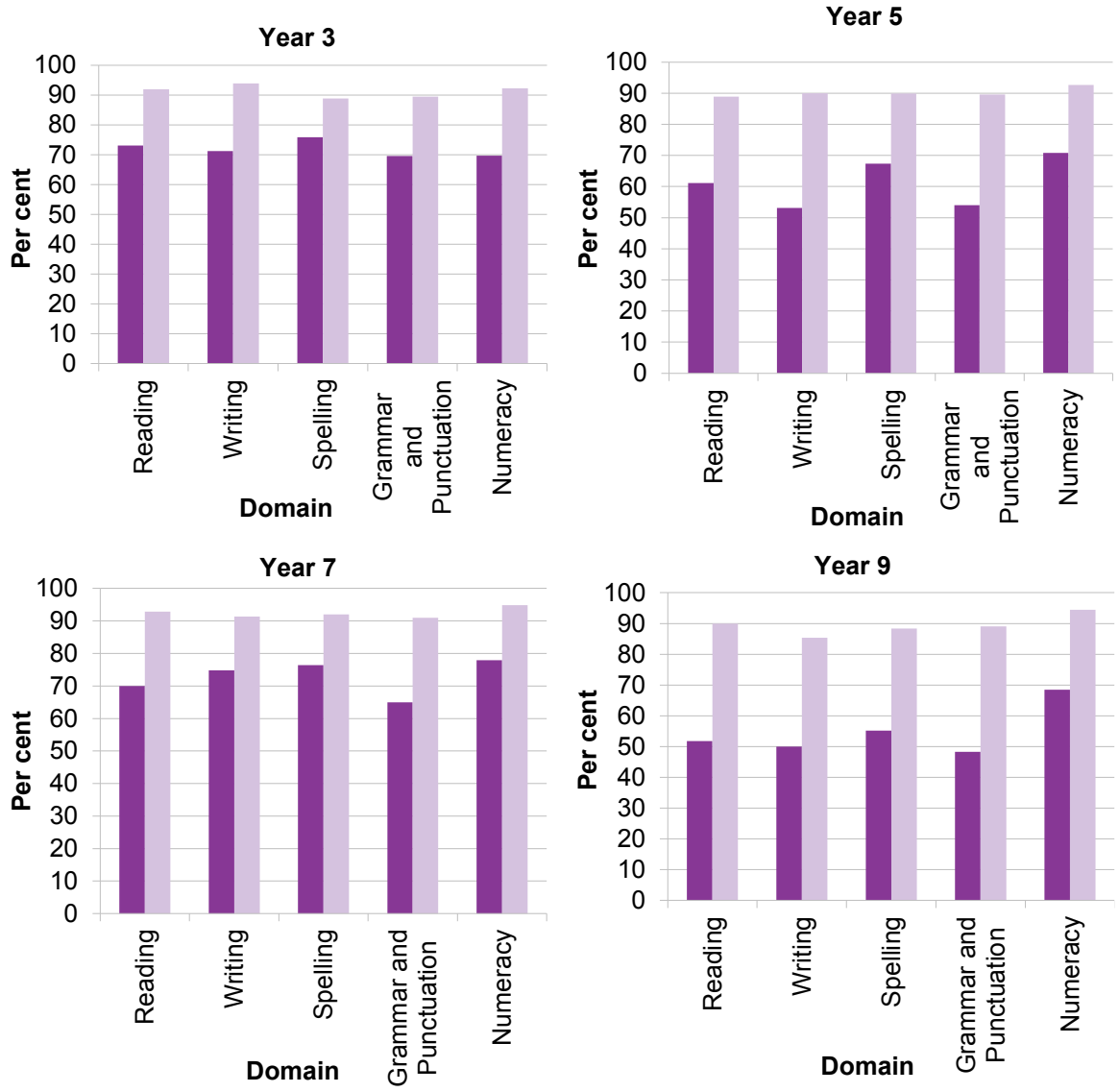
Source: Commission for Children and Young People and Child Guardian, *Views of Children and Young People in Foster Care Queensland 2010*

Data from the most recent survey of children and young people in home-based foster and kinship care indicate that, consistent with previous years, children and young people report a high level of satisfaction with their current carers. In addition, the vast majority of children and young people surveyed indicated that they felt safe in their current placement and young people (those aged approximately 9–18 years) gave an average of 8.8 out of 10 for their happiness in their current placement. Both children and young people indicated that they were happy at least most of the time, however, a substantial proportion (36.6%) of young people indicated that they worried about things most or all of the time and 44.5% of children indicated that they worried a lot.

The data also reveal that children and young people experience a number of difficulties while in care, including issues with obtaining permission to participate in activities. Just under one third (30.8%) indicated that permission is not often or never given in time to do things and 46.8% felt that the types of things that permission is required for are unreasonable, a sentiment echoed by 29.6% of the carers who responded on behalf of young children. Young people also indicated that while they felt listened to, particularly by their carers, almost half (47.3%) indicated that they rarely or never have a say in what happens to them.

Through a data matching process across agencies, it is possible to assess the proportions of children in out-of-home care reaching minimum benchmarks on NAPLAN tests compared to their peers throughout the state. More information about NAPLAN is available in the Education chapter.

Figure 6.15 Students achieving national minimum academic standards by child protection status, Queensland, 2009



Notes: Students exempt from testing are included in the proportions as students who were below the National Minimum Standard. Proportions exclude students who were absent or who withdrew from the tests.

Includes those children subject to a child protection order granting custody or guardianship to the Director-General for a minimum of two years at the time of the test. This includes children in care in both government and non-government schools.

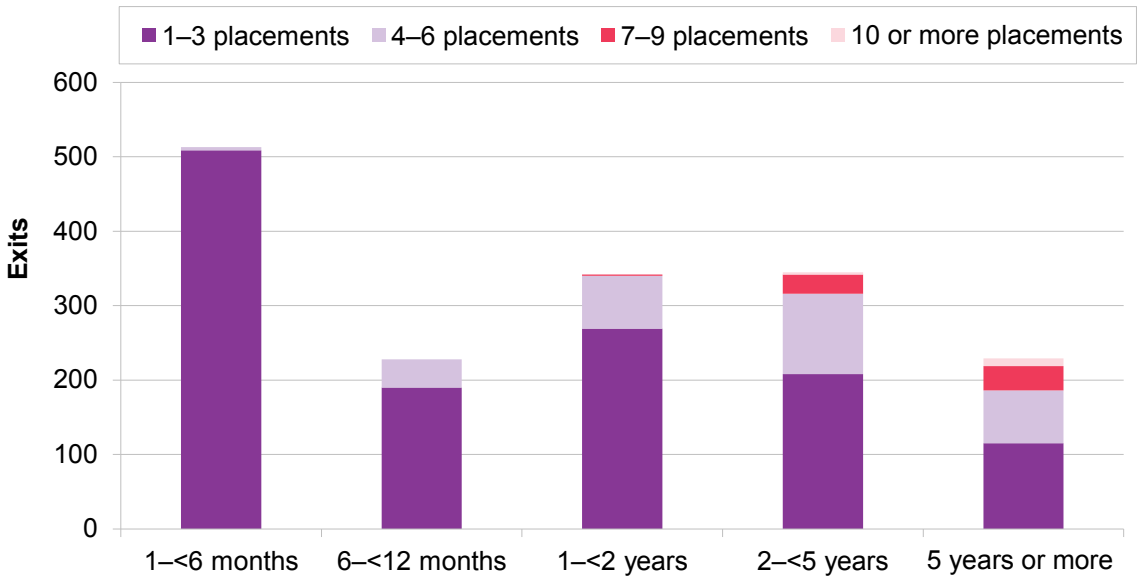
Source: Queensland Studies Authority, Department of Communities, Child Safety Services *2008-09 - Child Protection Partnerships Report*

The figures available relate to children and young people who have been in the care of the department for at least two years at the time they sat the NAPLAN tests. Across all year levels and all subject domains, these children and young people were less likely to reach the minimum benchmarks than their peers. The greatest discrepancies were seen in Year 9 writing (48.1% of children in out-of-home care reaching minimum benchmarks compared to 83.7% of Year 9 students overall), Year 9 grammar and punctuation (50.0% of children in out-of-home care compared to 88.1% of Year 9 students generally) and Year 5 reading (51.3% compared to 86.9%). Across all year levels, the gap between the proportions of children in out-of-home care reaching benchmarks and the proportions of their peers reaching benchmarks was smallest for numeracy (68.8% compared to 92.0% for Year 3 students, 65.8% compared to 90.4% for Year 5, 68.1% compared to 94.9% for Year 7 and 71.7% compared to 92.4% for Year 9).

Leaving care

Children are considered to have exited care when they are no longer in the custody or guardianship of the department. This may be because they have been reunified with their family, have transitioned to independence upon turning 18 or have had their care transferred to another jurisdiction (either through a federal court order or through a transfer to another state's jurisdiction). Even after children exit out-of-home care, the department may continue to engage the family in further ongoing intervention. In other cases, children and families will be engaged in a voluntary support service case or be referred to other agencies for assistance.

Figure 6.16 Children exiting care by length of time in care and number of placements, Queensland, 2009-10



Note: Counts all children who exited out-of-home care during the reference period. Exited care is defined as children who left out-of-home care in the reference period and did not return within two months. Children who exited out-of-home care more than once during the year are counted only once, irrespective of the number of times they exited.

Source: Department of Communities, *Our Performance*

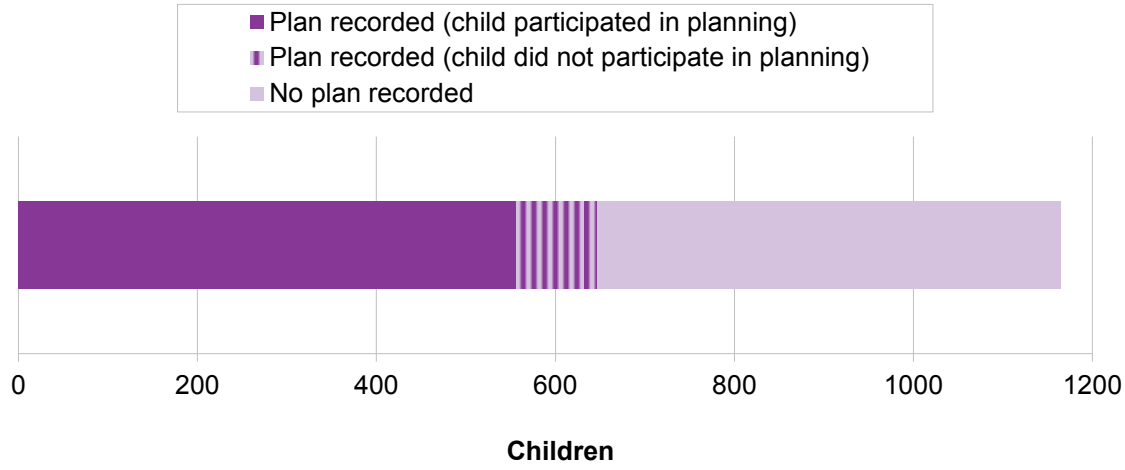
In 2009-10, 1,658 children exited care. Just under half (45%) of these children had been in care for less than one year at the time of their exit. Exits after more extended periods of care were less common, with children exiting after five or more years making up 14% of exits. This pattern was

largely consistent with previous years, although there was a slight increase in the proportion exiting after five or more years and a corresponding decline in the proportions exiting more quickly.

As in previous years, the majority (78%) of children who exited care in 2009-10 had had three or fewer placements. A sizeable minority had between four and six placements (18%) or between seven and nine placements (4%). A very small group of 13 children, all of whom had been in care for at least two years, experienced ten or more placements. The proportion of children exiting care with three or fewer placements was slightly lower in 2009-10 compared to previous years. This is to be expected given the larger proportion of children exiting care after more extended periods; however, it may also be indicative of poorer placement stability for children in care. More detailed data than are currently available is needed to properly assess the placement stability of children exiting care.

At 30 June 2010, 1,165 young people were aged between 15 and 17 and were on orders granting custody or guardianship to the chief executive. The department's current policy requires that all of these children should have a leaving care plan that prepares them for their transition to independence upon turning 18.

Figure 6.17 Proportion of 15–17 year olds subject to orders granting custody or guardianship to the chief executive with a transition from care plan at 30 June, Queensland, 2010



Source: Department of Communities, *Our Performance*

At 30 June 2010, 55.5% of young people aged 15–17 years had a transition from care plan recorded; however, 90 had not been involved in the development of their plan as required. Given this, 47.8% of young people preparing to transition from care had a plan in accordance with the departmental policy.

Outcomes for children and young people in the child protection system

The annual Child Guardian report series provides an assessment of the extent to which the child protection system is meeting the needs of children and young people reliant upon its services, as measured against 10 Key Outcome Indicators. The *Child Guardian Report – Child Protection System 2009-10* was published in late 2011. This report provides critical information to government and non-government service providers to assist in the development of policy and the design of programs that can affect improved services for individual children and young people.

Chapter 7:

Criminal justice system

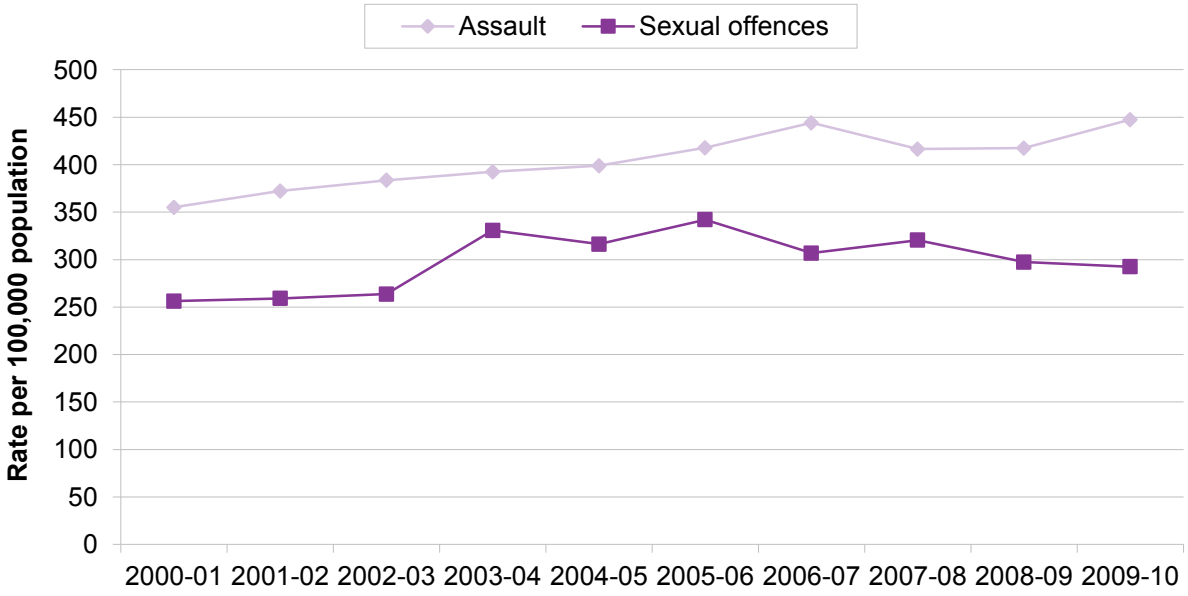
This chapter collates statistics on victimisation and youth offending sourced from several Australian Bureau of Statistics publications, including *Crime Victimisation, Australia* and *Prisoners in Australia*. These publications include Queensland Police Service data. Outcomes for youth offenders, including police action, youth justice conferencing and youth detention, are also discussed. *Snapshot 2011* contains in-depth information regarding young people in youth detention sourced from the Commission's most recent *Views of Young People in Detention Centres* survey. The issue of 17 year olds in adult prisons is also discussed.

Victims of crime

Official victimisation rates only include offences against the person (as opposed to property offences) reported to or coming to the attention of the police; however, analysis of reported crime figures can reveal trends in victimisation over time and identify groups within the population most at risk. As demonstrated in the recent Crime Victimisation Survey carried out by the ABS, personal offences are often not reported (Australian Bureau of Statistics, 2010b). It is estimated that just two-in-five physical assaults (41.1%) and robberies (42.2%) and one-in-five sexual assaults (21.4%) were reported to police in Queensland in 2008–09. The figures below are therefore not reflective of the total incidence of crime in the community.

In 2009-10, there were 9,619 offences against the person recorded in Queensland where the victim was aged 0–17. This equated to a rate of 8.9 per 1,000 young people (891.0 per 100,000). The bulk of these offences (83.0%) were assaults and sexual offences which were recorded at a rate of 447.4 per 100,000 young people and 292.4 per 100,000 young people respectively. Other less common offences included robbery (27.5 per 100,000) and kidnapping and abduction (9.4 per 100,000). Murder, attempted murder and manslaughter were rare, with recorded rates of 0.8, 0.9 and 0.2 per 100,000 respectively.

Figure 7.1 Victims of assault and sexual offences aged 0–17 years (per 100,000), Queensland, 2000-01 to 2009-10



Source: Analysis based on Queensland Police Service data and estimated resident population (ABS cat. no. 3201.0)

Rates of assault and sexual offences, which combined comprise over four-fifths of the recorded offences against victims aged 0–17 years, were both higher in recent years compared to a decade ago. Assaults, which have risen since 2000-01, increased 26% from 355.0 per 100,000 in 2000-01 to 447.4 per 100,000 in 2009-10. While victimisation of sexual offences was also higher in 2009-10 when compared with rates in 2000-01 (256.2 per 100,000 in 2000-01 to 292.4 per 100,000 in 2009-10), the rate in 2009-10 was the lowest it has been since 2002-03.

Figure 7.2 Victims of assault and sexual offences aged 0–17 years (per 100,000) by age and gender, Queensland, 2009–10

Source: Analysis based on Queensland Police Service data and estimated resident population (ABS cat. no. 3201.0)

When victimisation rates of assaults and sexual offences are disaggregated by age and gender very clear and consistent patterns emerge. Older children of both genders are more likely to be recorded as victims. Females are more likely to be recorded as victims overall due to their over-representation as victims of sexual assault. Males are more likely to be recorded as the victims of assaults. For both males and females, assaults become more common with age, while victimisation of sexual offences peak in the 10–14 years age bracket.

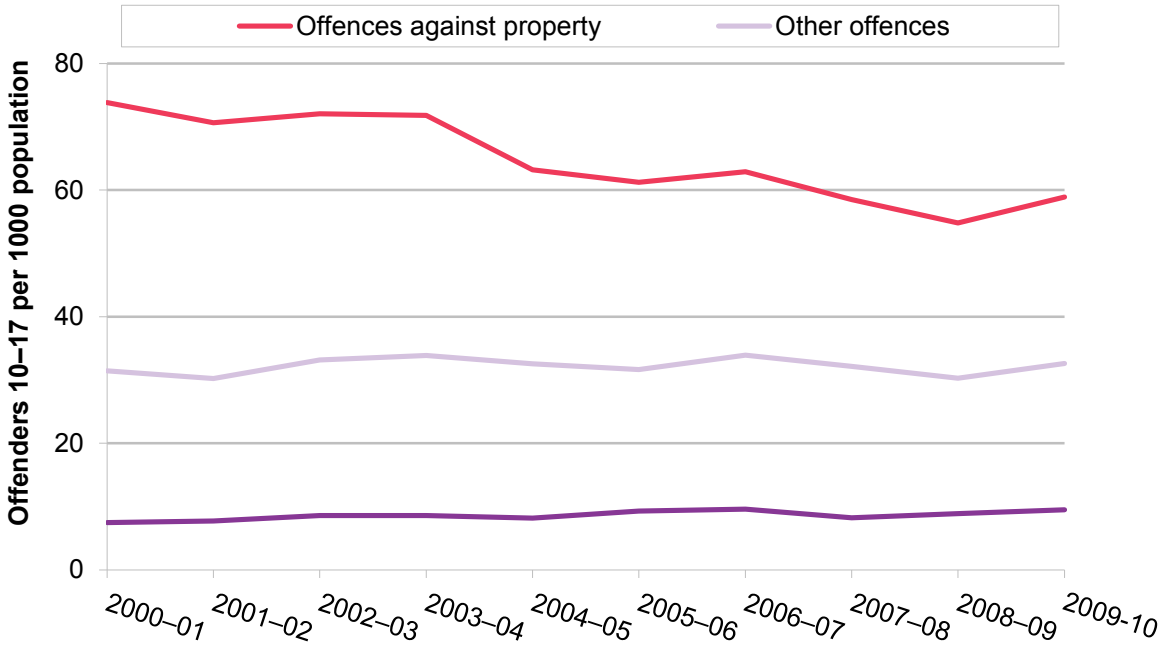
Offending patterns

Offender information from police statistics is based on reported offences which have been cleared and for which an offender has been identified. In the Queensland criminal justice system, children under the age of 10 are not held criminally responsible for offences. Statistics relate to offences rather than to distinct offenders. As such, the number of offences recorded will exceed the number of distinct offenders.

Offences are divided into three major categories:

- offences against property, including theft, unlawful entry and property damage
- offences against the person, including assaults, sexual offences and robbery, and
- other offences, including good order offences and drug offences.

Figure 7.3 Offences by 10–17 year olds (per 1,000) by offence type, Queensland, 2000–01 to 2009–10



Source: Analysis based on Queensland Police Service data and estimated resident population (ABS cat. no. 3201.0)

Property offences have consistently been the most commonly committed by 10–17 year olds. Notwithstanding a rise in 2009-10, property offences committed by young people have generally declined over the last decade. The offending rate for offences against the person and for other offences (including drug offences, trespassing and good order offences) have remained relatively stable with the rates for 2009-10 9.5 per 1,000 and 32.6 per 1,000 respectively.

Figure 7.4 Offences by 10–17 year olds (per 1,000) by age and gender of offender and offence type, Queensland, 2009–10

Source: Analysis based on Queensland Police Service data and estimated resident population (ABS cat. no. 3201.0)

As with victimisation rates, offending rates are clearly patterned by age and gender. Males are more likely to be recorded as an offender across all age categories and offence types. For males, property offences and offences against the person were relatively consistent amongst young people aged 15–17 years, while recorded female offending was highest amongst 15 year olds and consistent for 16 and 17 year olds. Other offences, including good order offences and drug offences, show a different pattern with offending steadily increasing with age such that they outnumber property offences among 17 year olds.

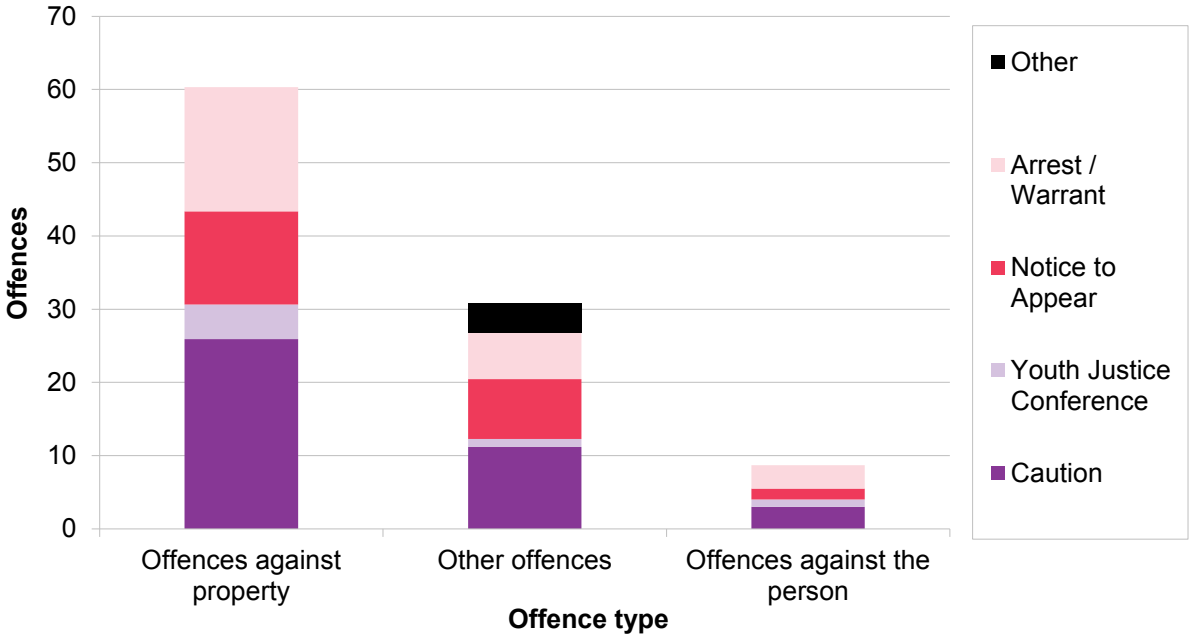
Outcomes for offenders and alleged offenders aged 10-16

This section focuses on offences committed by 10–16 year olds dealt with under the *Juvenile Justice Act 1992*. It excludes young people aged 17 who commit offences, as they are treated as adults under the Criminal Code in Queensland, but it may include 17 year olds dealt with for offences committed before they reached 17.

Police action

Police officers are obliged to consider diversionary measures (such as taking no action, formal caution, and referral to youth justice conferencing) before taking further action. Considerations that can influence the implementation of diversionary measures include the type and severity of the offence and the offender's prior history.

Figure 7.5 Recorded offending by young people aged 10–16 years by offence type and police action, Queensland, 2009-10



Source: Analysis based on Queensland Police Service data

Police issued cautions for more than two-fifths (40.1%) of offences committed by juveniles in 2009-10. The proportion of each offence type resulting in a caution ranged between 33.3% for offences against the person to 42.8% for property offences. An additional 6.7% of offences were diverted to youth justice conferences with offences against the person most likely to result in a youth justice conference (10.8% of offences against the person). Around one-quarter of offences resulted in a notice to appear (22.5%) and a similar proportion (26.4%) resulted in an arrest or warrant. Offences against the person were more likely to result in an arrest than other offence types (35.2% of offences against the person resulted in an arrest).

Conferencing

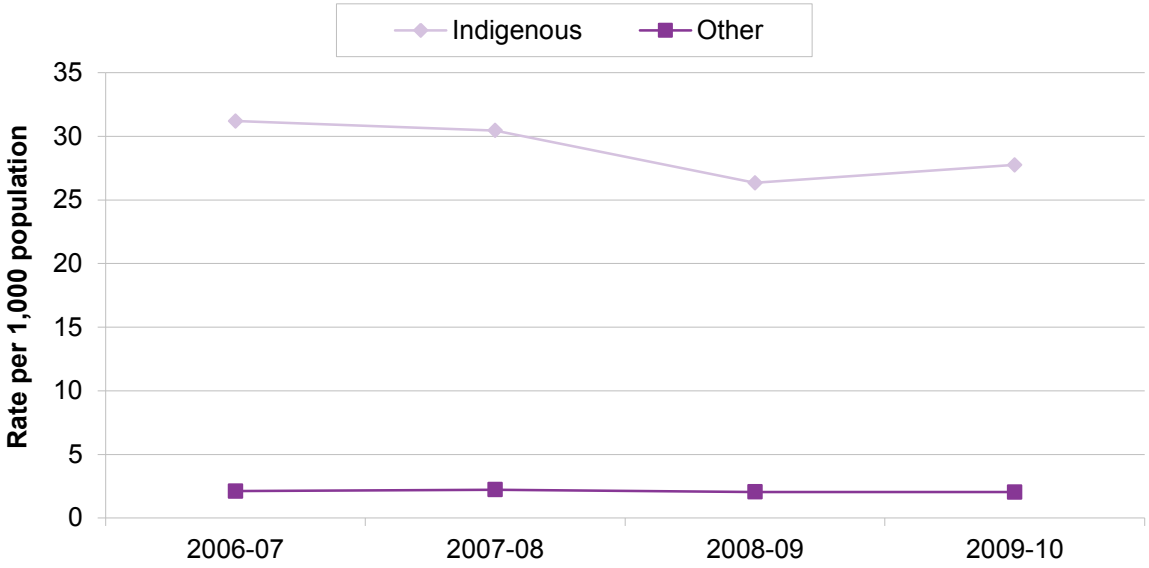
Youth justice conferences were introduced in Queensland in 1996, offering an alternative to court proceedings by allowing the victim and offender to discuss the offence and negotiate an agreement about how the offender can make amends. In 2009–10, there were 2,513 referrals conferenced, a decrease of 4.6% from 2008–09 (Childrens Court of Queensland, 2010). Police diversionary referrals (included in Figure 7.5) made up almost one-half (48.0%) of youth justice conferences in 2009–10, with the balance being referred from the courts. In 96% of conferences, the parties reached an agreement.

Supervision orders

Supervised justice orders in Queensland include probation, community service, intensive supervision, conditional release, detention and supervised release orders. At 30 June 2010, there were 1,531 distinct young people subject to supervised youth justice orders in Queensland. The majority of young people under supervision were on probation (60.3%) and over one-third (31.4%) were subject to community service orders. Smaller proportions were subject to intensive supervision (0.2%),

conditional release (3.0%), supervised release (2.5%) and other forms of community-based detention (3.3%).

Figure 7.6 Distinct young people subject to supervised youth justice orders as at 30 June (per 1,000 young people aged 10-16 years) by Indigenous status, Queensland, 2006-07 to 2009-10



Note: Other includes non-Indigenous, unknown and not stated
Data is a count of young people within supervised youth justice order types. If a young person is on more than one type of order they are counted once for each type.

Source: Department of Communities (unpublished data)

At 30 June 2010, the rate of Indigenous young people subject to supervised youth justice orders was 27.8 per 1,000 young people aged 10–16 years. This was more than 13 times the rate for non-Indigenous young people, which was 2.0 per 1,000 young people. Over the last four years, the rate for non-Indigenous young people has remained stable between 2.0 and 2.2 per 1,000 young people aged 10-16 years. The rates for Indigenous young people have declined somewhat, from 31.2 per 1,000 young people at 30 June 2007, although the over-representation of Aboriginal and Torres Strait Islander young people has remained pronounced.

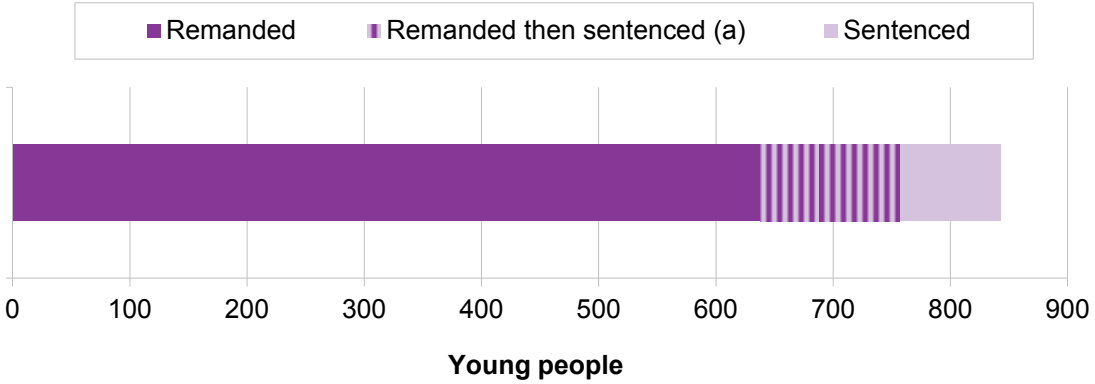
Youth detention

There are two youth detention centres in Queensland operated by the Department of Communities which is responsible for administration of the *Youth Justice Act 1992*. The Brisbane Youth Detention Centre has a built capacity for 118 young people and accommodates males from Rockhampton south and females from across the state. The Cleveland Youth Detention Centre, which is located in Townsville, has a built capacity of 48 (an interim capacity of 60) and accommodates males from north of Rockhampton.

A variety of programs and supports are available within each of the detention centres and these are delivered by the Department of Communities in conjunction with government and non-government partners, such as Queensland Health and the Department of Education and Training. The Department of Education and Training also provides a specialised education and vocational training program that young people participate in during normal school hours.

Young people may be sentenced to detention after pleading or being found guilty of an offence or alternatively, they may be remanded to detention while court processes are finalised.

Figure 7.7 Distinct young people in Queensland youth detention centres at any time during the year by legal status, Queensland, 2009-10



Note: Counts distinct young people who were in detention at any time during the year, including those admitted to detention prior to the reference period, who were still in detention at the commencement of the reference period. Excludes young people in watchhouses.
Legal status is derived from the episode in detention that was current at 30 June 2010. If a young person had exited detention prior to 30 June 2010, legal status is derived from the most recently ended episode in detention prior to 30 June 2010.

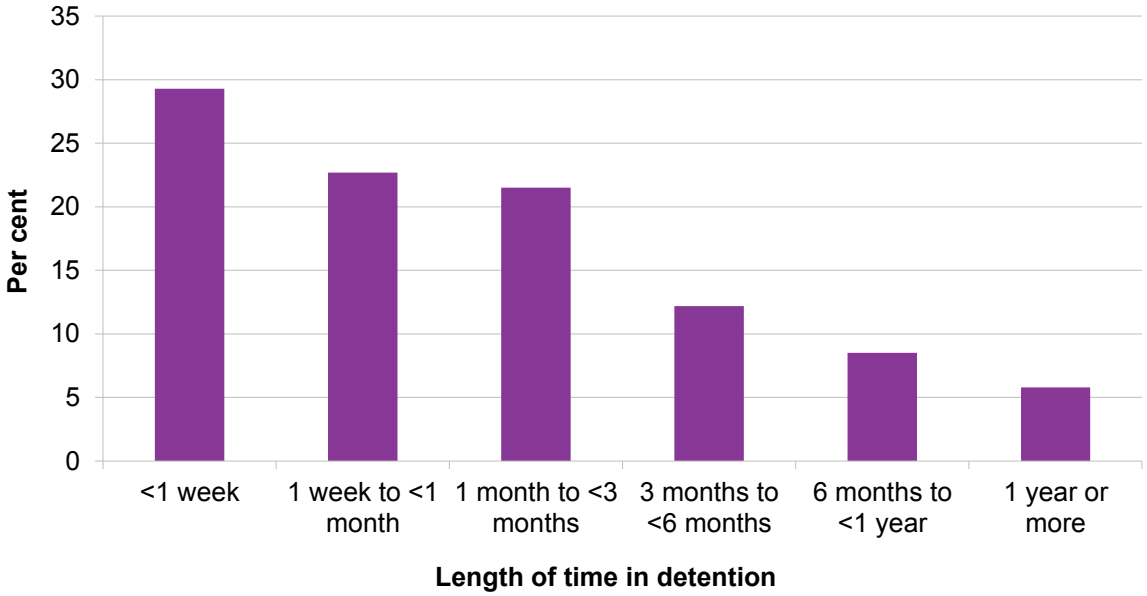
a. Refers to a continuous period in detention where the young person was initially remanded in custody and later sentenced.

Source: Department of Communities (unpublished data)

Data provided by the Department of Communities shows that at any time over the course of 2009-10, 843 distinct young people aged 10–16 years were in youth detention centres in Queensland. As shown above, the vast majority (757 or 89.8%) of these young people were held on remand, including 119 young people who were subsequently sentenced to a period of detention. In total, 205 young people (24.3% of those detained in 2009-10) were sentenced to a period of detention.

Males were more likely to be detained making up 84.1% of those spending time in detention in 2009-10. Indigenous young people were also strongly over-represented, making up 53.0% of those spending time in detention. While children can be remanded or sentenced to detention from the age of 10, detention of children this age is relatively uncommon. In 2009-10, only one child aged 10 years spent time in detention. The vast majority (90.4%) of young people spending time in detention were aged 14 or older.

Figure 7.8 Distinct young people in youth detention centres at any time during the year by length of time in detention, Queensland, 2009-10

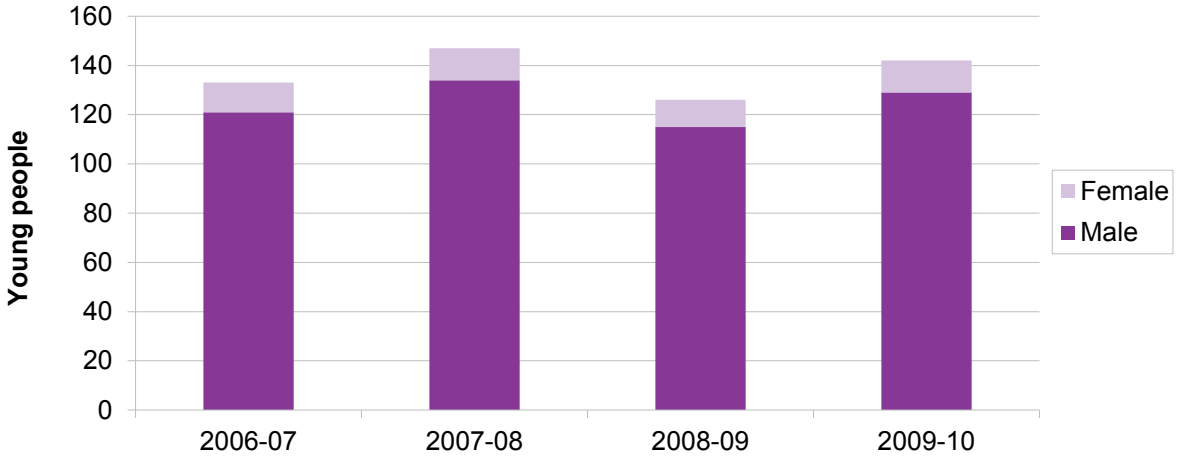


Note: Excludes young people in watchhouses. Length of time in detention is calculated as the time between the 30 June 2010 (or the young person's most recent exit from detention if they were not in detention at 30 June 2010) and the young person's most recent entry to detention. An exit and re-entry on the same day is not counted as a break.

Source: Department of Communities (unpublished data)

In 2009-10, almost one third (29.3%) of the young people in detention over the year were detained for less than a week. Of the 843 distinct young people who spent time in detention in 2009-10, only around one in twenty (5.8%) were there for a year or longer. This relative concentration of young people spending short periods of time is reflective of the large proportions of young people being held on remand. While over 800 young people were held in detention during the year, because the majority stay for only short periods, the population of young people in detention at any given time is much smaller. As young people enter and leave detention throughout the year, the population also tends to fluctuate. For this reason, an average daily number of young people in detention over the year is used to measure the size of the detained population. The average daily number is sensitive to the number of young people admitted to detention over the course of the year, as well as the length of time they remain in detention.

Figure 7.9 Average daily number of young people in detention by gender, Queensland, 2006-07 to 2009-10

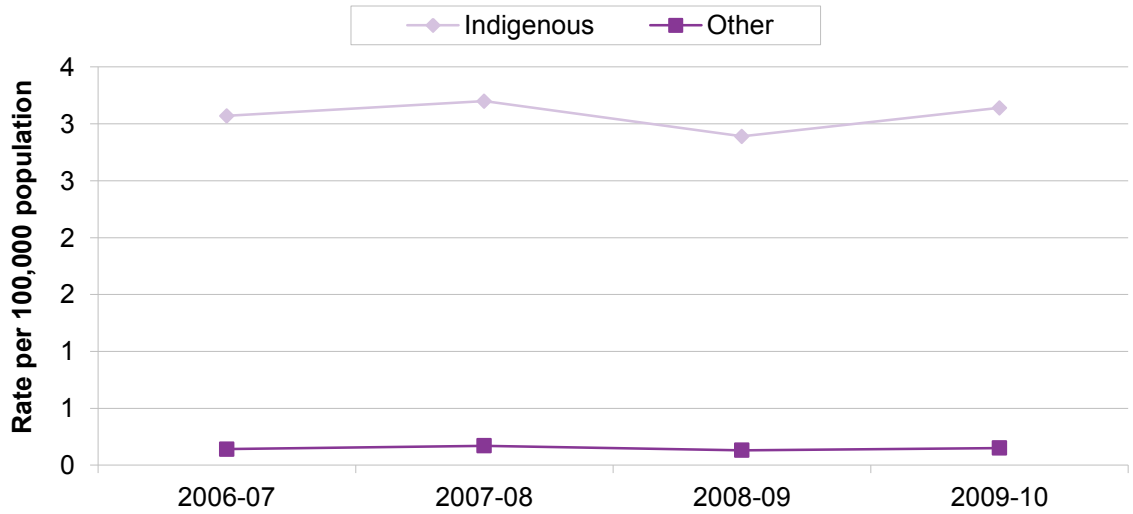


Note: Excludes young people in watchhouses.
Average daily number in detention is calculated by averaging the total number of persons in detention on all days in the reference period.

Source: Department of Communities (unpublished data)

Average daily numbers of young people have fluctuated somewhat over recent years but have remained broadly consistent. In 2009-10, there were, on average, 142 young people in detention each day. This was an increase from 2008-09 when the average was 127, but still slightly below the 2007-08 average of 147. The average number of females in detention each day in 2009-10 was 13. For males, the average was 129 meaning males were approximately 10 times as likely to be in detention on any given day when compared to females.

Figure 7.10 Average daily number of young people in detention (per 1,000 aged 10–16 years) by Indigenous status, Queensland, 2006-07 to 2009-10



Note: Other includes non-Indigenous, unknown and not stated
Calculated using the average daily number of young people in detention, divided by the estimated population of 10 to 16 year olds in Queensland at the start of the period.

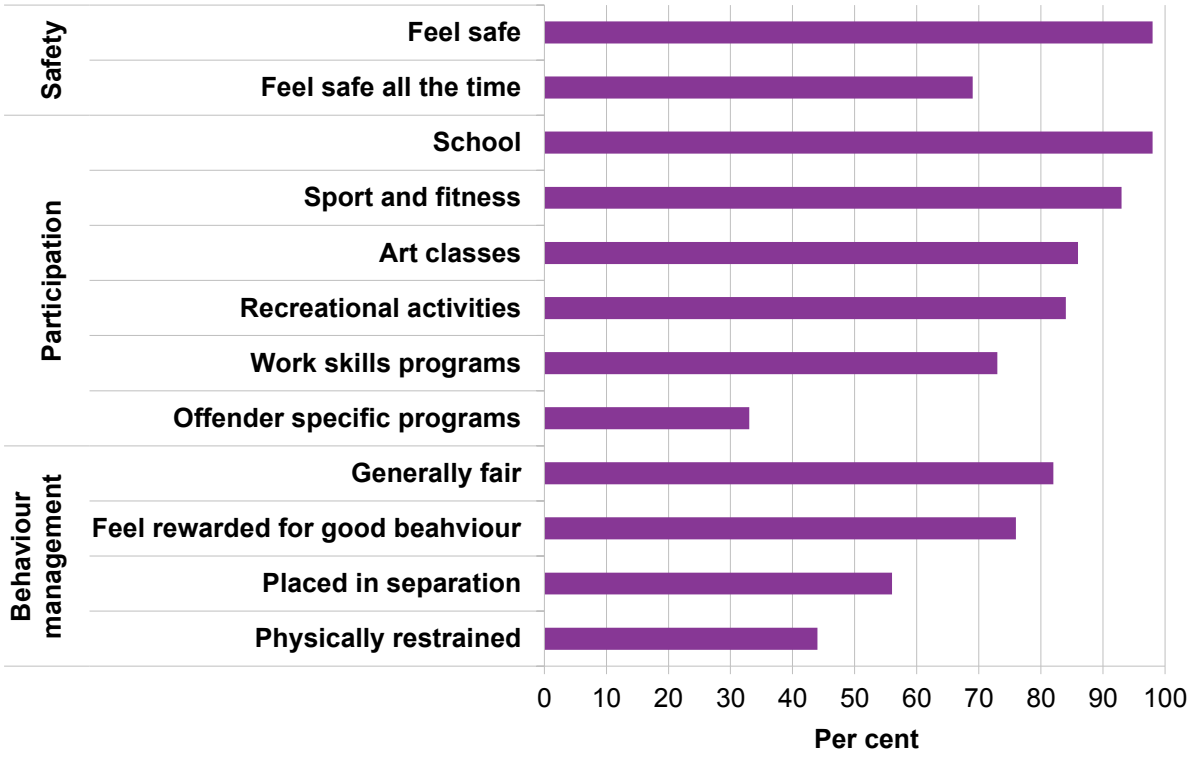
Source: Department of Communities (unpublished data)

The vast over-representation of Aboriginal and Torres Strait Islander young people in detention is evident in the average daily counts with Indigenous young people detained at a rate of 3.14 per 1,000 compared to 0.15 per 1,000 for non-Indigenous young people. On a given day in 2009-10, Indigenous young people were almost 21 times more likely to be in detention than non-Indigenous young people. These rates and the large disparities between them have remained relatively consistent over recent years.

The Commission has a special role in relation to young people in detention. Through its Community Visitor Program, the Commission regularly visits detention centres to assess and report on the quality of care and living conditions provided, as well as the safety and wellbeing of the young people living in detention. Community Visitors are able to facilitate local resolution to issues identified during visits and also provide reports and information to inform the Commission's advocacy on a broader systemic level.

The *Views of Young People in Detention Centres* survey is an important part of this monitoring and advocacy work. The survey is administered by the Commission's Community Visitors and research staff in conjunction with the centres' teaching staff and youth workers on a biennial basis. The findings of the most recent survey, released in October 2011, are based on the responses of 109 young people, representing 92% of the detention population on the days the survey was administered. The survey was comprised of 87 questions covering ten domains of young peoples' experiences of detention ranging across their admission to detention, the care and support they receive while in detention and their planning for transition back into the community. Selected responses in relation to feelings of safety, participation in programs while in detention and behaviour management are presented below.

Figure 7.11 Selected responses from the Views of Young People in Detention Centres 2011



Source: *Views of Children and Young People in Detention Centres Queensland 2011*

In the most recent survey, 98% of respondents indicated that they felt safe and 69% indicated feeling safe all of the time. Young people in detention participated in a variety of programs. Almost all (98%) of young people were participating in school at the time of the survey and significant proportions were participating in sport and fitness (93%), art classes (86%), recreational activities (84%) and work skills programs (73%). Only 33% were participating in offender specific programs. Young people reported that they thought the behaviour management in the centres was generally fair (82%); however, only three-quarters (76%) reported that they felt rewarded for good behaviour. Of some concern, around one in seven young people reported hearing staff say something they found offensive or hurtful, including claims of derogatory language being used by some youth workers. Also of concern, over half of respondents (56%) reported being placed in some form of separation while in detention and just under half (44%) reported being physically restrained.

Young people were asked to rate their satisfaction with the quality of care they received overall. The median score was 8 out of 10 with 49% rating the quality of care 9 or 10 out of 10.

17 year olds in adult prisons

Queensland is the only state or territory that treats 17 year olds as adults in the criminal justice system and detains them in adult prisons. This is a clear contravention of the United Nations Convention on the Rights of the Child to which Australia is a signatory. Young people held in adult prisons do not have access to the same educational opportunities as young people detained in youth detention centres, nor do they have access to the same support services.

The Commission continues to advocate for the transfer of 17 year old offenders from adult prisons to youth detention centres, and their treatment in accordance with the provisions of the *Youth Justice Act 1992*, to improve their access to developmentally appropriate services and their prospects for rehabilitation. In a policy position paper *Seventeen Year Olds in Queensland's Adult Prisons*, the Commission calls for all young offenders under the age of 18 years to be dealt with in a way that promotes their rights, safety, physical and mental wellbeing and ultimately, their responsible, beneficial and socially acceptable development.

Positive action, beginning with a clear commitment and timeframe from the Queensland Government, is necessary to remove 17 year olds from adult prisons. It is proposed that transferring all 17 year olds from adult prisons into youth detention is the crucial first step but it is not the complete solution. More detailed exploration must be undertaken to determine the most effective way for 17 year olds to be transferred to the youth justice system as part of a continuum of interventions and supports that address risk factors for children and young people across the years of their development.

At 30 June 2010, there were 35 seventeen year olds (32 males, 3 females) being held in adult prisons in Queensland (Australian Bureau of Statistics, 2010c).

Future directions

Snapshot 2011 contains data derived from a range of sources which converge to provide a contemporary point-in-time representation of the health, safety and wellbeing of children and young people in Queensland.

The *Snapshot* series is continually evolving with the inclusion of emerging indicators when new data collections become available. By reporting annually, improvements and areas that require attention can be identified. This information can be used by policy makers and service providers to promote and protect the rights and interests of all children in Queensland.

The Commission plays a lead role in advocating for positive change for children and young people in Queensland, and partners with government and community service providers to manage the risks to children and young people in regulated service environments.

In 2011-12, the Commission will continue its legislated responsibility to promote, protect and uphold the rights, interests and wellbeing of children and young people across Queensland, particularly those who are most vulnerable, through a range of programs and initiatives.

National Framework for Protecting Australia's Children

The National Framework for Protecting Australia's Children aims to improve the safety and wellbeing of Australia's children. The Commission has been actively involved in the framework at all stages of its development. In 2010-11, the Commission:

- provided advice to consultants engaged by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) on the early development stage of a proposed national survey of children and young people in out-of-home care
- provided advice to the Australian Institute of Family Studies based on the Commission's research and advocacy work, and assisted in shaping the development of the national survey
- appeared before the Senate Legal and Constitutional Affairs Legislation Committee as a representative of the Australian Children's Commissioners and Guardians on the Inquiry into the Commonwealth Commissioner for Children and Young People Bill 2010, and
- conducted the national survey of peak organisations, on behalf FaHCSIA, to determine the extent of movement of volunteers and workers between jurisdictions, and developed a report to further consider ways to enhance national consistency in Working with Children Checks.

In 2011-12, the Commission will continue to:

- consult with the Senate Legal and Constitutional Affairs Legislation Committee to explore the potential role for a national Commissioner for Children and Young People
- participate in the national Working with Children Checks sub-working group
- provide feedback on the National Research Agenda for Protecting Children 2011-2014
- provide advice on monitoring the implementation of the *National Standards for Out of Home Care*, and
- research young people's experience of transitioning from care to independent living by working with stakeholders to develop a leaving care study.

Commission Community Visitors

The Commission's Community Visitors independently monitor the safety and wellbeing of children and young people living in foster homes, residential and respite facilities, supported accommodation, youth detention centres, mental health facilities and boarding schools throughout Queensland, through a program of regular and frequent visits to these potentially vulnerable individuals.

The unique information gathered by Community Visitors assists service providers and other stakeholders to understand the perspectives of children and young people in these facilities, and how systems, policies and practices translate into tangible outcomes and contribute to creating a robust evidence base for systemic improvement.

During 2010-11, over 7,600 children and young people were visited in foster homes, residential services, mental health facilities and detention centres. The information gathered through these visits has helped to generate early alerts for the Commission on service delivery issues affecting children and young people, and to inform the Commission's advocacy with service providers.

In 2011-12, the Commission will continue to independently verify the safety and wellbeing of children and young people in statutory care services by engaging with them directly through regular visits from Community Visitors. The Commission will maintain its flexible, risk management based approach to

the Community Visitor program, which allows for better-targeted visits and more effective responses to the issues raised by children and young people. This flexibility will ensure the program continues to evolve, change and operate effectively and dynamically, and enable the Commission to meet its statutory functions in monitoring and improving outcomes for children and young people in care.

Complaints and investigations

The Commission has a legislative responsibility to receive, investigate and assist in resolving complaints about services provided to children and young people in the child safety and youth justice systems in Queensland. In 2010-11, the Commission's Complaints team resolved 4,699 issues, including serious or complex matters at times.

In 2010-11, the Commission also finalised six formal investigation and review activities resulting in 52 recommendations made to the Department of Communities, Queensland Health, the Department of Education and Training and the QPS. Key recommendations for practices, policies, and procedures arising from these investigations and reviews included improving processes for inter-agency information sharing and collaboration and enhancement of policies and procedures for officers working with Aboriginal and Torres Strait Islander children and young people in the child protection system. The Commission will monitor the implementation of these recommendations in 2011-12.

The Commission will also continue to promote engagement with children by further raising awareness of the Commission's complaints function among government and non-government service providers.

Giving a voice to children and young people in the child protection and youth justice systems

Views of Children and Young People Surveys

The Commission listens to and considers the concerns and views of children and young people, particularly those who are most vulnerable. One way the Commission does this is to conduct regular surveys of children and young people in foster, kinship and residential care and in detention centres.

The *Views of Young People in Residential Care 2012* survey will present the experiences and identified needs of young people living in residential care facilities in Queensland. This survey constitutes a recurrent component of the Commission's strategy to engage with vulnerable young people.

In 2010-11, the Commission undertook a review of this survey in consultation with a range of stakeholders in the residential care sector. This review has led the Commission to make some changes to strengthen the survey and better inform current practice and policy. Importantly, the revised survey will gather information to help monitor the implementation of the Department of Communities' and Peak Care's new practice model for statutory residential care in Queensland – the 2010 Contemporary Model of Residential Care for Children and Young People in Care.

The *Views of Children and Young People in Foster Care 2012* survey will capture the views and experiences of children and young people living in foster and kinship care in Queensland. Topics to be covered include young people's views about their safety; health and wellbeing; education; placement history and stability; participation in decision-making; contact with family and community; and support and advocacy.

These surveys will continue to provide an important perspective on the effectiveness of Queensland's child protection system; help identify issues in relation to young people's safety, wellbeing and rights and inform child protection policy and practice decisions.

The *Views of Young People in Detention Centres 2011*, published in late 2011, captures the experiences and needs of young people living in youth detention centres in Queensland. This survey is an integral part of the Commission's monitoring activities in youth detention centres, and assists the Commission to engage with a particularly marginalised group, facilitating a better understanding of their needs and the determinants of their safety and wellbeing.

The survey covers ten content areas: admission to detention; basic entitlements and self-expression' family and community contact; interactions with staff; education and other programming; health care; behaviour management; complaints and advocacy; legal matters; and transition planning and aftercare.

The results of the most recent survey will be used in 2011-12 to help set priorities for the Commission's monitoring activities, such as investigations, reviews and audits, and to inform the development of policy, practices and interventions for young people leaving detention and at risk of entering detention. The Commission will also commence work on its fourth survey of young people in detention centres, to be published in 2013.

Monitoring and reporting on the child protection and youth justice systems

Child Guardian Report – Child Protection System

The Commission's annual *Child Guardian Report – Child Protection System* provides an independent and objective analysis of the extent to which the Queensland child protection system meets the needs of children and young people reliant upon its services. The report utilises a broad evidence base from multiple data sources, including the perspective of the children and young people who receive services, to evaluate the system under a number of key outcomes. These outcomes include effective assessment; appropriate intervention; safe and stable care; best education and health possible; individual needs met; and successful reunifications and transitions from care.

The Child Guardian Report: Child Protection System 2009-10 was published in late 2011 and provides critical information to government and non-government service providers to assist them in developing policies and programs to improve services for children and young people. This report is constantly evolving and increasing its coverage by utilising emerging data sets.

Child Guardian Report – Youth Justice System

During 2010-11, the Commission developed a framework for the future systemic monitoring of Queensland's youth justice system and consulted with a number of key agencies, including the Department of Communities and Queensland Police Service. The Commission's proposed youth justice monitoring framework is comprised of three outcome areas: youth offending and prevention; diversions; and supervision, intervention and reintegration.

The proposed framework was released in the form of a consultation report in late 2011 allowing for broader consultation with youth justice system service providers and stakeholders. Feedback on this

report will be used to develop the Commission's inaugural *Child Guardian Report: Youth Justice System 2010-11*, which is scheduled for release in 2012.

Youth justice advocacy

In 2010-11, the Commission released a policy position paper calling for 17 year olds to be removed from adult prisons and treated in accordance with the provisions of the *Youth Justice Act 1992*. Queensland is the only Australian state or territory where 17 year olds are treated as adults in the criminal justice system. The Commission also recommends that, until such time as 17 year olds can be transferred into the youth justice system, steps be taken to monitor the safety, wellbeing and experiences of 17 year olds in adult correctional facilities, for example by allowing Community Visitors to access all 17 year olds in adult correctional facilities.

Since the release of the paper, the Commission has continued dialogue with key agencies to press for a response to the Commission's recommendations. The Commission is continuing to advocate and collaborate with the Department of Communities and Department of Corrective Services to implement its recommendations in 2011-12.

Preventing child deaths

The Commission records the deaths of all children in Queensland in the Child Death Register. Recording and analysing these deaths allows for the identification of modifiable risk factors that can be addressed to reduce the recurrence of similar fatalities. The Commission's *Annual Report: Deaths of Children and Young People in Queensland* series provides information on the instances and leading causes of all child deaths in Queensland.

In late 2011, the Commission released the final project reports for the *Reducing Youth Suicide in Queensland* and *Keeping Country Kids Safe* initiatives which used data from the Queensland Child Death Register. These reports will provide the Commission and other stakeholders with a basis for progressing advocacy in relation to deaths of children in rural areas and deaths of children by suicide.

In 2011-12, the Commission will lead and support child death prevention by continuing to:

- work towards establishing national benchmarks for risks associated with child deaths by progressing the work of the Australia and New Zealand Child Death Review and Prevention Group
- participate as a member of the Impacted Children Project Steering Committee developed in response to the Commission's data regarding regions with high levels of cluster suicides
- inform academic research relating to child death prevention, including to the National Centre for Health Information Research and Training, Royal Children's Hospital, Mater Hospital and Australian Institute for Suicide Research and Prevention
- participate as a key stakeholder in initiatives relating to drowning prevention, including those arising from the review of Queensland's swimming pool safety laws and the implementation of the Queensland Government's Swimming Pool Safety Improvement Strategy
- engage with stakeholders to strengthen child risk management strategies within regulated service environments, and
- monitor outcomes arising from the Senate Standing Committee on Community Affairs References Committee Inquiry into Suicide in Australia and advocate for associated funding for Queensland to have an appropriate focus on the needs of children and young people.

Advocacy to improve outcomes for Aboriginal and Torres Strait Islander children and young people

In 2011-12, the Commission will inform and influence approaches for overcoming Indigenous disadvantage by continuing to:

- collect and distribute data on key areas of vulnerability for Aboriginal and Torres Strait Islander children and young people, including health, education and social outcomes
- link with Aboriginal and Torres Strait Islander community groups to provide information about the role of the Commission in the promotion of the rights, interests, safety and wellbeing of Queensland's vulnerable children
- finalise work on the Indigenous Child Placement Principle Audit 2010, including an analysis of the implementation of the recommendations in the inaugural audit in 2008 aimed at improving outcomes for Indigenous children and young people in care, and releasing the Indigenous Child Placement Principle Audit Report 2010, and
- provide feedback on the implementation of the Cape York Welfare Reform Trial.

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commission for
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Speaking up for Queensland children

Annual Report:
Deaths of children and young people Queensland 2010-11

About this Report

This report has been prepared under section 146 of the Commission for Children and Young People and Child Guardian Act 2000. It describes the outcomes or research initiated by the Commission for Children and Young People and Child Guardian into the deaths of children and young people in Queensland registered in the period 1 July 2010 – 30 June 2011.

Publication of this report is intended to allow the community and stakeholders to engage with issues of significant public interest.

If English is not your first language and you would like assistance to understand this Report, you can contact us on 0732116700 or freecall 1800 688 275 and we will arrange an interpreter to communicate the report to you.

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We value the views of our readers and invite you to give us feedback in this report.

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Contact for enquiries and proposed changes

All enquiries regarding this document should be directed in the first instance to the Commission's Systemic Monitoring and Review Program, PO Box 15217, Brisbane City East QLD 4002 or email data@ccypcg.qld.gov.au

Acknowledgements

This Annual Report: Deaths of children and young people, Queensland, 2010-11 was developed and updated by the Commission for Children and Young People and Child Guardian.

The Commission acknowledges the unique and diverse cultures of Aboriginal and Torres Strait Islander people and notes that throughout this document the term Aboriginal and Torres Strait Islander has been used to collectively describe two distinct groups of people. The Commission respects the beliefs of the Aboriginal and Torres Strait Islander peoples and advises that there is information regarding Aboriginal and Torres Strait Islander deceased people in this final report.

Information security

This document has been security classified using the Queensland Government Information Security Classification (QGISCF) as PUBLIC and will be managed according to the requirements of the QGISCF

commission for children and young people and child guardian

31 October 2011

The Honourable Karen Struthers MP
Minister for Community Services and Housing and Minister for Women
Parliament House
George Street
Brisbane Qld 4000

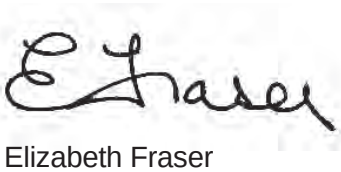
Dear Minister

In accordance with section 146 of the *Commission for Children and Young People and Child Guardian Act 2000*, I hereby provide to you the Commission's annual report analysing the deaths of Queensland children and young people.

The report analyses the deaths of all children and young people in Queensland registered in the period 1 July 2010 – 30 June 2011, with a particular focus on external (non-natural) causes.

I draw your attention to section 146(7) of the *Commission for Children and Young People and Child Guardian Act 2000*, which requires you to table this report in the Parliament within 14 days of receipt.

Yours sincerely



Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

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The Commission would also like to acknowledge the contribution of data from other Australian agencies and/or committees who perform similar child death review functions. For the third year in a row, the Commission has utilised this data to compile an interstate overview representing further steps towards developing a nationally comparable child death review dataset.

The contribution of officers of the Commission's Systemic Monitoring and Review Program who maintained the register, analysed the data and prepared the report is also acknowledged.

Foreword

On behalf of the Commission, I would like to extend my sincere condolences to the families and friends of the 465 children and young people whose deaths have been registered in 2010–11.

This report analyses the deaths of these children and young people, with a particular focus on the circumstances and risk factors surrounding external (non-natural) causes of death and sudden unexpected deaths in infancy.

The Commission's mandate to review, register, analyse and report on trends and patterns in child deaths, as embedded in Chapter 6 (Child Deaths) of the *Commission for Children and Young People and Child Guardian Act 2000*, honours Australia's commitment as a signatory to the United Nations Convention on the Rights of the Child (UNCROC). In particular, Article 24 of UNCROC requires that among other things, parties shall fully implement measures designed to achieve the highest attainable standard of health, including taking measures to diminish infant and child mortality.

Analysing the circumstances of child deaths and identifying modifiable risk factors is critical to the development of appropriate strategies to reduce fatalities in the future. To achieve better outcomes for children, it is necessary to influence behaviours and actions through a range of mechanisms, including legislation, policy and program design, and community engagement and education.

As at 30 June 2011, the Commission's child death register held data in relation to 3,544 Queensland children and young people who have died since 1 January 2004. I believe the child death review processes undertaken by my officers to be vital in helping us take steps to modify the risk factors contributing to preventable fatalities.

The Commission actively supports systemic advocacy in four key ways, namely:

- through providing tailored data to recognised stakeholders in support of their research and advocacy
- by providing evidence-based submissions to help inform policy development and legislative processes
- by conducting our own original research into areas of concern identified through our analysis of the Child Death Register, where no other stakeholders are active, and
- through the preparation and publication of this report each year.

In 2010–11 the Commission welcomed a number of opportunities to share its data and provide timely and authoritative advice to inform legislative reforms and influence the development of prevention strategies, policies and procedures. The Commission's Child Death Register data provided the evidence base for 10 major policy submissions on a range of matters across the prevention continuum. Examples include providing support for the Department of Communities, Sport and Recreation Services regarding off-road motorcycling management strategies and providing feedback to the Australian Building Codes Board regarding proposed changes to the Building Code relevant to childhood injury prevention.

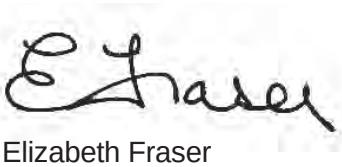
A significant event for Queensland in 2010–11 was the unprecedented flood crisis. Thirty-five people died in this event, including a number of children and young people. The Commission subsequently submitted evidence to inform the independent Commission of Inquiry into the chain of events leading to the floods, their aftermath, and the state's response. The Commission's evidence from the Queensland child death register showed that a total of 19 children and young people have drowned in flood-related events since 2004, including 6 directly attributed to the January 2011 floods. While the majority of child deaths which occurred in the 2010–11 floods were entirely unforseen, the Commission identified evidence that risk-taking on the part of parents and caregivers and young people themselves have contributed to a number of deaths since 2004. The Commission recommended further research in the areas of community education and targeting young people with safety messages about the dangers of entering floodwaters.

We recognise that providing high quality, up-to-date and readily accessible data is key to our strategy of supporting our stakeholders undertaking advocacy and research aimed at preventing fatalities in children and young people. The Commission's child death register provides a uniquely comprehensive and contemporary dataset for use in the research and reporting of risk factors and the development of strategies for preventing child mortality. In 2010–11 the Commission continued efforts to promote the use of this dataset to inform childhood death and injury prevention initiatives.

The Commission received a total of 42 requests for child death register data, an increase from 26 requests in 2009–10. An important initiative was the publication of findings from research into low-speed vehicle run-over conducted by the Burns and Trauma Research Group, Royal Children's Hospital. This research, published in the international journal *Injury Prevention*, was supported by data from the Commission's child death register and noted the Commission's "pioneering effort" in data management.

This is the Commission's seventh annual report analysing the deaths of children and young people in Queensland. As the Commission's database on child mortality continues to grow, so do the opportunities to work together to reduce childhood mortality and morbidity. In the year ahead I will publish final reports on the Commission's research into rural deaths and youth suicide. I encourage all relevant stakeholders to engage in this research and to contact the Commission to explore other opportunities for collaboration. Two specific areas of collaboration I will be pursuing relate to the fatal maltreatment of children and, more generally, the management of (non-fatal) injury data in Queensland, which may have untapped potential in helping support and explain our mortality data.

I look forward to continuing to work with all of our stakeholders in the year ahead to improve outcomes for children and young people in Queensland.



Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

Executive summary

Background

The Commission for Children and Young People and Child Guardian is an independent statutory body charged with responsibility for protecting and promoting the rights, interests and wellbeing of Queensland children and young people under the age of 18.

The Commission's child death review functions began on 1 August 2004, making this the seventh annual report on child deaths in Queensland. Under Chapter 6 (Child Deaths) of the *Commission for Children and Young People and Child Guardian Act 2000*, the Commission is responsible for:

- maintaining a register of the deaths of all children and young people in Queensland
- reviewing the causes and patterns of deaths of children and young people
- conducting broad research in relation to child deaths
- making recommendations for improvements to laws, policies, procedures and practices to help reduce the likelihood of child deaths, and
- preparing an annual report to Parliament and the public regarding child deaths.

Child deaths in Queensland, 1 July 2010 – 30 June 2011

In the 12-month period from 1 July 2010 to 30 June 2011, the deaths of 465 children were registered in Queensland, a rate of 43.3 deaths per 100,000 children and young people aged 0–17 years. This is the lowest reported rate since 2005–06.

The below table shows the numbers and rates of child deaths registered in Queensland each year since 2004–05.

Year	Number of deaths *n*	Rate per 100,000
2004–05	481	49.6
2005–06	425	43.0
2006–07	510	50.6
2007–08	488	47.5
2008–09	521	49.7
2009–10	485	45.2
2010–11	465	43.3

Data source: Queensland Child Death Register (2004–2011)

Of the 465 deaths registered in 2010–11:

- 55.7% of deaths were of males, 44.3% were female
- diseases and morbid conditions accounted for the majority of deaths (74.2%)
- over 16% of deaths were due to external causes (transport, drowning, suicide, fatal assault or other non-intentional injury)
- over 66% of deaths were of infants under 1 year of age, and
- Aboriginal and Torres Strait Islander children accounted for 13.1% of deaths and died across all causes at 2.2 times the rate of non-Indigenous children in Queensland.

The following table shows the total number of deaths, as well as the rate and leading natural and external cause of death for each age category.

Age category	Total number of deaths	Percentage of total deaths (0–17 years)	Rate per 100,000	Leading natural cause for age category	Leading external cause for age category
Under 1 year	310	66.7%	463.1 per 100,000	Perinatal conditions (262.9 per 100,000)	–
1–4 years	39	8.4%	16.3 per 100,000	Congenital anomalies (1.8 per 100,000)	Drowning/ Transport (2.1 per 100,000)
5–9 years	28	6.0%	9.8 per 100,000	Neoplasms (3.9 per 100,000)	Transport (1.4 per 100,000)
10–14 years	32	6.9%	10.8 per 100,000	Neoplasms (2.0 per 100,000)	Transport (2.0 per 100,000)
15–17 years	56	12.0%	30.3 per 100,000	Neoplasms (4.9 per 100,000)	Suicide (8.7 per 100,000)
Total	**465**	**100.0%**	**43.3 per 100,000**	**Perinatal conditions (15.2 per 100,000)**	**Transport (2.9 per 100,000)**

Data source: Queensland Child Death Register (2010–11)
– Infants under 1 year of age died almost exclusively as a result of diseases and morbid conditions. As such, no leading external cause of death has been listed for this age category.

Transport

- Children and young people died from transport incidents at a rate of 2.9 deaths per 100,000 children aged 0–17 years in Queensland (31 deaths).
- The rate of child deaths from transport incidents has increased slightly when compared to the last reporting period however is still well below the rates recorded in previous years.
- Transport incidents accounted for 6.7% of all child deaths, and were the leading external cause of death, accounting for 41.3% of all external cause deaths.
- The greatest number of transport fatalities occurred in motor vehicles (58.1%), followed by pedestrian deaths (25.8%).

Commission's key prevention activities

Off-road motorcycling **–** since 2004, 38 children and young people have died as a result of motorcycle or quad bike crashes. Around half of these incidents occurred 'off-road' where licensing laws do not apply. In 2010–11, the Commission continued to provide data to support the Department of Communities, Sport and Recreation Services regarding off-road motorcycling management strategies.

Drowning

- Children and young people drowned at a rate of 1.3 deaths per 100,000 children and young people aged 0–17 years in Queensland (14 deaths).
- Drowning accounted for 3.0% of child deaths, and 18.7% of external cause deaths.
- In line with previous findings, drowning was the equal leading cause of death for children aged 1–4 years.
- Eleven drowning deaths occurred in non-pool locations, compared with 3 in swimming pools. This was the lowest number of swimming pool drowning deaths since the Commission commenced reporting in 2004.

- Six children and young people drowned in the January 2011 Queensland flood event. Since 2004, the Commission has recorded a total of 19 deaths of children and young people in flooded waterways.

Commission's key prevention activities

***Swimming pool safety* –** Since the inception of the Queensland Government's Swimming Pool Safety Improvement Strategy in 2008, the Commission has been a key stakeholder in the review and re-development of Queensland's swimming pool safety laws. The Commission has previously provided a range of supporting data and risk factor information regarding child drowning, and has been an active participant in the development of associated safety initiatives including the mandatory reporting of immersion incidents and the need for educational awareness-raising campaigns. During 2010–11 the Commission continued to provide supporting data to the Department of Infrastructure and Planning to assist in the implementation of the legislative reforms.

Suicide

- Suicide accounted for the deaths of 21 children and young people, a rate of 2.0 per 100,000 children and young people aged 0–17 years in Queensland.
- Deaths by suicide accounted for 4.5% of all deaths of children or young people, with suicide accounting for 41% of external cause deaths among those aged 10–17 years.
- For the second year in succession, suicide was the leading cause of death for children aged 15–17 years. Historically, transport incidents have been the leading cause of death for this age category.
- Four children in the 10–14 year age category suicided, along with another child aged 9 years. The Commission is concerned by the very young age of children who suicided in 2010–11.
- Children and young people who were known to the child protection system suicided at a rate of 7.3 per 100,000 children, compared with 2.0 per 100,000 for all Queensland children aged 0–17 years.
- Precipitating incidents were identified in 16 of the 21 suicides, while seventeen of the 21 children and young people (81%) were identified as having previous suicidal thoughts and/or behaviours. It is crucial that all threats or talk or suicide are taken seriously.

Commission's key prevention activities

***Impacted Children Project* –** the aim of this project is to structure a whole-of-government postvention strategy to reduce the incidence of contagion and cluster youth suicides. The Queensland Police Service is currently developing an outcomes paper arising from the pilot process which concluded in 2010–11. Over the coming year the Commission will continue to consult with relevant stakeholders in support of a multi-agency approach to assisting the Queensland Police Service in implementing suitable postvention response strategies throughout Queensland.

Fatal assault and neglect

- Five of the 465 children who died were fatally assaulted or neglected, at a rate of 0.5 deaths per 100,000 children and young people aged 0–17 years in Queensland.
- Three of the 5 victims of fatal assault and neglect were infants under 1 year of age and another was 1 year of age. The other child aged 1–4 years died as a consequence of inflicted injuries received as an infant.
- In 2010–11, one child was victim of a murder-suicide. Since 2004, 10 Queensland children and young people have died in domestic homicide incidents where the perpetrator subsequently suicided or attempted suicide.

Sudden unexpected deaths in infancy

- Sudden unexpected deaths in infancy (SUDI) is defined as the death of an infant under 1 year of age with no immediately obvious cause.
- SUDIs accounted for 17.8% of infant deaths (55 deaths), and occurred at a rate of 82.2 per 100,000 infants aged less than 1 year or 0.9 deaths per 1000 live births.
- The total of 55 SUDI deaths in 2010–11 was 1 more than in the previous reporting period of 2009–10 and the highest number recorded since 2004.
- Aboriginal and Torres Strait Islander infants died suddenly and unexpectedly at 3.3 times the rate of non-Indigenous infants.
- Infants known to the child protection system died suddenly and unexpectedly in 2010–11 at 1.8 times the rate of all Queensland children (9.3 per 100,000 children known to the child protection system compared to 5.1 per 100,000 for the general population).

Commission's key prevention activities

***SUDI epidemiological analysis* –** with a comprehensive 7 year SUDI dataset established, the Commission recognises that this very complex group of deaths would benefit from detailed epidemiological analysis. In 2010–11 the Commission finalised arrangements with Queensland Health for the provision of expect clinical advice in select cases of SUDI. Review of deaths under this agreement will commence in 2011–12. It is the Commission's intention to collate and analyse the clinical advice provided and release a dedicated and detailed review of SUDI triennially.

Aboriginal and Torres Strait Islander status

- Of the 465 child deaths, 13.1% were of Aboriginal and/or Torres Strait Islander children (61 deaths).
- The majority of Indigenous deaths were of children under 1 year of age, accounting for 67.2%.
- Aboriginal and Torres Strait Islander children die at 2.2 times the rate of non-Indigenous children.
- Indigenous infants die suddenly and unexpectedly at 3.3 times the rate of non-Indigenous infants.

Commission's key prevention activities

***Closing the Gap* –** in 2008 the Australian Government and all state and territory governments agreed to work towards 6 specific targets to significantly reduce the gap in life expectancy and outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians. One of these targets involved halving the gap in mortality rates for Aboriginal and Torres Strait Islander children under the age of 5 years by 2018.

In support of this initiative, the Commission provides mortality data for Indigenous and non-Indigenous children to the Queensland Treasury, Office of Economic and Statistical Research, for inclusion in the Queensland Government contribution to the Closing the Gap report.

Children known to the child protection system[1]

- Due to the complex circumstances often present in their lives, children known to the child protection system are a vulnerable and at-risk cohort. Overall, in 2010–11 children known to the child protection system died at a rate of 40.3 deaths per 100,000, compared with 43.3 deaths per 100,000 for all Queensland children. This is the first year since reporting commenced that the rate for children in the child protection system has been exceeded by all Queensland children.[2]
- However, compared with the Queensland population aged 0–17 years, children known to the child protection system were:
  - 3.7 times more likely to suicide
  - 1.8 times more likely to die suddenly and unexpectedly as an infant.

Future directions

This is the Commission's seventh year of registering, reviewing and reporting on the deaths of children and young people in Queensland, and as such the Commission's capacity to identify and report on trends, patterns and, importantly, risk factors in child deaths is now well established.

The Commission is committed to working collaboratively with stakeholders to identify opportunities for its child death data to inform policy formulation and prevention efforts at both a state and national level. This commitment is reflected by the Commission's further research in the areas of childhood suicide, deaths in rural and remote areas, and fatal maltreatment, as well as through leading or participating in a number of prevention initiatives.

Reducing Youth Suicide in Queensland

The Commission has consistently identified suicide as the leading or second-leading cause of death for children aged 10–14 years and adolescents aged 15–17 years in Queensland. In response, the Commission developed an in-depth project reviewing the suicides of Queensland children and young people.

The *Reducing Youth Suicide in Queensland* (RYSQ) project involved a detailed review of the lives and deaths of children and young people who died by suicide in Queensland between 1 January 2004 and 31 December 2007.

The project aim is to establish a solid and contemporary evidence base support prevention efforts targeted at children and young people, with the aim of helping reduce youth suicide in Queensland.

The Commission's final report on the project will be released in 2011–12. The Commission will continue to support the work of key stakeholders in identifying options for improving prevention and early intervention strategies through its maintenance of the Child Death Register and provision of data and trend information.

Keeping Country Kids Safe

The Commission has found that children in country areas are 2.4 times more likely to die as a result of non-intentional injury than those in the city. In 2008–09 the Commission launched the *Keeping Country Kids Safe* initiative, a project aimed at developing a comprehensive injury prevention dataset to support the needs of children living in rural communities.

The Commission has collated and analysed the results of its research and consultation, and will publish a final project report in 2011–12. This report will detail the views of rural communities, outline key issues identified by government and industry stakeholders, and identify future directions in research and prevention efforts to assist stakeholders in ongoing work to reduce death and injury to children in rural areas. The Commission will continue to support research in this area through the provision of detailed datasets to genuine researchers.

Fatal Child Maltreatment project

In 2010–11 the Commission, through research combining a comprehensive review of the existing research literature with its own analysis of maltreatment-related deaths since 2004, developed a revised set of categories for the classification of assault and neglect deaths.

In 2010–11 the Commission will publish a summary report of data on maltreatment-related death in Queensland using the revised classification system.

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[1] For the purposes of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child. It should be noted that the cases discussed in this report are not the same cohort of cases referred to in the Child Death Case Review Committee (CDCRC) Annual Report. The CDCRC Annual Report discusses cases of children known to the child protection system that were considered by the CDCRC during 2010–11 (which may be different to the cases that actually occurred during this period, as a result of the timeframes associated with the review process).

[2] This may be due to the growth in population of children known to the child protection system (ranging from a 6% increase in 2007-08 to a 27% increase in 2009-10) when compared to the total population growth of children and young people. Consequent changes in counting methodologies may also be a factor. Furthermore, the total population of children used to calculate rates for 2010-11 were the same as the population used for 2009-10. This is due to the fact that disaggregated population estimates for 2010-11 were not available.

Supporting child death and injury prevention initiatives

The Commission continues to welcome opportunities to contribute to a wide range of child death and injury prevention initiatives.

During 2010–11 the Commission prepared 10 major policy submissions on a range of matters across the injury prevention continuum including:

- the provision of a detailed submission to the independent Commission of Inquiry into the chain of events leading to the 2010–11 Queensland flood event, their aftermath, and the state's response
- submitting to the Joint Select Committee on Cyber-Safety on issues pertaining to the challenges presented by social networking sites in responding to the deaths of children and young people
- providing support for the Department of Communities, Sport and Recreation Services regarding off-road motorcycling management strategies, and
- providing feedback to the Australian Building Codes Board regarding proposed changes to the Building Code relevant to childhood injury prevention.

The Commission also participated in a range of committees and working groups throughout the year, including:

- chairing the Australian and New Zealand Child Death Review and Prevention Group
- participating as a member of the Queensland Injury Prevention Council (QIPC)
- participating as a member of the Australian Mortality Data Interest Group (AMDIG)
- participating as a member of the Royal Life Saving Society Queensland "Keep Watch" Steering Committee, and
- participating as a member of the Queensland Police Service "Impacted Children" Steering Committee in relation to suicide postvention.

Child Death Register Access

The Commission, through its strategy of providing access to data in the child death register, supports a range of stakeholders in the development and implementation of programs, policies and initiatives which require a solid and contemporary evidence base. The overarching aim of this strategy is to promote the information collected in the child death register to stakeholders (at both the state and national level) and identify opportunities for the Commission to engage with stakeholders and share its dataset and key findings, in particular those arising from its risk factor analysis, to inform ongoing prevention efforts.

During 2010–11, the Commission was pleased to respond to 42 requests for data from external stakeholders, including:

- providing data on drowning deaths to the Department of Infrastructure and Planning; Royal Life Saving Society Australia; Workplace Health and Safety Queensland; and Kidsafe Queensland
- providing information and data regarding motorcycle and quad bike fatalities to support research and prevention initiatives conducted by the National Centre for Health Information Research and Training; Department of Communities, Sport and Recreation Services; and Royal Children's Hospital
- providing regional breakdowns of child mortality data to assist in research and program development by Queensland Health; SIDS and Kids Queensland; and the Australian Institute of Suicide Research and Prevention, and
- identifying product-related deaths for research conducted by the National Centre for Health Information Research and Training.

An important initiative was the publication of findings from research into low-speed vehicle run-over conducted by the Burns and Trauma Research Group, Royal Children's Hospital. This research, published in the international journal *Injury Prevention*, was supported by data from the Commission's child death register and recognised the Commission's "pioneering effort" in data management.

Queensland Injury Prevention Council

Since the Queensland Injury Prevention Council (QIPC) commenced operating in 2008, it has made an important and significant contribution towards reducing injury and supporting a safe childhood and youth in Queensland through investments in research to inform policy and practice.

In 2010–11, the QIPC has:

- continued its existing projects to address the ongoing issues of childhood drowning and low speed vehicle runovers
- continued to support two post-graduate scholarships related to childhood drowning and Aboriginal and Torres Strait Islander injury prevention and safety promotion
- commenced funding further injury prevention projects, including: evaluating new motor vehicle child passenger restraint legislation in Queensland; reducing the severity of burn injuries amongst the paediatric population; and studying the attitudes to and use of alcohol amongst youth in Queensland
- fostered relationships with the academic sector, including the delivery of injury prevention courses and the incorporation of injury prevention modules into existing course material, and
- conducted the *Evidence to Action Symposium* in Townsville and the *Injury Prevention in Queensland: Results and Recommendations Seminar* in Brisbane.

In 2010–11 the Trauma Plan for Queensland was reviewed following 4 years of implementation. The QIPC is in the process of preparing a new strategic plan to identify future goals in injury prevention in Queensland. The Commission will continue to work closely with the QIPC to help achieve positive outcomes for Queensland children.

Australia and New Zealand Child Death Review and Prevention Group

The Commission currently chairs the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG), which is a cooperative of agencies working to identify and action preventable child deaths by sharing information on issues and trends in reporting on child deaths.

While the ANZCDR&PG does not currently report on child mortality as a single entity, the group is committed to working collaboratively to maximise the potential for the breadth of knowledge held in each jurisdiction to contribute to national consistency in reporting, particularly in relation to risk factor information and the promotion of consistent prevention messages.

Report structure

Chapter 1 provides an overview of the causes of deaths of the 465 children aged from birth to 17 years registered in Queensland between 1 July 2010 and 30 June 2011.

Chapter 2 provides an analysis of those deaths registered in the reporting period which were due to diseases and morbid conditions.

Chapters 3 to 7 provide analyses of the following external causes of death of children and young people in Queensland in 2010–11: transport, drowning, other non-intentional injury-related death, suicide and fatal assault and neglect.

Chapter 8 details the future direction for the reporting and analysis of SUDI in Queensland.

Chapter 9 details child death prevention activities undertaken by the Commission, and monitors the implementation of the recommendations made by the Commission in previous annual reports.

Chapter 10 gives an overview of national child death statistics for 2009 as provided by child death review mechanisms in New South Wales, Victoria, South Australia and Tasmania.

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Part I: Introduction and overview

Chapter 1

This section provides an overview of child deaths in Queensland for 2010–11.

Key findings

- The deaths of 465 children and young people were registered in Queensland between 1 July 2010 and 30 June 2011.
- Children in Queensland died at a rate of 43.3 per 100,000 children and young people aged 0–17 years. This is the second lowest recorded rate since the Commission began reporting in 2004-05.
- The rate of death from diseases and morbid conditions was the lowest recorded in any reporting period. Deaths from external causes were also the lowest recorded.
- The rate of sudden unexpected deaths in infancy was the highest number recorded across the last 7 years, however is considered relatively stable.
- Transport was the leading external cause of death followed by suicide.
- The rate of drowning was the lowest ever recorded, despite the 6 drownings directly attributed to the January 2011 Queensland floods.
- Aboriginal and Torres Strait Islander children were over-represented, dying at 2.2 times the rate of non-Indigenous children. Aboriginal and Torres Strait Islander children were most at risk of dying within the first year of life followed by the 15-17 year age category. Similar patterns are evident in non-Indigenous children.
- The number of Aboriginal and Torres Strait Islander children who died from external causes in this reporting period has increased, with Aboriginal and Torres Strait Islander children 3.9 times more likely to die from external causes in 2010–11.
- Overall, children known to the child protection system died at a rate of 40.3 deaths per 100,000, compared with 43.3 deaths per 100,000 for all Queensland children. In 2010–11, children known to the child protection system were 3.7 times more likely to suicide.

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Chapter 1

Deaths of Queensland children and young people, 2009–10

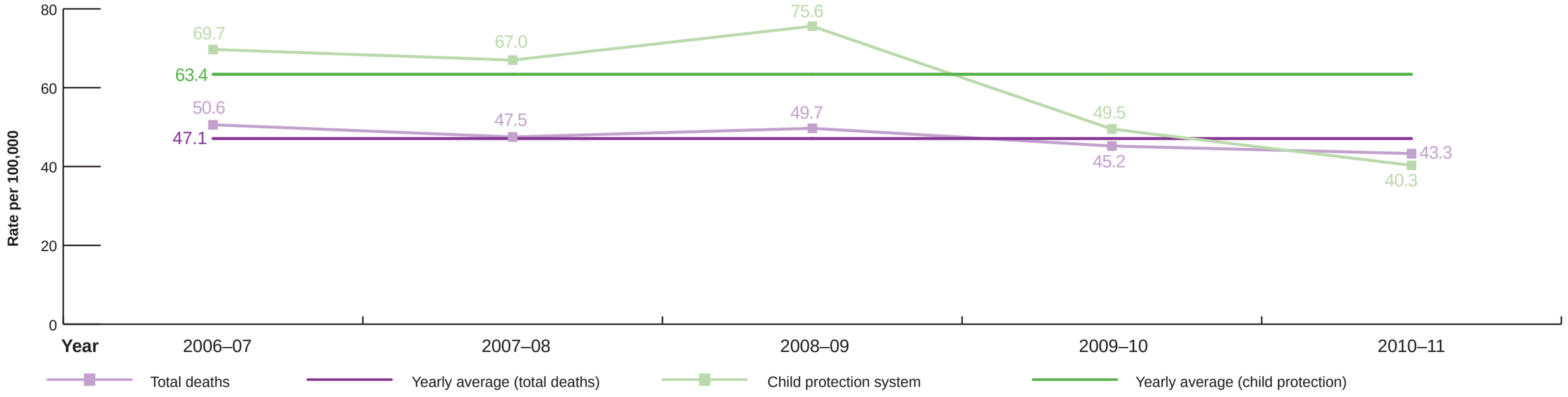
Table 1.1: Summary of deaths of children and young people in Queensland, 2006–2011[1]

	2006-07		2007-08		2008-09		2009-10		2010-11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All deaths											
Deaths of children 0–17 years	510	50.6	488	47.5	521	49.7	485	45.2	465	43.3	47.1
Cause of death											
Diseases and morbid conditions	**405**	**40.2**	**373**	**36.3**	**422**	**40.2**	**379**	**35.3**	**345**	**32.1**	**36.7**
SIDS and undetermined causes (infants)	*26*	*2.6*	*26*	*2.5*	*36*	*3.4*	*31*	*2.9*	*17*	*1.6*	*2.6*
Undetermined > 1 year	*4*	*0.4*	*1*	*	*7*	*0.7*	*2*	*	*1*	*	*
External causes	**105**	**10.4**	**115**	**11.2**	**99**	**9.1**	**85**	**7.9**	**75**	**7.0**	**9.1**
Transport	*46*	*4.6*	*52*	*5.1*	*44*	*4.2*	*27*	*2.5*	*31*	*2.9*	*3.8*
Suicide	*19*	*1.9*	*21*	*2.0*	*15*	*1.4*	*20*	*1.9*	*21*	*2.0*	*1.8*
Drowning	*18*	*1.8*	*14*	*1.4*	*19*	*1.8*	*19*	*1.8*	*14*	*1.3*	*1.6*
Other non-intentional injury-related death including fire	*12*	*1.2*	*17*	*1.7*	*17*	*1.6*	*11*	*1.0*	*4*	*0.4*	*1.2*
Fatal assault and neglect	*10*	*1.0*	*11*	*1.1*	*4*	*0.4*	*8*	*0.7*	*5*	*0.5*	*0.7*
Cause of death pending at time of reporting	**0**	*	**0**	*	**0**	*	**21**	**2.0**	**45**	**4.2**	**1.3**
Sudden Unexpected Deaths in Infancy (SUDI)											
Sudden unexpected infant deaths	44	79.8	36	63.2	48	77.8	54	80.7	55	82.2	76.9
Gender											
Female	210	42.8	214	42.8	224	43.9	187	35.8	206	39.5	40.8
Male	300	58.1	274	52.0	297	55.1	297	53.9	259	47.0	53.0
Aboriginal and Torres Strait Islander status											
Indigenous	70	105.6	56	83.1	70	102.4	61	88.2	61	88.2	93.1
Non-Indigenous	440	46.8	432	45.0	451	46.0	424	42.2	404	40.2	43.9
Known to the child protection system											
Known to the child protection system	60	69.7	61	67.0	77	75.6	64	49.5	61	40.3	63.4
Age category											
Under 1 year	322	583.8	293	514.4	326	528.6	326	487.0	310	463.1	511.4
1–4 years	63	29.5	59	26.9	64	28.1	48	20.1	39	16.3	24.0
5–9 years	21	7.6	40	14.3	41	14.5	28	9.8	28	9.8	11.2
10–14 years	38	13.1	28	9.6	31	10.5	28	9.4	32	10.8	10.6
15–17 years	66	38.3	68	38.1	59	32.4	55	29.8	56	30.3	33.4

[1] *Data source: Queensland Child Death Register (2006–11)*
** Rates have not been calculated for numbers less than 4.*

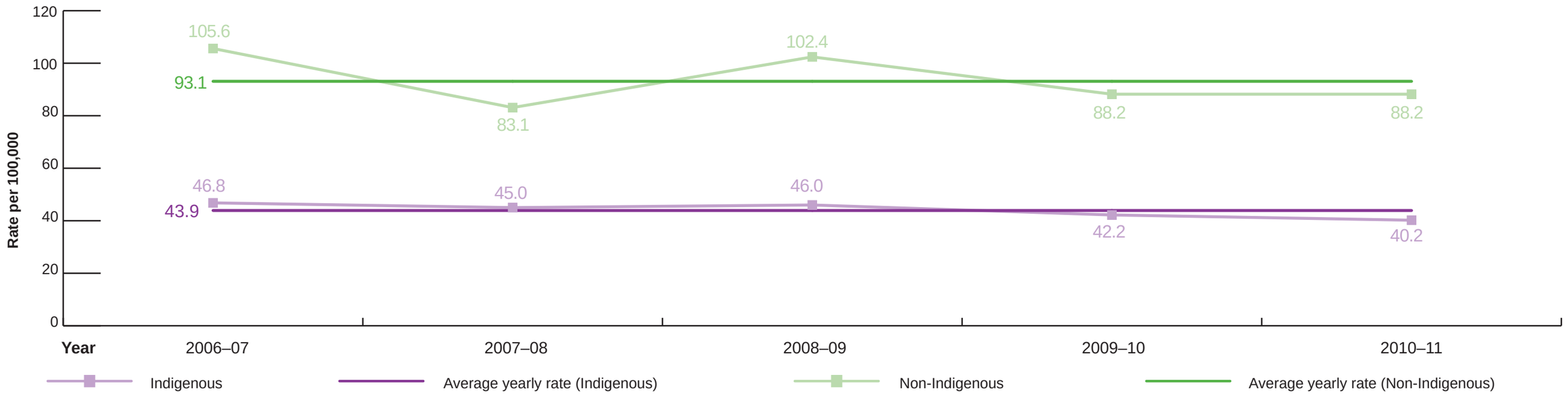
[a] *Excludes the death of 1 infant of indeterminate sex.*
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates that were not published in previous reports have been re-calculated based on the denominator data used for the preparation of the relevant report.
3. Rates are calculated per 100,000 children (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
4. Rates for cause of death are calculated per 100,000 children aged 0–17 years in Queensland in each year, with the exception of sudden unexpected deaths in infancy, which is calculated per 100,000 infants under the age of 1 year in Queensland.
5. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
6. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
7. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 1.1: Deaths of children and young people in Queensland, 2006–2011



Data source: Queensland Child Death Register (2006–2011)
Notes: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.
2. Rates for children known to the child protection system are calculated per 100,000 children and young people aged 0–17 years who were known to the Department of Communities in the 3 years prior to their death.

Figure 1.2: Deaths of Aboriginal and Torres Strait Islander children 2006–2011



Data source: Queensland Child Death Register (2006–2011)
Note: 1. Rates are calculated per 100,000 Aboriginal and Torres Strait Islander and per 100,000 non-Indigenous children and young people aged 0–17 years in Queensland.

Child deaths in Queensland: findings, 1 July 2010 – 30 June 2011

Overview

Between 1 July 2010 and 30 June 2011, the deaths of 465 children and young people were registered in Queensland, a rate of 43.3 per 100,000 children and young people aged 0–17 years. This is the lowest recorded rate since 2005-06.

Males comprised 55.7% of child deaths in 2010–11, compared with 44.3% for females.

The majority of all child deaths were of children under 1 year of age (66.7%), occurring at a rate of 463.1 deaths per 100,000 infants in Queensland. Sixty-nine percent of infant deaths occurred within the first 28 days of life. Young people aged 15–17 years had the next highest rate of death.

Table 1.2: Child deaths by gender and age category

Age category	Female	Male	Total		
	n	*n*	*n*	%	Rate per 100,000
Under 1 year	137	173	310	66.7	463.1
1–4 years	22	17	39	8.4	16.3
5–9 years	14	14	28	6.0	9.8
10–14 years	8	24	32	6.9	10.8
15–17 years	25	31	56	12.0	30.3
Total	**206**	**259**	**465**	**100**	**43.3**
Rate per 100,000	**39.5**	**47.0**	**43.3**		

Data source: Queensland Child Death Register (2010–11)
Notes: 1. Rates are calculated per 100,000 children and young people in each age/gender category.
2. Total rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Cause of death

Table 1.3 below broadly outlines the causes of death for the 465 children and young people whose deaths were registered in 2010–11. For full details of causes of death by ICD-10 mortality coding classifications, see Appendix 1.2.

Table 1.3: Cause of death by age category

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total	Rate per 100,000
	n	*n*	*n*	*n*	*n*	*n*	
Diseases and morbid conditions	**265**	**24**	**19**	**17**	**20**	**345**	**32.1**
SIDS and undetermined causes (infants)	17	0	0	0	0	17	1.6
Undetermined > 1 year	0	0	0	0	1	1	*
External causes	**6**	**12**	**8**	**14**	**35**	**75**	**7.0**
Transport	**1**	**5**	**4**	**6**	**15**	**31**	**2.9**
Motor vehicle	*0*	*2*	*2*	*3*	*11*	*18*	*1.7*
Motorcycle/quad bike	*0*	*0*	*0*	*1*	*1*	*2*	*
Pedestrian	*1*	*3*	*2*	*1*	*1*	*8*	*0.7*
Watercraft	*0*	*0*	*0*	*0*	*2*	*2*	*
Suicide	**0**	**0**	**1**	**4**	**16**	**21**	**2.0**
Drowning	**1**	**5**	**3**	**3**	**2**	**14**	**1.3**
Pool	*0*	*2*	*0*	*1*	*0*	*3*	*
Non-pool	*1*	*3*	*3*	*2*	*2*	*11*	*1.0*
Other non-intentional injury-related death	**1**	**0**	**0**	**1**	**2**	**4**	**0.4**
Accidental threats to breathing	*0*	*0*	*0*	*1*	*0*	*1*	*
Electrocution	*0*	*0*	*0*	*0*	*1*	*1*	*
Accidental suffocation and strangulation in bed	*1*	*0*	*0*	*0*	*0*	*1*	*
Fire	**0**	**0**	**0**	**0**	**1**	**1**	*
Fatal assault	**3**	**2**	**0**	**0**	**0**	**5**	**0.5**
Cause of death pending	**39**	**3**	**1**	**1**	**1**	**45**	**4.2**
Total	**310**	**39**	**28**	**32**	**56**	**465**	**43.3**
Rate per 100,000	**463.1**	**16.3**	**9.8**	**10.8**	**30.3**	**43.3**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.
2. Rates for age categories are calculated per 100,000 children and young people in each age category.
3. Although deaths that only occur within a certain age category (SIDS, suicide) are generally expressed as a rate per 100,000 children within that age category (for example, infants under 1 year, or young people aged 10–17 years), all rates have been calculated per 100,000 children and young people aged 0–17 years in Queensland to enable comparison across all causes of death. Age-specific death rates are discussed in the chapters relating to each cause of death.

Diseases and morbid conditions

Deaths from diseases and morbid conditions occurred at a rate of 32.1 per 100,000 children and young people, and accounted for 74.2% of child deaths in 2010–11. The most common diseases and morbid conditions causing death were perinatal conditions and congenital malformations, deformations and chromosomal abnormalities. These causes accounted for 71.0% of the deaths from diseases and morbid conditions.

Deaths from diseases and morbid conditions were most common in infants aged under 1 year, with the majority of these occurring in infants aged less than 28 days (77.0% of infant deaths from diseases and morbid conditions).

Seventeen infants died from Sudden Infant Death Syndrome (SIDS) and other undetermined causes. SIDS and undetermined causes are considered by the World Health Organisation to be 'natural cause' deaths. Deaths from diseases and morbid conditions and SIDS and undetermined are discussed further in *Chapter 2, Deaths from diseases and morbid conditions,* and in *Chapter 8, Sudden unexpected deaths in infancy.*

External causes

External causes of death (transport, drowning, other non-intentional injury, suicide and fatal assault) accounted for 16.1% of child deaths, and occurred at a rate of 7.0 deaths per 100,000 children and young people aged 0–17 years. As shown in Table 1.1, the rate of death from external causes in 2010–11 is the lowest recorded in all reporting periods to date.

Transport

Transport incidents were the leading external cause of death, occurring at a rate of 2.9 deaths per 100,000 children and young people aged 0–17 years in Queensland. While this is a very slight increase on the rate of death from transport incidents in the last reporting period, the rate is significantly lower than recorded in previous years.

Motor vehicle crashes were the most common type of fatal transport incident, followed by pedestrian fatalities. There was a significant increase in the number of teen fatalities in 2010–11 when compared to the last reporting period.

Drowning

Deaths as a result of drowning occurred at a rate of 1.3 per 100,000 children aged 0–17 years in Queensland. This is the lowest rate recorded in all reporting periods since 2004. This rate includes the 6 deaths directly attributed to the January 2011 Queensland floods which significantly increased the number of drowning incidents of children and young people in 2010–11.

While drowning has historically been the leading overall cause of death for children aged 1–4 years, in 2010–11, transport and drowning were shared as the leading external causes of death for children in the 1-4 year age category.

This reporting period recorded the lowest number of pool drownings since 2004-05. The majority of drownings occurred in non-pool locations.

Once again, inadequate supervision was an important factor in almost all drowning deaths of children aged less than 5 years in 2010–11.

Other non-intentional injury-related death

Children died as a result of other non-intentional injury (that is, a non-intentional injury that is not a drowning or transport incident) at the lowest recorded number since reporting began in 2004–05 (a total of 4 deaths).

Suicide

Children and young people in Queensland suicided at a rate of 2.0 deaths per 100,000 children aged 0–17 years. The rate has remained relatively stable over the past 7 years.

Since 2004–05, suicide had represented the second-leading cause of death in young people aged 15–17 years, behind transport incidents. However, in 2009–10, suicide was, for the first time, the leading cause of death for young people in this age category. This may have been attributed to the unprecedented decrease in the number of transport fatalities during 2009–10. Notwithstanding, in 2010–11, suicide has again featured as the leading cause of death in young people aged 15-17 years.

Fatal assault and neglect

There were 5 deaths due to assault and neglect of children in Queensland in 2010–11. This is the second lowest recorded number of deaths by this cause since reporting began in 2004-05. Three of the victims of fatal assault and neglect were infants aged under 1 year and two were aged between 1 and 4 years. This is consistent with the Commission's research indicating that the youngest children are at the highest risk of fatal assault and neglect.

Cause of death pending

Forty-five of the 465 deaths registered in 2010–11 were pending an official cause of death at the time of reporting, and could not be readily classified into one of the categories discussed above.

Sudden unexpected deaths in infancy

Sudden unexpected deaths in infancy (SUDI) is not a cause of death, but a research classification that groups together the deaths of apparently normal infants who would be expected to thrive, yet for reasons often unknown do not survive.

The Commission includes infant deaths (children less than 1 year of age) in the SUDI grouping where the death:

- was sudden in nature
- was unexpected, with no previously known conditions that were likely to cause death, and
- did not have an immediately obvious cause.

Despite the wide variation in official causes of death, SUDI cases share many similarities and are grouped together for the purpose of analysis. Chapter 8, *Sudden unexpected deaths in infancy* provides further detail of SUDI deaths in 2010–11, and outlines the future direction of analysis and reporting of SUDI in Queensland. SUDI cases are also counted under the appropriate cause of death.

The deaths of 55 infants were classified as SUDI, a rate of 82.2 per 100,000 infants under 1 year (0.9 per 1,000 live births). The rate of SUDI deaths in 2010–11 is considered stable.

Of the SUDI deaths, nearly 60% were awaiting an official cause of death. Of those infants with an official cause of death at the time of reporting, Sudden Infant Death Syndrome (SIDS) and other undetermined causes were the most commonly certified causes (73.9%).

Cause of death by age category

Table 1.4 summarises the leading causes of death in each age category.

Table 1.4: Leading cause of death by age category

Rank	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years
1	**Perinatal conditions** (218.1 per 100,000)	**Congenital anomalies** (3.4 per 100,000)	**Neoplasms** (3.1 per 100,000)	**Neoplasms** (2.4 per 100,000)	**Suicide** (8.7 per 100,000)
2	**Congenital anomalies** (125.5 per 100,000)	**Neoplasms** (2.9 per 100,000)	**Transport** (1.4 per 100,000)	**Transport** (2.0 per 100,000)	**Transport** (8.1 per 100,000)
3	**Cause of death pending** (62.7 per 100,000)	**Transport** (2.1 per 100,000)	**Diseases of the nervous system** (1.4 per 100,000)	**Suicide** (1.3 per 100,000)	**Neoplasms** (4.9 per 100,000)
4	**SIDS & undetermined causes** (25.4 per 100,000)	**Cause of death pending** (2.1 per 100,000)	**Congenital anomalies** (*)	**Diseases of the circulatory system** (*)	**Diseases of the nervous system** (*)
5	**Diseases of the nervous system** (9.0 per 100,000)	**Drowning** (2.1 per 100,000)	**Drowning** (*)	**Drowning** (*)	**Endocrine, nutritional and metabolic diseases** (*)

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates are calculated per 100,000 children and young people in each age category.

Under 1 year

Conditions originating in the perinatal period were the most frequent cause of death for infants under 1 year of age, accounting for 46.1% of the deaths in this age category. This was followed by congenital anomalies (27.1% of infant deaths).

1–4 years

While drowning has consistently been the leading cause of death for 1-4 year olds (with the exception of the 2007-08 reporting period), congenital anomalies was the leading cause of death for 1-4 year olds in 2010–11 (20.5%). Deaths as a result of neoplasms accounted for the next highest number of deaths for children in this age category followed by drowning and transport incidents and undetermined causes of death.

5–9 years

Neoplasms were the leading cause of death for children aged 5–9 years. This is in line with all previous reporting periods except 2008–09, in which transport was the leading cause of death for this age category. In 2010–11, transport was the second leading cause of death for children in this age category (equal with deaths due to diseases of the nervous system).

10–14 years

As per the last two reporting periods, neoplasms were the leading cause of death for this age category, followed by transport incidents. Earlier reporting periods consistently featured transport and suicide as the leading causes of death among 10–14 year olds.

15–17 years

For the second year in a row, suicide was the leading cause of death for young people in this age category, followed closely by transport incidents.

Aboriginal and Torres Strait Islander status

Of the 465 children and young people who died, a total of 61 were identified as Aboriginal or Torres Strait Islander. This includes 8 cases where other documentation (such as the Police Report of Death to a Coroner) indicated that the child was Aboriginal or Torres Strait Islander, although this was not reflected in death registration information.

Table 1.5 outlines the causes of death by age category for the total 61 Aboriginal and Torres Strait Islander children. The greatest proportion of these children were under 1 year of age (67.2%) followed by young people in the 15-17 year age category. This is consistent with patterns of death by age category for non-Indigenous children.

Aboriginal and Torres Strait Islander children died at 2.2 times the rate of non-Indigenous children, with a rate of 88.2 deaths per 100,000 Indigenous children aged 0–17 years, compared with 40.2 deaths per 100,000 for non-Indigenous children.

Table 1.5: Aboriginal and Torres Strait Islander deaths by cause of death and age category

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total	Rate per 100,000 Indigenous children	Rate per 100,000 non-Indigenous children
	n	*n*	*n*	*n*	*n*	*n*		
Diseases and morbid conditions	**30**	**3**	**2**	**0**	**0**	**35**	**50.6**	**30.9**
SIDS and undetermined causes (infants)	2	0	0	0	0	2	*	1.5
External causes	**1**	**2**	**2**	**3**	**8**	**16**	**23.1**	**5.9**
Suicide	0	0	0	2	5	7	10.1	1.4
Drowning	0	1	1	0	1	3	*	1.1
Other non-intentional injury	0	0	0	1	0	1	*	*
Fatal assault	1	0	0	0	0	1	*	0.4
Transport	0	1	1	0	2	4	5.8	2.7
Cause of death pending	**10**	**0**	**0**	**0**	**0**	**10**	**14.5**	**3.5**
Total	**41**	**5**	**4**	**3**	**8**	**61**	**88.2**	**40.2**
Rate per 100,000 (Indigenous)	**969.3**	**31.4**	**21.0**	*	**71.8**	**88.2**		
Rate per 100,000 (non-Indigenous)	**428.9**	**15.3**	**9.0**	**10.4**	**27.7**	**40.2**		

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 Aboriginal and Torres Strait Islander children aged 0–17 years in Queensland, and per 100,000 non-Indigenous children aged 0–17 years in Queensland.
2. Although deaths that only occur within a certain age category (such as SIDS and suicide) are generally expressed as a rate per 100,000 children within that age category (for example, under 1 year; 10–17 years), all rates have been calculated per 100,000 children and young people aged 0–17 years in Queensland to enable comparison across all causes of death. Age-specific death rates are discussed in the chapters relating to each cause of death.

The number of deaths of Indigenous children from external causes has increased when compared to the last reporting period. Deaths from external causes occurred at 3.9 times the rate in the population of Aboriginal and Torres Strait Islander children than in the non-Indigenous population (Aboriginal and Torres Strait Islander children died at 1.7 times the rate in the non-indigenous population in the last reporting period).

While transport incidents were the leading external cause of death for non-Indigenous children, the leading external causes of death for Aboriginal and Torres Strait Islander children was suicide. This is consistent with the last reporting period. The number of Aboriginal and Torres Strait Islander young people who took their own lives in 2010–11 has increased significantly when compared to the last reporting period, however the rate is stable when compared to previous reporting periods. While the Commission has previously reported in 2009–10 that Indigenous young people were almost 13 times more likely to suicide than non-Indigenous young people in Queensland, in 2010–11 Indigenous young people were 7.5 times more likely to suicide than non-Indigenous young people.

Once again, the number of Aboriginal and Torres Strait Islander child deaths due to drowning has been consistently low when compared to the non-Indigenous population. This is in contrast to research which shows high rates of Indigenous child drowning nationally.

Ten of the 41 deaths of Aboriginal and Torres Strait Islander infants were classified as SUDI, a rate of 236.4 per 100,000 Indigenous infants. This is 3.3 times the rate of SUDI deaths among non-Indigenous infants (71.8 deaths per 100,000 non-Indigenous infants). This represents a decrease in SUDI deaths among Aboriginal and Torres Strait Islander infants when compared to the last reporting period (and a corresponding increase in SUDI deaths among non-Indigenous infants).

The Commission will continue to monitor any trends in the gap between Indigenous and non-Indigenous infant mortality over the coming years.

Geographical distribution (ARIA+)

Remote areas of Queensland recorded the highest rate of child death, with 50.1 deaths per 100,000 children aged 0–17 years living in regional areas. Regional areas recorded the next highest rate of child death (48.3 per 100,000), followed by metropolitan areas with 36.1 per 100,000 children

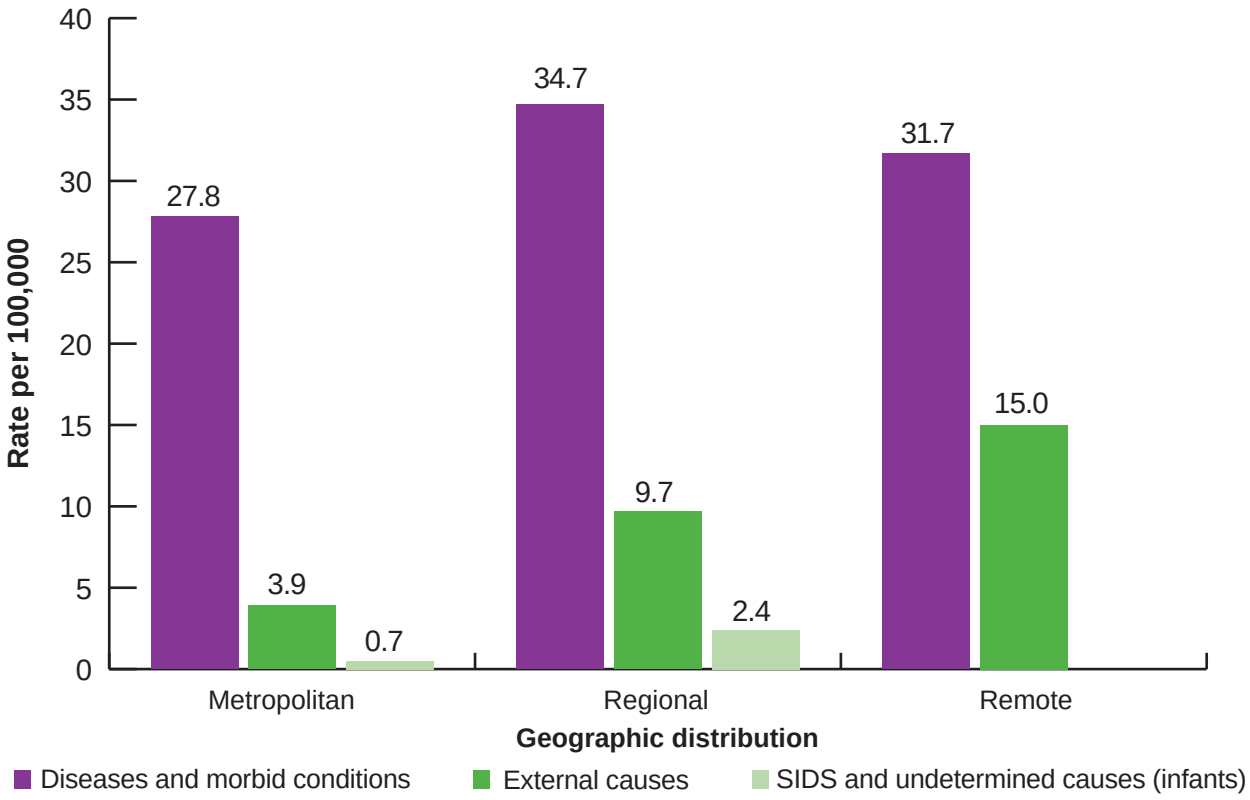
Deaths from diseases and morbid conditions were highest in regional areas (34.7 per 100,000) while external causes were most common in remote areas (15.0 per 100,000).

The rate of transport incidents and drowning were highest in regional areas. The rate of suicide was highest in remote areas (8.3 per 100,000 children residing in remote areas). This represents a significant change when compared to the last reporting period where the suicide rate was highest in regional areas (2.4 per 100,000 children residing in remote areas).

Rates of death from diseases and morbid conditions, SIDS and undetermined causes and external causes are illustrated in Figure 1.3. For detailed findings regarding cause of death by geographic area, see Appendix 1.3.

Queensland was not the usual place of residence for 18 of the 465 children and young people who died in Queensland in 2010–11 (see Appendix 1.4).

Figure 1.3: Geographical distribution of child deaths by cause of death



Data source: Queensland Child Death Register (2010–11)

Notes: 1. Eighteen children were not classified as their usual residence was outside Queensland. For further details, see Appendix 1.4.
2. This figure represents rates of death, not actual numbers.
3. The number of deaths from SIDS and undetermined causes in remote areas was not large enough to facilitate the calculation of rates. The deaths of infants from SIDS and undetermined causes in this area are therefore not represented here.

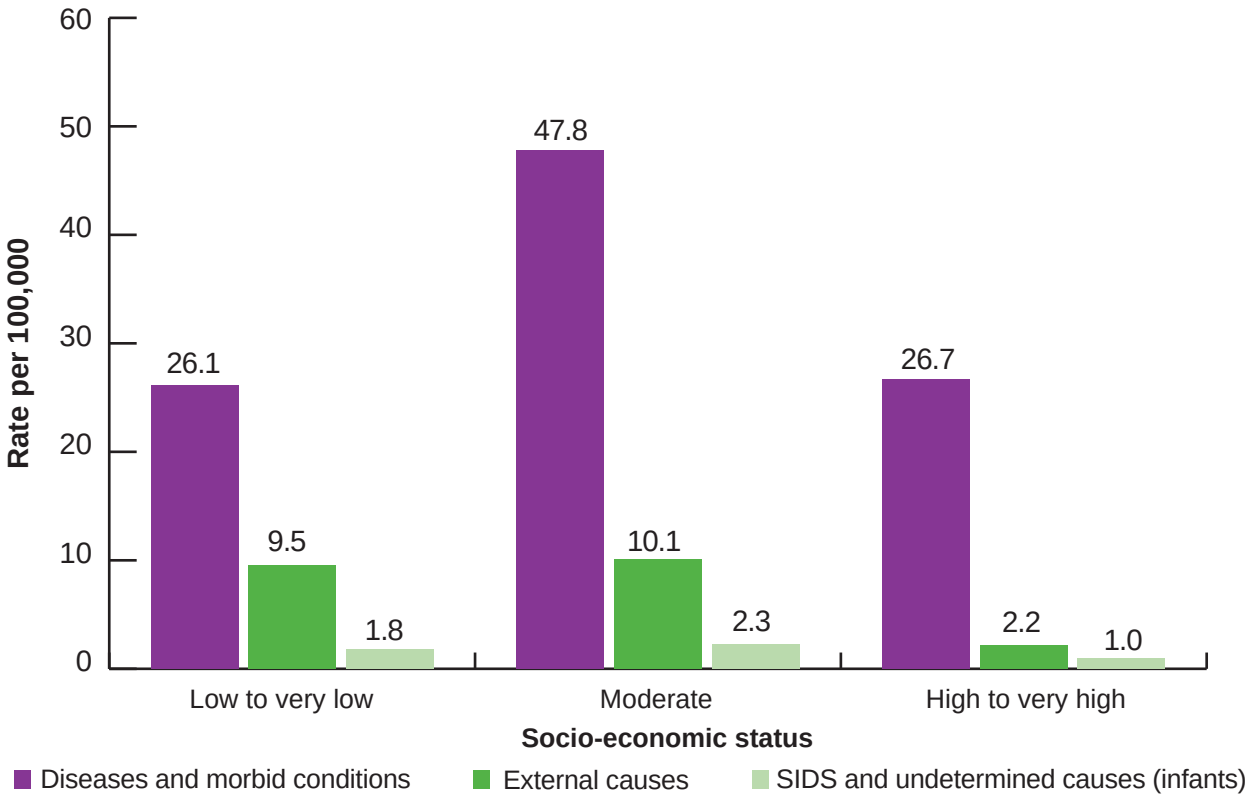
Socio-economic status (SEIFA)

Children living in moderate socio-economic areas recorded the highest rate of child deaths (63.0 per 100,000 children). Low to very low socio-economic areas recorded a rate of 40.6 per 100,000, while high to very high socio-economic areas recorded the lowest rate of child deaths (31.6 per 100,000). This is in contrast to the last reporting period, where children living in low to very low socio-economic areas recorded the highest rate of child death.

Deaths from diseases and morbid conditions were highest in moderate socio-economic areas. Moderate socio-economic areas also recorded the highest rate of death from external causes.

These results are illustrated in Figure 1.4. For detailed findings regarding cause of death by socio-economic status, see Appendix 1.5.

Figure 1.4: Socio-economic status of child deaths by cause of death



Data source: Queensland Child Death Register (2010–11)
Notes: 1. Eighteen children were not classified as their usual residence was outside Queensland. For further details, see Appendix 1.4.
2. This figure represents rates of death, not actual numbers.

Children known to the child protection system

Of the 465 children and young people whose deaths were registered in 2010–11, 61 were known to the child protection system. For the purpose of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

Information sources available to the Commission also enable the identification of cases where, while the deceased child had not come to the attention of the Department of Communities, the child's siblings had. In an additional 5 cases, only the deceased child's siblings were known to the child protection system.

The causes of death for children known to the child protection system are shown in Table 1.7.

Of the children known to the child protection system, 45.9% died as a result of diseases and morbid conditions, and 37.7% as a result of external causes. The leading external cause of death for children known to the child protection system was suicide (7.3 per 100,000). This represents an increase when compared to the last reporting period.

Comparative rates of death

Families of children who have been known to the child protection system are often characterised by chaotic social circumstances such as parental substance abuse, family violence, mental illness, transience and a history of involvement with corrective services. As such, children known to the child protection system comprise a vulnerable and at-risk cohort. The rate of deaths for all children has surpassed the rate of deaths for children known to the child protection system in 2010–11 for the first time since reporting commenced in 2004-05. This may be due to the growth in population of children known to the child protection system over the past 5 years (ranging from 6% in 2007-08 to 27% in

2009–10) when compared to the total population growth of children and young people. Consequent changes in counting methodologies may also be a factor. Furthermore, the total population of children as used to calculate rates for 2010–11 was the same as the population used for 2009–10. This is due to the fact that disaggregated population estimates for 2010–11 were not available.

It is preferable that children and young people who are at-risk come to the attention of the child protection system, which then provides an opportunity for assessment and intervention based upon an increasing understanding of the risk factors at play. As such, members of the community should be encouraged to continue reporting any concerns about the safety of children. If there is a reason to suspect a child in Queensland is experiencing harm, or is at risk of experiencing harm, it is important that risk factors be assessed by child protection experts. Early intervention and prevention can make a difference.

Available data about the deaths of children known to the child protection system

This report examines the deaths of 61 children whose deaths were registered by the Registry of Births, Deaths and Marriages in the reporting period (1 July 2010 – 30 June 2011). This figure is different to the number of deaths that actually *occurred* in this period. For example, the death of a child that occurs in June may not be registered until July/August, carrying the review of this death to the following reporting period.

The reporting of child deaths by date of registration accords with datasets managed by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, as well as the child death data managed by other Australian states and territories.

When a child known to the child protection system dies in Queensland, an additional review is triggered that explores the quality of child protection service delivery, including whether any actions or inactions of the service system contributed to the death. This process involves an initial review by the Department of Communities and subsequent oversight by the independent Child Death Case Review Committee (CDCRC). Due to legislative mandates and timeframes associated with these review processes, figures published by the Department of Communities and the CDCRC about the number of deaths of children known to the child protection system differ in some respects. The following table explains the key differences.

Table 1.6: Available data about deaths of children known to the child protection system

Figure	Data source	Methodology
61 (Deaths registered in 2010–11)	*Annual Report: Deaths of Children and Young People, Queensland 2009–10*	Reviews risk factors in deaths of children and young people known to the child protection system in Queensland that were registered in 2010-11. The review process involves analysis of available death records, for example, police reports to Coroner (where available) and autopsy findings.
63 (Deaths that occurred in 2010–11)	Commission for Children and Young People and Child Guardian, Queensland Child Death Register	The Commission's Child Death Register is able to report on the number of deaths of children known to the child protection system that occurred in 2010-11, that is, the child or young person died between 1 July 2010 and 30 June 2011.
65 (Deaths the department became aware of during 2010–11 that require a child death case review)	Department of Communities	Section 246D of the *Child Protection Act 1999* requires the department to conduct a review of its involvement with a child within 6 months of becoming aware of the death of a child that was known to the child protection system in the 3 years prior to their death. For the purpose of its reporting, the department does not report on the actual number of deaths that occurred during 2010–11, but instead reports on the number of deaths it became aware of in the period.

Table 1.7: Cause of death of children known to the child protection system by age category

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Child known	Siblings known	Child or siblings known	Rate per 100,000 in child protection system	Rate per 100,000 all Queensland children
	n	*n*	*n*	*n*	*n*	*n*	*n*	*n*		
Diseases and morbid conditions	**14**	**7**	**2**	**3**	**2**	**28**	**1**	**29**	**19.2**	**32.1**
SIDS and undetermined causes (infants)	4	0	0	0	0	4	1	5	3.3	1.6
Undetermined >1 year	0	0	0	0	0	0	0	0	0	*
External causes	**2**	**6**	**1**	**6**	**8**	**23**	**1**	**24**	**15.9**	**7.0**
Transport	1	2	0	1	0	4	1	5	3.3	2.9
Drowning	0	2	0	0	0	2	0	2	*	1.3
Suicide	0	0	1	4	6	11	0	11	7.3	2.0
Other non-intentional injury	0	0	0	1	1	2	0	2	*	*
Fire	0	0	0	0	1	1	0	1	*	*
Fatal assault	1	2	0	0	0	3	0	3	*	0.5
Cause of death pending	**10**	**0**	**0**	**0**	**0**	**10**	**3**	**13**	**8.6**	**4.2**
Total	**26**	**13**	**3**	**9**	**10**	**61**	**32**	**66**	**40.3**	**43.3**

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates of death for children known to the child protection system are based on the number of distinct children known to the Department of Communities in the 3 year period before the 2010–11 financial year.
2. Rates have only been calculated for cases where the deceased child was known to the child protection system, not for cases where the departmental involvement was with the child's siblings only.
3. Rates of death for all Queensland children are based on the number of children aged 0–17 years in Queensland.

Coronial deaths

Of the 465 deaths of children and young people registered in 2010–11, 33.5% were reportable under the Coroners Act 2003 (156 deaths). At the time of reporting, coronial findings had been finalised for 14.1% of reportable deaths. Autopsy reports were provided in all of the finalised cases and in 36 of the cases where coronial findings are still outstanding.

Cause of death information provided by the Registry of Births, Deaths and Marriages was available in 65.4% of reportable deaths. No cause of death information was available in 34.6% of cases.

Part II: Deaths from diseases and morbid conditions

Chapter 2

This section provides details of child deaths from diseases and morbid conditions, ranging from congenital anomalies and perinatal conditions through to cancer and infections.

Key findings

- In 2010–11, the deaths of 345 children and young people were the result of diseases and morbid conditions, a rate of 32.1 deaths per 100,000 children and young people aged 0–17 years in Queensland.
- The most common causes of death as a result of diseases and morbid conditions were certain conditions originating in the perinatal period (13.7 deaths per 100,000 children and young people aged 0–17 years), followed by congenital malformations, deformations and chromosomal abnormalities (9.1 deaths per 100,000). Together, these causes accounted for 71.0% of the deaths from diseases and morbid conditions.
- Children in their first year of life are particularly vulnerable to disease and morbid conditions. Infants accounted for 76.8% of deaths from diseases and morbid conditions.
- Aboriginal and Torres Strait Islander children died from diseases and morbid conditions at a rate of 50.6 per 100,000 Indigenous children aged 0–17 years (compared with 30.9 deaths per 100,000 non-Indigenous children).
- The rate of death of Aboriginal and Torres Strait Islander children from diseases and morbid conditions has fluctuated over the previous 5 years, ranging between 50.6 and 81.5 deaths per 100,000 Indigenous children. The rate of 50.6 deaths in 2010–11 is the lowest in the past 5 years.
- No deaths occurred as a result of the H1N1 virus (swine flu), human immunodeficiency virus (HIV), hepatitis or other potentially sexually transmissible infections (STIs).
- In 2010–11, the Commission reviewed Sudden Cardiac Death (SCD) in children and young people. Between 1 July 2004 and 30 June 2011, there were 23 cases where a child or young person died suddenly and unexpectedly from an underlying condition that appears cardiac-related, of which the child or their family were not aware prior to their death.

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Chapter 2

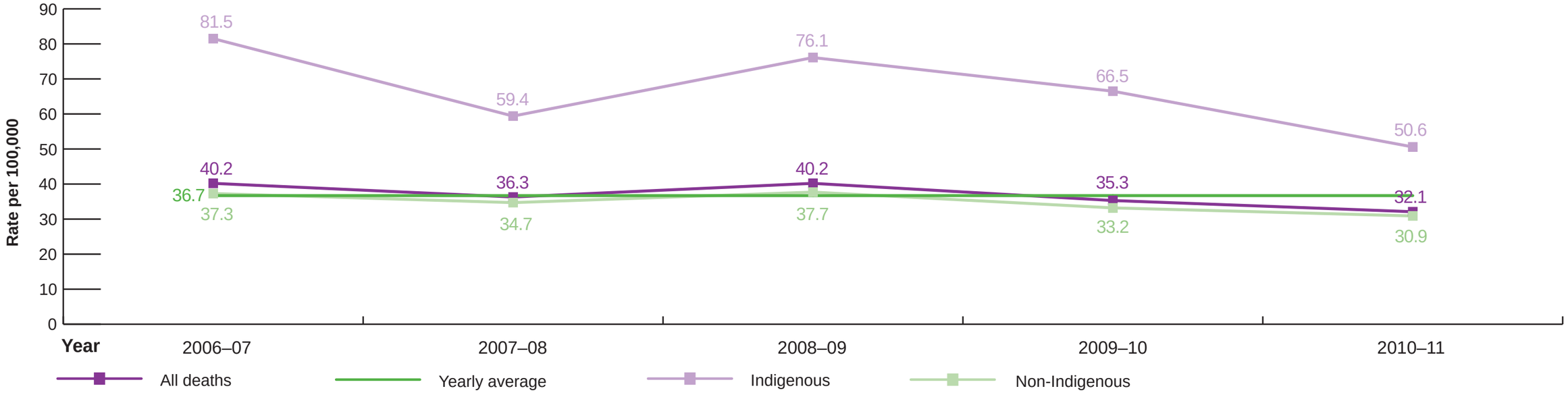
Deaths from diseases and morbid conditions

Table 2.1: Summary of deaths from diseases and morbid conditions of children and young people in Queensland, 2006–2011

	2006–07		2007–08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All deaths from diseases and morbid conditions											
Diseases and morbid conditions	405	40.2	373	36.3	422	40.2	379	35.3	345	32.1	36.7
Gender											
Female	170	34.7	168	33.6	185	36.2	149 a	28.5	162	31.0	32.7
Male	235	45.5	205	38.9	237	44.0	229 a	41.5	183	33.2	40.4
Aboriginal and Torres Strait Islander status											
Indigenous	54	81.5	40	59.4	52	76.1	46	66.5	35	50.6	66.4
Non-Indigenous	351	37.3	333	34.7	370	37.7	333	33.2	310	30.9	34.6
Known to the child protection system											
Known to the child protection system	35	40.7	30	32.9	46	45.1	32	24.7	29	19.2	33.8
Perinatal conditions											
Perinatal conditions	159	279.4	136	220.8	152	233.1	157	236.7	147	234.8	230.4
Indigenous	*22*	*541.0*	*14*	*318.0*	*16*	*343.4*	*14*	*295.3*	*20*	*447.1*	*369.1*
Congenital anomalies											
Congenital anomalies	92	9.1	115	11.2	111	10.6	92	8.6	98	9.1	9.7
Indigenous	*6*	*9.1*	*10*	*14.8*	*10*	*14.6*	*12*	*17.3*	*8*	*11.6*	*13.5*
Neoplasms (cancers and tumours)											
Neoplasms	33	3.3	32	3.1	25	2.4	31	2.9	34	3.2	3.0
Indigenous	*4*	*6.0*	*3*	*	*4*	*5.9*	*2*	*	*1*	*	*4.1*
Infections											
Infections	17	1.7	15	1.5	30	2.9	19	1.8	12	1.1	1.8
Indigenous	*8*	*12.1*	*1*	*	*9*	*13.2*	*5*	*7.2*	*2*	*	*7.3*

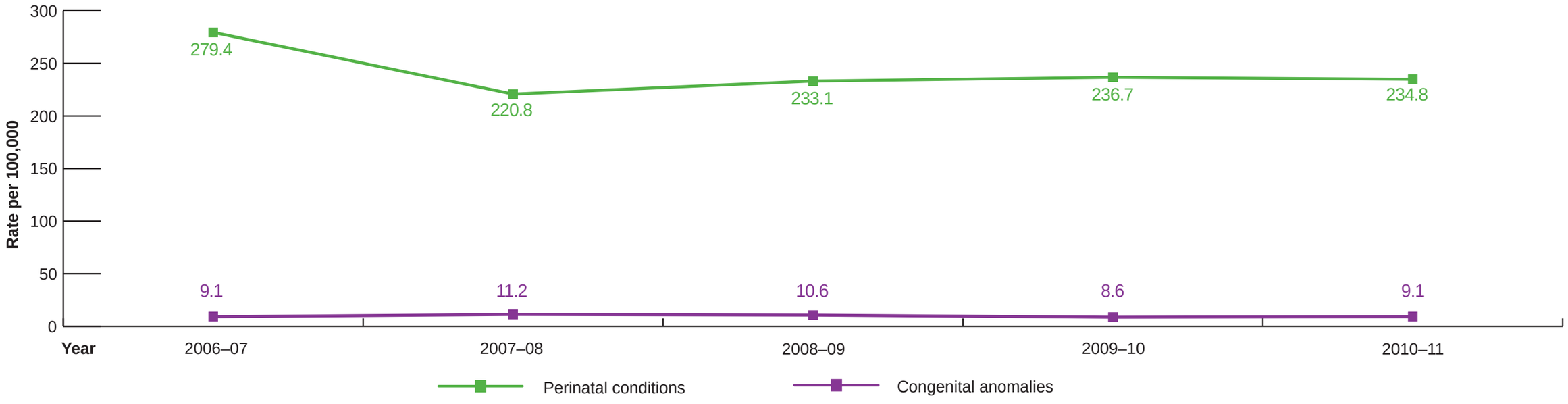
Data source: Queensland Child Death Register (2006–2011)5
** Rates have not been calculated for numbers less than 4.*
[a] Excludes the death of 1 infant of indeterminate sex.
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates are calculated per 100,000 children (in the gender/Indigenous status bracket stated) in Queensland in each year.
3. Rates for the various types of diseases and morbid conditions are calculated per 100,000 children aged 0–17 years in Queensland in each year, with the exception of 'Perinatal conditions', which is calculated per 100,000 infants under the age of 1 year in Queensland.
4. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
5. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
6. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 2.1: Deaths from diseases and morbid conditions, 2004–2011



Data source: Queensland Child Death Register (2006–2011)
Notes: 1. Rates are calculated per 100,000 Aboriginal and Torres Strait Islander and per 100,000 non-Indigenous children and young people aged 0–17 years in Queensland.

Figure 2.2: Deaths from diseases and morbid conditions – leading causes, 2006–2011



Data source: Queensland Child Death Register (2004–2010)
Note: 1. Rates for perinatal conditions are calculated per 100,000 infants under 1 year of age in Queensland.
2. Rates for congenital anomalies have been calculated per 100,000 children and young people aged 0–17 years in Queensland.

Diseases and morbid conditions: findings, 2010–11

Between 1 July 2010 and 30 June 2011, 345 children and young people died from diseases and morbid conditions in Queensland, representing 74.2% of all child deaths and a rate of 32.1 deaths per 100,000 children and young people aged 0−17 years.

Table 2.2 shows the causes of all child deaths from diseases and morbid conditions, broken down by ICD-10 chapter level classifications.

Table 2.2: Deaths from diseases and morbid conditions by ICD-10 chapter level classification

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total		Rate per 100,000
	n	*n*	*n*	*n*	*n*	*n*	%	
Certain conditions originating in the perinatal period (P00–P96)	146	1	0	0	0	147	42.6	13.7
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	84	8	3	1	2	98	28.4	9.1
Neoplasms (C00–D48)	2	7	9	7	9	34	9.9	3.2
SIDS and undetermined causes (R95–R99)	17	0	0	0	1	18	5.2	1.7
Diseases of the nervous system (G00–G99)	6	1	4	2	3	16	4.6	1.5
Endocrine, nutritional and metabolic diseases (E00–E90)	2	2	1	1	2	8	2.3	0.7
Diseases of the respiratory system (J00–J99)	2	2	1	2	1	8	2.3	0.7
Certain infectious and parasitic diseases (A00–B99)	3	2	0	0	0	5	1.4	0.5
Diseases of the circulatory system (I00–I99)	1	0	0	3	1	5	1.4	0.5
Diseases of the digestive system (K00–K99)	0	1	1	1	0	3	0.9	*
Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D00–D89)	1	0	0	0	0	1	0.3	*
Mental and behavioural disorders (F00–F99)	0	0	0	0	1	1	0.3	*
Diseases of the genitourinary system (N00–N99)	1	0	0	0	0	1	.03	*
Total	**265**	**24**	**19**	**17**	**20**	**345**	**100.0**	**32.1**
Rate per 100,000	**395.9**	**10.1**	**6.6**	**5.7**	**10.8**			

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates are calculated per 100,000 children and young people in each age category.
2. Although deaths that only occur within a certain age category (such as perinatal conditions) are generally expressed as a rate per 100,000 children within that age category (for example, infants under 1 year), rates for causes of death have been calculated per 100,000 children and young people aged 0–17 years in Queensland to enable comparison across all causes of death.

The main causes of mortality from diseases and morbid conditions were conditions originating in the perinatal period and congenital malformations, deformations and chromosomal abnormalities. Together these causes accounted for 71.0% of all deaths from diseases and morbid conditions.

Neoplasms accounted for 9.9% of deaths from diseases and morbid conditions, while SIDS and other undetermined causes accounted for 5.2%. This includes the deaths of children over the age of 1 year who died of undetermined causes.

Gender

Of the 345 children who died, 53.0% were male and 47.0% were female. Male and female children died from diseases and morbid conditions at similar rates, with a rate of 33.2 deaths per 100,000 male children aged 0–17 years in Queensland, compared with 31.0 deaths per 100,000 female children.

Age

There is a generally inverse relationship between children's age and deaths due to diseases and morbid conditions. That is, the likelihood of children dying from diseases and morbid conditions decreases with increasing age.

Infants under 1 year

Children were significantly more likely to die from diseases and morbid conditions in the first year of life than at any other age, with infants under 1 year accounting for 76.8% of deaths due to diseases and morbid conditions, a rate of 395.9 deaths per 100,000 infants (4.2 deaths per 1000 live births).

Infant deaths are divided into neonatal and post-neonatal periods. Neonatal deaths are those that occur in the first 28 days after birth (0–27 days), while post-neonatal deaths occur during the remainder of the first year (28–365 days). The numbers of deaths from diseases and morbid conditions decrease significantly in the post-neonatal period.

Table 2.3 shows the age and cause of infant deaths.

In total, 77.0% of infant deaths due to diseases and morbid conditions occurred in the neonatal period, a rate of 3.3 neonatal deaths per 1000 live births, with 63.7% of these occurring on the day of birth. A further 19.1% of neonatal deaths had occurred by the end of the first week.

The majority of infant deaths in the neonatal period were the result of conditions originating in the perinatal period (2.1 deaths per 1000 live births), followed by congenital malformations, deformations and chromosomal abnormalities (0.1 deaths per 1000 live births).

Infants died from diseases and morbid conditions in the post-neonatal period at a rate of 1.0 deaths per 1000 live births. Conditions originating in the perinatal period, congenital malformations, deformations and chromosomal abnormalities, and SIDS and undetermined causes were the leading causes of death in the post-neonatal period.

Table 2.3: Age and cause of infant deaths

	Neonatal (age in days)			Neonatal total	Post-neonatal (age in months)											Post-neonatal total	Total infants
Cause of death	**<1**	**1–6**	**7–27**	**n**	**1***	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**n**	**n**
Certain conditions originating in the perinatal period (P00–P96)	87	24	18	129	8	2	2	0	1	2	0	2	0	0	0	17	146
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	42	13	13	68	3	2	6	1	0	1	0	0	3	0	0	16	84
SIDS and undetermined causes (R95–R99)	0	0	2	2	5	1	2	3	2	1	0	1	0	0	0	15	17
Diseases of the nervous system (G00–G99)	0	2	1	3	0	0	0	1	1	0	0	0	1	0	0	3	6
Endocrine, nutritional and metabolic diseases (E00-E90)	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2
Diseases of the respiratory system (J00–J99)	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2	2
Certain infectious and parasitic diseases (A00–B99)	0	0	0	0	0	2	0	0	0	0	0	0	0	1	0	3	3
Diseases of the circulatory system (I00–I99)	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1
Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50–D89)	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Neoplasms (C00–D48)	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	2	2
Diseases of the genitourinary system (N00–N99)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	1
Total	**130**	**39**	**35**	**204**	**16**	**7**	**11**	**5**	**5**	**4**	**1**	**3**	**6**	**2**	**1**	**61**	**265**

Data source: Queensland Child Death Register (2010–11)
** 28 days to 2 months*

1–4 years

Children aged 1−4 years died from diseases and morbid conditions at a rate of 10.1 deaths per 100,000 children in this age category.

The leading causes of death in this age category were congenital malformations, deformations and chromosomal abnormalities, followed by neoplasms.

5–9 years

Children aged 5−9 years died from diseases and morbid conditions at a rate of 6.6 deaths per 100,000 children aged 5−9 years.

Neoplasms accounted for the largest number of deaths in this age category, followed by diseases of the nervous system.

10–14 years

Children aged 10−14 years had the lowest rate of death from diseases and morbid conditions, dying at a rate of 5.7 deaths per 100,000 children aged 10−14 years.

The leading cause of death in this age category was neoplasms. This was followed by diseases of the circulatory system.

15–17 years

Young people aged 15−17 years were the second-most likely age category to die from diseases and morbid conditions after infants, at a rate of 10.8 deaths per 100,000 young people aged 15−17 years.

The leading causes of death in this age category were neoplasms followed by diseases of the nervous system.

Aboriginal and Torres Strait Islander status

Thirty-five children and young people who died from diseases and morbid conditions were Aboriginal or Torres Strait Islander. Twenty-eight identified as Aboriginal, 5 as Torres Strait Islander and 2 as both Aboriginal and Torres Strait Islander.

Aboriginal and Torres Strait Islander children died from diseases and morbid conditions at a rate of 50.6 deaths per 100,000 Aboriginal and Torres Strait Islander children aged 0−17 years (compared with 30.9 deaths per 100,000 non-Indigenous children).

As shown in Figure 2.1, the rate of death of Aboriginal and Torres Strait Islander children from diseases and morbid conditions has fluctuated somewhat over the previous 5 years, ranging between 50.6 and 81.5 deaths per 100,000 Indigenous children.

Geographical distribution (ARIA+)

Children living in regional areas of Queensland died at a rate of 34.7 deaths per 100,000 children aged 0−17 years. Remote areas recorded the next highest rate at 31.7 deaths per 100,000. Metropolitan areas had the lowest rate of death from diseases and morbid conditions with 27.8 deaths per 100,000.

Queensland was not the usual place of residence for 15 of the 344 children. Eleven of these children usually resided in New South Wales.

Socio-economic status (SEIFA)

The rate of death from diseases and morbid conditions was highest in moderate socio-economic areas, with 47.8 deaths per 100,000 children aged 0−17 years, compared with 26.7 deaths per 100,000 children living in high to very high socio-economic areas and 26.1 deaths per 100,000 children living in low to very low socio-economic areas.

Children known to the child protection system

Of the 345 children who died from diseases and morbid conditions, 8.4% were known to the child protection system[1] in the 3 years before their death (29 deaths). Children known to the child protection system died from diseases and morbid conditions at a lower rate than that of all Queensland children (19.2 deaths per 100,000 children known to the child protection system, compared with 32.1 deaths per 100,000 children in Queensland). While the number of children known to the child protection system who have died from this cause has decreased over the past three years, the rate has been heavily influenced by the sharp increase of the denominator figure.

In 1 additional case, the Police Report of Death to a Coroner (Form 1) indicated that the family had a history of involvement with the child protection system in relation to the deceased child's siblings only.

Deaths from diseases and morbid conditions: major causes

As discussed earlier, the main causes of mortality from diseases and morbid conditions were conditions originating in the perinatal period and congenital malformations, deformations and chromosomal abnormalities, followed by neoplasms. These causes are considered in detail in this section.

Deaths as a result of infection are also discussed in this section. Within the World Health Organisation's classification system (ICD-10), deaths due to infection may be categorised separately, according to which part of the body they affect. Deaths due to infection are, in the main, both unexpected and potentially preventable, and are therefore worthy of further consideration.

Perinatal conditions

Perinatal conditions[2] are diseases and conditions that originated during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. These include maternal conditions that affect the newborn, such as complications of labour and delivery, disorders relating to fetal growth, length of gestation and birthweight, as well as disorders specific to the perinatal period such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders.

As the vast majority of perinatal deaths occurred in infants (99.3%) all rates in this section have been given for infant populations.

[1] For the purpose of this report, a child is deemed to have been known to the child protection system if, within three years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

[2] Perinatal conditions are those coded to ICD-10 Chapter XVI, Certain conditions originating in the perinatal period. These deaths have been coded based on medical cause of death only (as provided by the Registry of Births, Deaths and Marriages under s.48A of the *Births, Deaths and Marriages Registration Act 2003*). The Commission does not currently have access to either complete death certificates or perinatal data collection forms. Death certificates for infants who die in the neonatal period include information on birthweight and gestation that may be relevant to the underlying cause of death.

Table 2.4: Deaths due to perinatal conditions by gender

Cause of death	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00-P04)	33	29	62	92.6
Disorders related to length of gestation and fetal growth (P05-P08)	9	20	29	43.3
Respiratory and cardiovascular disorders specific to the perinatal period (P20-P29)	10	10	20	29.9
Digestive system disorders of fetus and newborn (P75-P78)	6	7	13	19.4
Haemorrhagic and haematological disorders of fetus and newborn (P50-P61)	4	5	9	13.4
Other disorders originating in the perinatal period (P90-P96)	4	5	9	13.4
Infections specific to the perinatal period (P35-P39)	1	2	3	*
Conditions involving the integument and temperature regulation of fetus and newborn (P80-P83)	1	1	2	*
Total	**68**	**79**	**147**	**219.6**
Rate per 100,000	**209.8**	**228.8**	**219.6**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
[a] Includes the death of one infant of indeterminate sex.
Note: 1. Rates are calculated per 100,000 children under 1 year of age in Queensland.

One hundred and forty-seven infants and children died from perinatal conditions, a rate of 219.6 deaths per 100,000 infants.

The majority of deaths due to perinatal conditions were caused by the fetus and/or newborn being affected by maternal factors or complications of pregnancy, labour and delivery, followed by disorders related to the length of gestation and fetal growth. Together these causes accounted for 61.9% of all deaths due to perinatal conditions.

Gender

Male infants died from perinatal conditions at a higher rate than females, with a rate of 228.8 deaths per 100,000 male infants, compared with 209.8 deaths per 100,000 female infants.

Aboriginal and Torres Strait Islander status

Around 13.6% of infants who died from perinatal conditions were Aboriginal or Torres Strait Islander (20 deaths). Aboriginal and Torres Strait Islander infants were over-represented in deaths from perinatal conditions, with a rate of 472.8 deaths per 100,000 Indigenous infants, compared with 202.5 deaths per 100,000 non-Indigenous infants.

Congenital anomalies

Congenital anomalies[3] are mental and physical conditions present at birth that are either hereditary or caused by environmental factors.

[3] ICD-10 Chapter XVII, Congenital malformations, deformations and chromosomal abnormalities.

Table 2.5: Deaths due to congenital anomalies by gender

Cause of death	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Congenital malformations of the circulatory system (Q20–Q28)	11	11	22	2.0
Other congenital malformations (Q80–Q89)	11	7	18	1.7
Chromosomal abnormalities, not elsewhere classified (Q90–Q99)	8	8	16	1.5
Congenital malformations and deformations of the musculoskeletal system (Q65–Q79)	5	7	12	1.1
Congenital malformations of the nervous system (Q00–Q07)	5	7	12	1.1
Congenital malformations of the urinary system (Q60–Q64)	3	6	9	0.8
Other congenital malformations of the digestive system (Q38–Q45)	7	0	7	0.7
Congenital malformations of the respiratory system (Q30–Q34)	2	0	2	*
Total	**52**	**46**	**98**	**9.1**
Rate per 100,000	**10.0**	**8.3**	**9.1**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Ninety-eight children and young people died from congenital anomalies, a rate of 9.1 deaths per 100,000 children aged 0−17 years.

The greatest number of deaths due to congenital anomalies was caused by malformations of the circulatory system, followed by other congenital malformations and chromosomal abnormalities.

Gender

Females died from congenital anomalies at a rate of 10.0 deaths per 100,000 female children aged 0−17 years, compared with 8.3 deaths per 100,000 male children.

Age

The majority of deaths due to congenital anomalies occurred in infants under 1 year of age (85.7%). Of the 84 infant deaths, most occurred in the neonatal period (81.0%).

Aboriginal and Torres Strait Islander status

Eight children who died from congenital anomalies were Aboriginal or Torres Strait Islander. Aboriginal and Torres Strait Islander children died from congenital anomalies at a rate of 11.6 deaths per 100,000 Indigenous children aged 0−17 years, compared with 9.0 deaths per 100,000 non-Indigenous children.

Neoplasms (cancers and tumours)

Although these terms are not synonymous, the term 'neoplasm'[4] is often used interchangeably with words such as 'tumour' and 'cancer'. Cancer includes a range of diseases in which abnormal cells proliferate and spread out of control. Normally, cells grow and multiply in an orderly way to form organs that have a specific function in the body. However, occasionally cells multiply in an uncontrolled way after being affected by a carcinogen, or after developing a random genetic mutation.

They may form a mass that is called a tumour or neoplasm. A 'benign neoplasm' refers to a non-cancerous tumour, whereas a 'malignant neoplasm' usually refers to a cancerous tumour (that is, cancer). Benign tumours do not invade other tissues or spread to other parts of the body, although they can expand to interfere with healthy structures.

[4] ICD-10 Chapter II, *Neoplasms*.

Table 2.6: Deaths due to neoplasms by gender

Type of neoplasm	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Eye, brain and other parts of the central nervous system (C69–C72)	4	6	10	0.9
Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue (C81–C96)	4	4	8	0.7
Mesothelial and soft tissue (C45-C49)	2	1	3	*
Thyroid and other endocrine glands (C73–C75)	2	1	3	*
Urinary tract (C64-C68)	2	0	2	
Bone and articular cartilage (C40-C41)	1	1	2	*
Malignant neoplasms of ill-defined, secondary and unspecified sites (C76-C80)	1	1	2	*
Skin (C43-C44)	0	2	2	*
Female genital organs (C51-C58)	1	0	1	*
Neoplasms of uncertain or unknown behaviour (D37-D48)	1	0	1	*
Total	**18**	**16**	**34**	**3.2**
Rate per 100,000	**3.4**	**2.9**	**3.2**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland

Thirty-four children and young people died from cancers and tumours, a rate of 3.2 deaths per 100,000 children aged 0−17 years.

The most common types of neoplasms were those of the eye, brain and other parts of the central nervous system, followed by neoplasms of lymphoid, haematopoietic and related tissue. Together these accounted for 52.9% of deaths from neoplasms.

Gender

Females died from neoplasms at a slightly higher rate than males (3.4 deaths per 100,000 female children aged 0−17 years, compared with 2.9 per 100,000 male children).

Age

Children aged 5–9 years and 15–17 years recorded the highest number of deaths from neoplasms.

Aboriginal and Torres Strait Islander status

One of the children who died of cancer was Torres Strait Islander.[5]

Infections

Infections[6] is a hybrid category composed of certain infections and parasitic diseases, diseases of the nervous system and diseases of the respiratory system.

[5] Rates have not been calculated for numbers less than 4.
[6] ICD-10 Chapter I, *Certain infectious and parasitic diseases*; ICD-10 Chapter VI, *Diseases of the nervous system*, codes G00–G09 only; ICD-10 Chapter X, *Diseases of the respiratory system*, codes J00–J22 only.
[7] Rates have not been calculated for numbers less than 4.

Table 2.7: Deaths due to infections by gender

Cause of death	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Influenza and pneumonia (J09–J18)	2	3	5	0.5
Other bacterial diseases (A30–A49)	2	2	4	0.4
Inflammatory diseases of the central nervous system (G00-G09)	0	2	2	*
Protozoal diseases (B50-B64)	0	1	1	*
Total	**4**	**8**	**12**	**1.5**
Rate per 100,000	**0.8**	**1.5**	**1.1**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland

Twelve children and young people died from infections, a rate of 1.1 deaths per 100,000 children aged 0−17 years.

The highest number of deaths due to infections were caused by influenza and pneumonia, followed by other bacterial diseases.

Gender

Males died from infections at a higher rate than females (1.5 deaths per 100,000 male children aged 0−17 years, compared with 0.8 per 100,000 female children).

Age

Deaths from infections generally decreased with the increasing age of the child. Ten of the 12 deaths occurred in infants under 5 years, with 6 occurring in the in the first year of life.

Aboriginal and Torres Strait Islander status

Two of the 12 children who died from infections were Aboriginal or Torres Strait Islander.[7]

Deaths from communicable (nationally notifiable) diseases

Communicable diseases (including infectious and parasitic diseases) are those diseases capable of being transmitted from one person to another, or from one species to another. A disease may be made notifiable to state health authorities if there is potential for its control. Most of the notifiable diseases are included on a core list agreed by all states and territories. The factors considered include the overall impact of the disease on morbidity and mortality, and the availability of control measures.

Notification allows authorities to detect outbreaks early and take rapid public health action, if necessary, and to plan and monitor these efforts. It also provides information on patterns of occurrence of disease. See Appendix 2.1 for the complete Notifiable Conditions Schedule contained in the *Public Health Regulation 2005*.

Four children and young people died of a notifiable condition as shown in Table 2.8.

[7] Rates have not been calculated for numbers less than 4.

Table 2.8: Notifiable conditions by gender

Cause of death	Female	Male	Total
	n	*n*	*n*
Whooping cough (A37)	0	1	1
Plasmodium falciparum malaria (B50)	0	1	1
Meningococcal infection (A39)	1	0	1
Total	**1**	**2**	**3**

Data source: Queensland Child Death Register (2010–11)

All of the deaths from notifiable conditions were due to vaccine-preventable conditions.[8]

No deaths from notifiable conditions were due to the H1N1 virus (swine flu), human immunodeficiency virus (HIV), hepatitis or other sexually transmissible infections (STIs). [9]

Sudden Cardiac Death

In 2010-11 the Commission undertook a review of all sudden and unexpected deaths of children and young people aged 1-17 years since 2004, in order to identify and report on the incidence of Sudden Cardiac Death in Queensland.

Sudden Cardiac Death in the young (SCD) is variably defined in the research literature.[10] However, for the purpose of the current review the Commission has adopted the following definition: an unexplained or presumed arrhythmic sudden death, occurring in a short time period (generally within 1 hour of symptom onset) in a child or young person with previously unknown cardiac disease.

While SCD is predominantly caused by pre-existing congenital cardiac abnormalities, it is best described as a 'syndrome' insofar as there are a number of different underlying cardiovascular disorders that may cause sudden death. In a substantial proportion of presumed cardiac-related deaths, post-mortem findings are negative – that is, a post-mortem does not identify a cause of death. In adults this may lead to a diagnosis of sudden arrhythmic death syndrome (SADS) however, the Commission has found that in children and young people in Queensland the cause of death is frequently certified as "undetermined", with the pathologist postulating cardiac-related causes as likely or possible. In cases where the cause of death cannot be determined at autopsy, the underlying diagnosis may sometimes only be identified by detecting abnormalities in living relatives.

It is very difficult to identify SCD in official statistics due to the number of underlying cardiac conditions that may cause sudden death, as well as the need for comprehensive information regarding the person's clinical background (including preceding symptoms and previous medical history), demographic details, the circumstances of the death and the findings at autopsy. As such, there is currently little to no research identifying the incidence of Sudden Cardiac Death in children and young people either nationally or in Queensland.

The findings presented below are preliminary findings based on a review of the deaths contained in the Queensland Child Death register between 1 July 2004 and 30 June 2011. The Commission intends to work collaboratively with relevant experts during 2011-12 to further refine the methodology for identifying and reporting on SCD in children and young people in Queensland.

[8] In Australia, programs of mass immunisation are mostly administered by state and territory governments. The curent National Immunisation Program Schedule (valid from July 2007) includes the following vaccinations: hepatitis B, diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, haemophilus influenza type b (HiB), pneumococcal conjugate, rotavirus, measles, mumps and rubella, meningococcal C, varicella (chicken pox), human papillomavirus (HVP).

[9] The *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005–2011* represents a whole-of-government approach to the management of HIV, hepatitis C and STIs across Queensland. Under this strategy the Commission has agreed to report numbers of deaths from HIV, hepatitis or other STIs.

[10] Within the research literature, Sudden Cardiac Death in the young usually refers to deaths of children, young people and adults aged 35 years or under, however the current review limits the upper age to 17 years, due the Commissions legislated mandate for review and reporting of deaths of children and young people only.

Table 2.9: Sudden cardiac death by year

Cause of death	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	Total
	n	*n*	*n*	*n*	*n*	*n*	*n*	*n*
Other forms of heart disease (I30–I52)	3	0	1	2	2	1	1	10
Congenital malformations of the circulatory system (Q20–Q28)	1	0	0	2	0	0	0	3
Ill-defined and unknown causes of mortality (R95–R99)	1	0	3	0	5	0	1	10
Total	**5**	**0**	**4**	**4**	**7**	**1**	**2**	**23**

Data source: Queensland Child Death Register (2004–11)

Between 1 July 2004 and 30 June 2011, there were 23 cases where a child or young person died suddenly and unexpectedly from an underlying condition that appears cardiac-related, of which the child or their family were not aware prior to death.

Seven the 23 cases of SCD were associated with sport or other physical activity (in the 24 hours prior to death). Sports activity in adolescents and young adults is associated with an increased risk of SCD, although it should be noted that SCD is predominantly caused by pre-existing cardiac conditions rather than the sporting activity.

Five of the 23 children and young people who died due to SCD had been reported to have been generally unwell prior to death (experiencing flu like symptoms or nausea/diarrhoea). Research suggests that certain arrhythmic conditions likely worsen in the setting of general ill-health.

Gender

Similar numbers of males and females died from SCD (12 males, 11 females).

Age

Deaths from SCD appear to generally distributed across all age groups, although children aged 5–9 had the lowest number of deaths.

Table 2.10: Sudden cardiac death by age category and gender

Age category	Female	Male	Total
	n	*n*	*n*
1–4 years	5	3	8
5–9 years	2	0	2
10–14 years	2	6	8
15–17 years	2	3	5
Total	**11**	**12**	**23**

Screening[11]

Due to the diversity of underlying cardiac conditions that may cause SCD and the range of investigations that may be necessary to identify these conditions, population-based screening of children and young people is not feasible.

However, screening first degree relatives of anyone who has had an unexplained death under the age of 40 years is recommended. This is because sometimes the underlying diagnosis (in the deceased) may only be identified by detecting abnormalities in living relatives. Research evidence suggests that depending on the level of screening undertaken, in 20–40% of cases a diagnosis will be made, with potentially lifesaving treatment for other family members. There is also evidence that the younger the person who has died (excluding the first year of life), the more likely it is that a diagnosis will be made in the family. As such, screening the first degree relatives of children and young people who have died due to SCD may have higher yields than the above mentioned figures.

When considering SCD in children and young people, optimal screening involves the parents and siblings of deceased children as many SCD conditions are autosomal dominant - this means that one of the parents must have the condition and siblings have a 50% chance of having the condition.

The investigations of first degree relatives should include:

- a comprehensive family history
- clinical examination
- 12-lead ECG
- echocardiogram
- holter monitor (24 hours or longer), and
- exercise ECG.

Further investigations may also be recommended in some cases. Genetic testing of the autopsy material also has an increasing role to play. Increasing knowledge is likely to give genetic testing a greater role in diagnosis and management in the future.

[11] The information presented on Screening has been kindly provided to the Commission by Dr Jim Morwood, Paediatric cardiologist/ electrophysiologist.

Part III: Non-intentional injury-related deaths

Chapter 3

This section provides details of child deaths from injury as a result of transport incidents.

Key findings

- In 2010–11, children and young people died in transport incidents at a rate of 2.9 deaths per 100,000 children and young people aged 0–17 years (31 deaths).
- The rate of child deaths from transport incidents has increased slightly when compared to the last reporting period however is still well below the rates recorded in previous years.
- Transport incidents remained the leading external cause of death overall and for children in the 5-9 year and 10–14 year age categories. For the second year in a row, suicide exceeded transport fatalities for 15-17 year olds in 2010-11.
- Over the past five years there have been 12 deaths of children due to low-speed vehicle run-overs (LSVRO). Research has identified that four-wheel drive vehicles were involved in almost half of these fatalities; drivers of the vehicles were commonly parents, and were reversing the vehicle at the time of the incident. The significance of LSVROs is further highlighted when injury data is considered. Kidsafe Queensland reports that approximately one toddler a week is run over in a driveway, typically by a reversing vehicle.

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Chapter 3

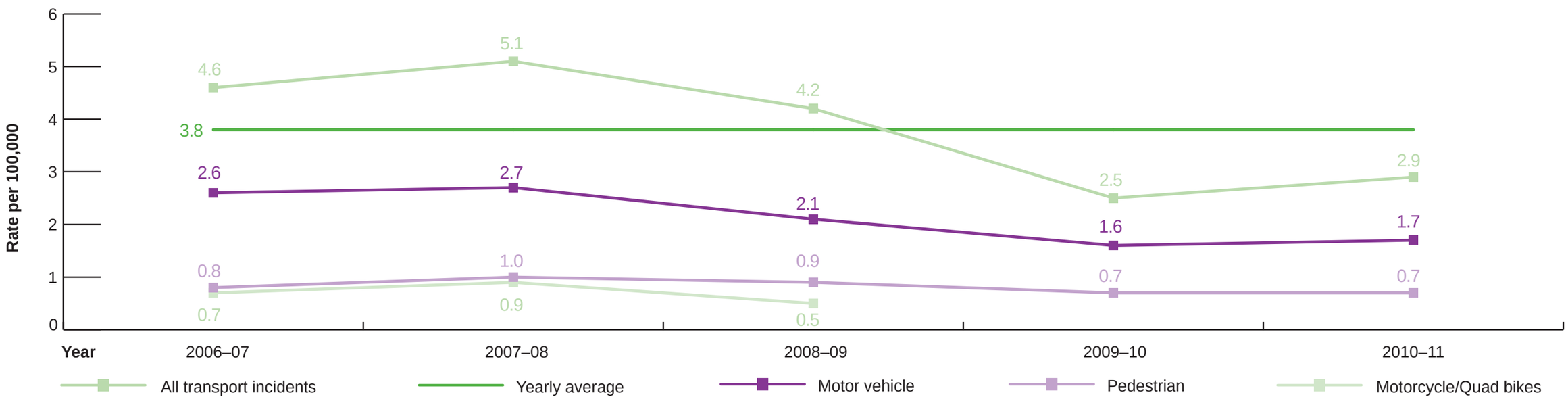
Transport

Table 3.1: Summary of transport deaths of children and young people in Queensland, 2006–2011

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All transport deaths											
Transport incidents	46	4.6	52	5.1	44	4.2	27	2.5	31	2.9	3.8
Gender											
Female	14	2.9	22	4.4	18	3.5	10	1.9	10	1.9	2.9
Male	32	6.2	30	5.7	26	4.8	17	3.1	21	3.8	4.7
Aboriginal and Torres Strait Islander status											
Indigenous	7	10.6	5	7.4	5	7.3	0	0.0	4	5.8	6.1
Non-Indigenous	39	4.1	47	4.9	39	4.0	27	2.7	27	2.7	3.7
Known to the child protection system											
Known to the child protection system	8	9.3	10	11.0	6	5.9	8	6.2	4	2.6	7.1
Age category											
Under 1 year	1	*	1	*	0	0.0	1	*	1	*	*
1–4 years	6	2.8	10	4.6	7	3.1	8	3.4	5	2.1	3.2
5–9 years	2	*	8	2.9	10	3.5	4	1.4	4	1.4	2.0
10–14 years	12	4.1	9	3.1	6	2.0	4	1.3	6	2.0	2.5
15–17 years	25	14.5	24	13.4	21	11.5	10	5.4	15	8.1	10.4
Motor vehicle											
Motor vehicle incidents	26	2.6	28	2.7	22	2.1	17	1.6	18	1.7	2.1
Gender											
Female	10	2.0	14	2.8	12	2.4	8	1.5	6	1.1	2.0
Male	16	3.1	14	2.7	10	1.9	9	1.6	12	2.2	2.3
Age category											
0–14 years	8	1.0	14	1.6	10	1.2	10	1.1	7	0.8	1.1
15–17 years	18	10.4	14	7.8	12	6.6	7	3.8	11	6.0	6.8
Pedestrian											
Pedestrian deaths	8	0.8	10	1.0	9	0.9	7	0.7	8	0.7	0.8
Low speed run-overs	*2*	*	*3*	*	*2*	*	*2*	*	*3*	*	*
Gender											
Female	3	*	4	0.8	3	*	2	*	2	*	*
Male	5	1.0	6	1.1	6	1.1	5	0.9	6	1.1	1.0
Age category											
Under 5 years	3	*	3	*	3	*	3	*	4	1.7	0.3
5–9 years	0	0.0	1	*	2	*	3	*	2	*	*
10-14 years	5	1.7	1	*	1	*	0	0.0	1	*	*
15–17 years	0	0.0	5	2.8	3	*	1	*	1	*	*
Motorcycle and quad bike											
Motorcycle and quad bike incidents	7	0.7	9	0.9	5	0.5	2	*	2	*	0.5

Data source: Queensland Child Death Register (2004–2011)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates that were not published in previous reports have been re-calculated based on the denominator data used for the preparation of the relevant report.
3. Rates are calculated per 100,000 children (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
4. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
5. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
6. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 3.1: Transport incidents, 2006–2011



Data source: Queensland Child Death Register (2006–2011)
Notes: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Transport-related fatalities: findings, 2010–11

Between 1 July 2010 and 30 June 2011, 31 children and young people died as a result of transport incidents (a rate of 2.9 deaths per 100,000 children aged 0–17 years in Queensland).

The rate of transport deaths has increased very slightly when compared with the last reporting period, but remains well below the rates recorded in previous years.

Age and gender breakdowns for transport fatalities are given in Table 3.2.

Table 3.2: Transport incident deaths by age category and gender

Age category	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Under 1 year	1	0	1	*
1–4 years	2	3	5	2.1
5–9 years	1	3	4	1.4
10–14 years	0	6	6	2.0
15–17 years	6	9	15	8.1
Total	**10**	**21**	**31**	**2.9**
Rate per 100,000	**1.9**	**3.8**	**2.9**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people in each age/gender category in Queensland.
2. Total rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Gender

Males accounted for 67.7% of transport deaths, with more males than females dying in transport incidents in each age category, with the exception of children aged under 1 year. Gender differences were most pronounced in the 10-14 year age category.

The rate of death for males who died in transport incidents was 2.0 times greater than that of females, consistent with previous reporting periods.

Research has established higher rates of death from injury for males, generally attributed to greater risk-taking behaviour displayed by boys. This is also true for young males as drivers, partially explaining the higher rate of male child death as a result of transport incidents.

Age

Under 1 year

One child under the age of 1 year died in a transport incident. This is consistent with previous Commission findings – children under the age of 1 are the least likely to die in transport incidents.

1–4 years

Children aged between 1 and 4 years accounted for the third-greatest number of transport deaths. Children in this age category died in transport incidents at a rate of 2.1 deaths per 100,000 children 1–4 years of age (5 deaths). This represents a decrease in this age category when compared to the last reporting period (8 deaths or a rate of 3.4 deaths per 100,000 1-4 years of age).

The types of transport incidents in which children aged 1–4 years were involved included being injured as pedestrians and as passengers in motor vehicles.

5–9 years

Four children in the 5–9 year age category died in transport incidents in 2010–11 (1.4 deaths per 100,000 children aged 5–9 years).

Two of the children in this age category were fatally injured as pedestrians, with the other two children fatally injured as passengers in motor vehicles.

10–14 years

Children aged 10–14 years had the second-greatest rate of death from transport incidents (2.0 deaths per 100,000 children aged 10–14 years).

In contrast to the last reporting period where all five young people in this age category died as passengers in motor vehicles, of the six fatalities in 2010-11, three young people died as passengers in motor vehicles. The other three young people died as a result of a pedestrian incident, a motor cycle incident and a non-collision motor vehicle incident.

15–17 years

In line with trends in previous years, young people aged 15–17 years were at greatest risk of death as a result of involvement in a transport incident. Fifteen young people aged between 15 and 17 years of age were killed in transport incidents, a rate of 8.1 deaths per 100,000 15–17 year olds in Queensland.

While there was a noted decrease in the number of young people aged 15-17 years who died in transport incidents in the last reporting period, this number has increased in 2010-11. The overall number of young people in this age category who died in transport incidents in 2010-11 still remains markedly lower than in previous years.

There has been a noted increase in the number of young people aged 15-17 years who were involved in motor vehicle fatalities as drivers (7 in 2010-11 compared to 1 in the last reporting period).

In 2007, the Queensland Government introduced a graduated licensing scheme for young drivers. Restrictions now apply to drivers under the age of 25 years, including in relation to the carrying of peer passengers, the use of mobile phones and driving high powered vehicles.

Aboriginal and Torres Strait Islander status

Four children and young people who died in transport incidents were Aboriginal or Torres Strait Islander. There were 3 females and 1 male who died in transport incidents in 2010-11.

Geographical distribution (ARIA+)

Children and young people who usually resided in regional areas had the highest rate of death from transport incidents at 3.1 deaths per 100,000. Children from metropolitan areas had the lowest rate of transport death, at 2.5 deaths per 100,000.

To facilitate an understanding of the areas in which transport fatalities more frequently occur, the following analysis of geographical distribution has been calculated on incident location (as provided in the Police Report of Death to a Coroner), rather than usual place of residence.

The majority of transport incidents occurred in regional areas of Queensland, with 15 deaths occurring in regional areas. This was closely followed by transport incidents in metropolitan areas, with 13 deaths occurring in metropolitan areas.

It is well recognised, both nationally and internationally, that road fatalities occur with greater frequency in regional and remote (or rural) areas. The Commission's findings for 2010–11 are consistent with those from all previous reporting periods, in which transport fatalities occurred more frequently in rural areas. There was a significant increase in 2010-11 in deaths occurring in metropolitan areas (13 deaths) when compared to the last reporting period (3 deaths).

Socio-economic status (SEIFA)

Research has found that the most disadvantaged children are more likely to die in transport-related incidents.

The highest rate of transport deaths was for children living in low to very low socio-economic areas (4.1 per 100,000; 18 deaths). Moderate socio-economic areas recorded the next highest rate (2.8 per 100,000; 6 deaths). Six children who usually resided in high to very high socio-economic areas died in transport incidents.[1]

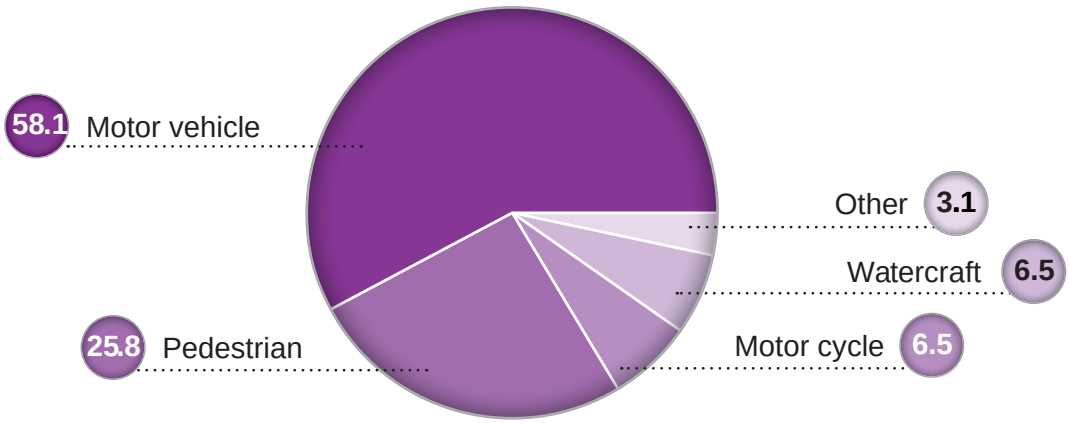
Children known to the child protection system

Of the 31 children who died in transport incidents, 4 were known to the child protection system.[2] Children known to the child protection system died in transport incidents at a rate of 2.6 deaths per 100,000, compared with 2.9 deaths per 100,000 children in Queensland. There was a decrease in the number of children and young people who were known to the child protection system and died in transport incidents in 2010-11 when compared to the last reporting period (8 deaths recorded).

Nature of transport incident

Figure 3.2 shows the percentage of deaths by type of transport fatality.

Figure 3.2: Nature of transport fatality



Data source: Queensland Child Death Register (2010–11)

The majority of transport fatalities occurred in motor vehicles (58.1%), followed by pedestrian deaths (25.8%). This pattern is consistent with that observed in previous years.

Motor vehicle

Eighteen children and young people died in motor vehicle crashes, a rate of 1.7 deaths per 100,000 children and young people aged 0–17 years in Queensland.

This is an increase of 1 incident when compared to the last reporting period.

The 18 children and young people were killed in 17 separate incidents. Just over half the deaths resulted from single vehicle crashes (10 deaths, 56%).

The gender and age of young people who died in motor vehicle crashes, as well as their role, are given in Table 3.3.

[1] Rates have not been calculated for numbers less than 4.

[2] For the purpose of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

Table 3.3: Motor vehicle incidents by role, age category and gender

Age category	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Drivers	**2**	**5**	**7**	**0.7**
15–17 years	2	5	7	3.8
Passengers	**4**	**7**	**11**	**1.0**
1–4 years	1	1	2	*
5–9 years	1	1	2	*
10–14 years	0	3	3	*
15–17 years	2	2	4	2.2
Total	**6**	**12**	**18**	**1.7**
Rate per 100,000	**1.1**	**2.2**	**1.7**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children in each age/gender category in Queensland.
2. Rates for subtotals and totals are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Gender

Males generally die in motor vehicle incidents at a higher rate than females. In 2010-11, males died at a rate of 2.2 per 100,000 male children aged 0-17 years (12 deaths), compared with 1.1 deaths per 100,000 female children (6 deaths).

Age

The majority of children involved in motor vehicle fatalities were in the 15–17 year age category (11 out of 18 deaths as a result of motor vehicle incidents). Young people in this age category typically have the greatest involvement in motor vehicle crashes because of their newly acquired roles as drivers and peer passengers. The number of fatalities in the 15-17 year age category has increased this year when compared to the last reporting period (where 7 out of 18 deaths in this age category were as a result of motor vehicle incidents). There has also been a marked increase in the number of young people in this age category who died whilst driving a motor vehicle when compared to the last reporting period (7 fatalities in 2010-11 compared to 1 fatality in the last reporting period).

Geographic distribution (ARIA+)

The rate of death from motor vehicle incidents was highest for children living in metropolitan areas (1.9 deaths per 100,000 children aged 0–17), followed by regional areas, with 1.2 deaths per 100,000. This is in contrast to the last reporting period where the rate of death was highest for children living in regional areas. Two deaths occurred in remote areas of Queensland.[3]

In relation to the location of motor vehicle incidents, 8 out of the 18 fatalities occurred in metropolitan areas, with 7 occurring in regional areas and the remaining 3 occurring in remote areas. Again, this is in contrast to the last reporting period where the overwhelming majority of fatalities occurred in regional fatalities (14 out of 18 fatalities).

Of the 8 fatalities occurring in metropolitan areas, 4 were on major roads, 3 on residential streets and 1 on a highway. Of significance is that 5 of these fatalities were considered likely to have involved speed as a factor. Of the 7 fatalities occurring in regional areas, 5 were on a highway.

Socio-economic status (SEIFA)

Children living in low to very low socio-economic areas recorded the highest rate of death as a result of motor vehicle incidents, with a rate of 2.7 deaths per 100,000.

[3] Rates have not been calculated for numbers less than 4.

Place and circumstances

Teenagers aged 15–17 years are a high risk group for motor vehicle fatalities (11 deaths; 6.0 per 100,000) and for the purposes of this section have been analysed separately from the deaths of children aged 0–14 years (7 deaths; 0.8 per 100,000).

Statistics have shown young drivers to be disproportionately involved in road crashes.

Young drivers face an increased risk for a number of reasons:

- the physical coordination and perceptual capabilities necessary for control of a motor vehicle are reportedly not as highly developed in young drivers
- peer passengers may distract from driving or encourage risky behaviour
- young drivers exhibit riskier driving behaviour such as speeding, inattention and driving under the influence of alcohol, and
- late-night driving has been identified as a risk factor for young driver crashes. Teens may be less experienced at driving at night, and risky driving behaviour, such as driving under the influence of alcohol, may be more likely to occur at night.

Role of child or young person

All of the children aged 0–14 who died as a result of a motor vehicle incident were involved as passengers. The 7 children were travelling in vehicles driven by their parents or other relatives. The number of fatalities involving children 0-14 years as passengers in 2010-11 has decreased when compared to the last reporting period where 10 fatalities were recorded.

Of the 11 fatalities of teens aged 15–17 years, 4 involved young people as passengers and 7 as drivers. One incident was a multiple fatality crash where two young passengers in the 15-17 years age category died in addition to another young adult passenger. As indicated, the number of teen driver fatalities has increased significantly when compared to the last reporting period.

Place and time of incident

Children 0–14 years most often died in incidents occurring on highways (4 deaths). No definitive patterns were evident regarding the types of roads on which teens were more likely to be involved in motor vehicle incidents, with the most fatalities in 2010-11 occurring on residential roads (4 deaths) followed by highways (3 deaths).

There were no significant trends identified in relation to the day and time motor vehicle fatalities occurred. However, teens were slightly more likely to be involved in a fatality between Thursday and Sunday between the hours of 3pm and 11pm. Children aged in the 0-14 years age category were most likely to be involved in a fatality during the day.

Speeding, drinking alcohol and other risk-taking behaviours

Speeding was identified as a factor in 6 of the 11 fatalities involving teens in the 15-17 years age category and in 1 fatality involving children in the 0-14 years age category. In total, speeding was considered a factor in 7 out of the 18 deaths of children and young people (44.4%).

The use of drugs or alcohol was noted as a factor in the death of 1 teen in the 15-17 years age category. A child aged in the 1-4 years category also died in an incident involving alcohol or drugs. In this case, the driver of the motor vehicle was believed to be affected by alcohol and drugs.

Teen risk-taking was identified in 4 of the 11 fatalities in the 15-17 years age category.

Excessive speeding was a factor in 3 of these incidents, with reports indicating that 2 deceased teen drivers were at least 30km/hr over the speed limit and 1 deceased driver was involved in street racing at the time of the incident. The teen driver alleged to be involved in street racing was unlicensed while another deceased driver was also in breach of the Queensland licensing laws due to carrying peer passengers outside of the designated hours (after 11pm).

The other fatality involving teen risk-taking occurred after an incident of ‘car surfing’. In this case, the teen was car surfing in a tray of a utility being driven in ‘circle work’ or ‘donuts’ and was crushed to death after the ute flipped onto its roof.

Fatigue was identified as a factor in at least 2 motor vehicle fatalities. Both these fatalities involved children aged 0-14 years. In one case, the driver of the motor vehicle is believed to have fallen asleep at the wheel, resulting in the death of a child aged 5-9 years.

Environmental Factors

Environmental factors were noted in 33.3% of the deaths of children and young people involving motor vehicles. Teen fatalities were most likely to involve environmental factors, with 5 of the 11 fatalities believed to have been influenced by environmental conditions. The most commonly attributed environmental factor for motor vehicle fatalities in 2010-11 was rain.

Seatbelts

The majority of children aged 0-14 years who died in a motor vehicle incident were noted to be wearing seatbelts or age-appropriate restraints (4 out of 7 children).[4] This is an increase from the last reporting period where only 3 out of 11 children in this age category were believed to have been wearing seatbelts or restraints. In at least 3 of the 11 fatalities involving teenagers, the young person was noted to be wearing a seatbelt at the time of the incident.

Peer passengers

The presence of peer passengers increases the risk of road crashes for young drivers. In 2007 the Queensland Government introduced new licensing laws for young drivers (under 25 years), which include provisions for carrying peer passengers. Young drivers may only carry one passenger under the age of 21 between the hours of 11pm and 5am (these restrictions exclude immediate family members).

There were 5 incidents involving peer passengers in 2010-11, with 1 incident being a multiple fatality where 2 teen passengers and 1 young adult died. In this instance, the driver was believed to be 17 years of age and was carrying peer passengers. In two of the other incidents, the young person was the driver.

A total of 12 out of the 18 motor vehicle fatalities occurred while travelling with young drivers under 25 years of age. The most common age of drivers involved in motor vehicle fatalities was 17 (8 drivers). Of the drivers aged 17 years, 5 out of 8 were killed in the incident. There was 1 incident involving a 15 year old (deceased) driver who was unlicensed and 1 incident involving a 16 year old (deceased) driver who held an interstate drivers licence.

Multiple fatalities

There were 5 multiple fatality incidents occurring in 2010-11, resulting in the deaths of 6 children.

Of these 5 incidents, 4 involved the deaths of a child passenger aged between 0-14 years and an immediate family member as the driver of the vehicle. There was 1 incident involving the deaths of three persons in a single motor vehicle incident. In this case, two passengers aged in the 15-17 years age category and 1 young adult died in the incident. There was a further incident involving the deaths of 4 persons in a single incident. The deceased child in this incident was in the 10-14 years age category, with the child's mother, father and adult sibling also dying in this incident.

[4] One child was noted by police as *not* wearing seatbelt or car restraint, while in the remaining 2 cases it is unknown whether the child was appropriately restrained.

Pedestrians

Eight children and young people died as pedestrians, a rate of 0.7 deaths per 100,000 children and young people aged 0–17 years.

Table 3.4 shows the number of pedestrian fatalities by gender, age category and rate.

Table 3.4: Pedestrian deaths by age and gender

Age category	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Low speed vehicle run-over				
Under 1 year	1	0	1	*
1-4 years	1	1	2	*
Total	**1**	**1**	**3**	*
Road crossing				
5–9 years	0	1	1	*
15–17 years	0	1	1	*
Total	**0**	**2**	**2**	*
Bystander incidents				
5–9 years	0	1	1	*
Total	**0**	**1**	**1**	*
Other				
1–4 years	0	1	1	*
10-14 years	0	1	1	*
Total	**1**	**2**	**2**	*
Grand Total	**2**	**6**	**8**	**0.7**
Rate per 100,000	*	**1.1**	**0.7**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people in each gender category in Queensland.

Gender

Six male pedestrians died, compared with 2 females.

Age

Research indicates that young toddlers are more likely to be injured in non-traffic situations, such as low-speed run-overs in driveways. Children between the ages of 3 and 9 are more often struck when entering the roadway, while the greater independence and mobility of older children and teenagers expose them to a higher number of risky traffic situations.

Pedestrian fatalities in 2010–11 were relatively widespread across age categories, with no discernible pattern evident. The age categories of incidents in 2010-11 were very similar to the last reporting period.

Place and circumstances

Low-speed vehicle run-overs of toddlers

'Low-speed vehicle run-over' (LSVRO) is a term used to describe incidents where a pedestrian is injured or killed by a slow-moving vehicle in a traffic or non-traffic area. Most of these incidents usually involve younger children (between the ages of 1 and 4 years) and occur in the driveway of their own home. Drivers tend to be members of their family, with vehicles reversing at the time of impact.

One female child under 1 year was involved in a LSVRO incident. It is noted that this child was almost 1 year old and was mobile. In addition, 2 children in the 1-4 year age group (one male and one female) were also fatally injured in LSVRO incidents.

Two of these incidents occurred in the driveway of a residential property, with the driver of the vehicles being extended family members. The third incident occurred at a recreation area, with the driver of the vehicle being an immediate family member. All vehicles were reversing at the time, with two at low speed and one at a higher speed due to the driver accidentally losing control of the vehicle and reversing suddenly. One vehicle was a sedan and two vehicles were four-wheel drives.

Other pedestrian fatalities

Of the remaining five pedestrian fatalities, 2 occurred while crossing roads. One of these incidents involved a teenager who crossed a road affected by alcohol and the other involved a child who ran out from behind a bus into the path of an oncoming vehicle. Pedestrian fatalities categorised as 'other' include a toddler who broke away from carers out onto a road and into the path of an oncoming vehicle and a child who inadvertently ran onto the road to avoid being attacked by a bird.

The bystander incident involved a child being struck by a vehicle in a shopping centre car park. This vehicle was being driven by an immediate family member.

Motorcycles

There were 2 deaths as a result of incidents involving motorcycles in 2010-11, with no fatalities recorded on quad bikes during this reporting period.

Both children were males, 1 in the 10-14 year age category and the other in the 15–17 year age category.

The incident involving the young person in the 10-14 year age category occurred on private property while riding for recreation. The young person was in charge of the vehicle at the time of the incident and was wearing a helmet at the time of the incident.

The incident involving the young person in the 15-17 year age category was a double fatality. It is not known who was driving the vehicle at the time of the incident. The young person was wearing a helmet at the time of the incident.

Watercraft

Two females aged 15-17 years died in a single incident involving a watercraft in 2010-11. In this incident, three young people were being towed behind a boat in a large inflatable tube known as a 'biscuit'. The tube impacted with the waterway bank.

Queensland floods 2011

There were three transport-related incidents resulting in the deaths of four children during the January 2011 Queensland floods. These incidents have not been counted here as they occurred in the context of drowning and have therefore been counted in Chapter 4, *Drowning*. However, the incidents involved children who were either travelling in motor vehicles to escape flash flooding or were travelling in motor vehicles entering flood waters.

Queensland Ambulance Service data

With fatalities representing only a small proportion of outcomes from transport incidents, injury data can be used to gain a more comprehensive understanding of the risks posed to children by vehicles and machinery.

The Queensland Ambulance Service (QAS) has provided data on the number of ambulance responses to transport incidents involving children in 2010–11. Table 3.5 outlines the total number of QAS responses, and includes both fatal and non-fatal injuries.

Table 3.5: Queensland Ambulance Service responses to transport incidents, 2010–11

Type of incident	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
	n	*n*	*n*	*n*	*n*	*n*
Motor vehicle	105	327	398	417	941	2188
Motorcycle	4	9	37	137	153	340
Bicycle	1	15	51	151	91	309
Pedestrian	3	22	30	55	38	148
Quad bike	1	5	6	14	9	35
Trail bike	0	0	3	15	7	25
Truck	0	2	6	4	8	20
Tractor	0	0	0	1	1	2
Snowmobile	0	0	1	0	0	1
Unknown	12	53	80	158	205	508
Total	**138**	**468**	**649**	**963**	**1511**	**3729**

Data source: Queensland Ambulance Service (2010–11)

As with mortality data, the number of children injured in transport incidents increases with increasing age, likely reflecting increased mobility and independence of older children. Motor vehicle collisions accounted for the greatest number of injuries overall, in line with the child death data presented in this report. Motor vehicle collisions also accounted for the greatest number of injuries within each age category.

Motorcycle incidents accounted for the second-highest number of injuries and involved children in all age categories. As per the last reporting period, the highest number of injuries occurred in the 10-14 and 15-17 year age categories. The number of pedestrian incidents is considered stable when compared to the last reporting period.

Supporting child death and injury prevention initiatives

In the *Annual Report: Deaths of Children and Young People, Queensland 2004–05* the Commission identified low-speed vehicle run-overs (LSVROs) of children as an issue of concern. Accordingly, the Commission recommended that the Parliamentary Travelsafe Committee investigate and report on ways to reduce these fatalities and injuries. The subsequent Travelsafe Investigation Report made 7 recommendations focused on addressing this issue, all of which were supported by the relevant agencies.

Based on the Commission's findings and the recommendations of the Travelsafe Committee, the Queensland Injury Prevention Council[5] has identified the prevention of LSVROs as one of its key priorities. In 2008–09 the QIPC provided funding, by way of research grants, to a range of research projects relating to the prevention of LSVROs.

[5] The QIPC is a Cabinet endorsed committee that was established in 2008. The 'goal of the QIPC is to substantially reduce injury rates and the severity of injuries in Queensland and to demonstrate national leadership in injury prevention activities. The QIPC reports to the Director-General Queensland Health and provides high level strategic advice in relation to injury prevention priorities, strategies and activities. The Council will be the authoritative body on injury prevention in Queensland' (Queensland Injury Prevention Council, *Annual Report 2008–09*, Brisbane, Queensland).

The Commission is a member of the QIPC and in 2010–11 provided data from the Queensland Child Death Register in support of a range of QIPC research projects, including those relating to the prevention of LSVRO incidents. In the year ahead, the Commission will continue to participate on the QIPC and provide relevant child death data to support the progression of these research projects.

In 2010–11 research conducted by the Burns and Trauma Research Group, Royal Children's Hospital, using data extracted from the Child Death Register regarding low-speed vehicle run-over incidents between 2004 and 2008, was published in the Injury Prevention journal. It identified that four-wheel drive vehicles were involved in almost half of these fatalities; drivers of the vehicles were commonly parents, and were reversing the vehicle at the time of the incident.

The Commission would also like to acknowledge the tireless efforts of Kidsafe Queensland in advancing prevention initiatives and community awareness about the significance of LSVRO.

Statewide strategy for the management of off-road motorcycling in Queensland

The Commission supports the development of a state-wide management strategy to reduce the number of deaths and injuries to children as a result of motorcycle and quad bike incidents and is a committed to working closely with stakeholders to implement this strategy.

In a positive step towards identifying and understanding the key risk factors, themes, and behaviours of children and young people who participate in off-road motorcycling, Sport and Recreation Services, Department of Communities, is undertaking a project to examine risk taking and perceptions, attitudes, beliefs and behaviours of young off-road motorcyclists and their parents/guardians. The project will include discussions within focus groups of young riders and their parents from both peri-urban and rural areas. The Department intends to analyse the information gathered from these focus groups and other relevant data sources in conjunction with the results of consultation with other key stakeholders, including the Commission. Findings from this research will be used to inform education and awareness strategies to encourage a culture of safe off-road motorcycling.

Part III: Non-intentional injury-related deaths

Chapter 4

This section provides details of child deaths as a result of drowning.

Key findings

- In 2010–11, children and young people drowned at a rate of 1.3 per 100,000 children and young people aged 0–17 years (14 deaths). This is the lowest recorded rate since the Commission began reporting in 2004–2005.
- Similar with previous years, drowning was the equal leading external cause of death for children aged 1–4 years, accounting for 5 deaths (2.1 per 100,000).
- This reporting period recorded the lowest number of pool drownings for 1–4 year olds since 2004–05 (2 deaths), with the 3 remaining drownings in this age category occurring in non-pool locations.
- There were 6 drownings directly attributed to the January 2011 Queensland Floods.

Supervise – active supervision is key to preventing child drownings. None of the children under the age of 5 years was in the direct line of sight of an adult supervisor at the time of the incident. Three of the 4 children under 5 years were left unsupervised for more than 5 minutes, with 2 of these unsupervised for between 15 and 30 minutes.

Maintain pool fences – pool fences must be compliant with relevant legislation and standards and need to be maintained in order to remain compliant. One of the 2 private swimming pools did not have a fence which would exclude them from compliance with the relevant standard.

Learn CPR – as positive health outcomes after immersions depend on the early initiation of resuscitation, pool owners, parents and carers should gain current resuscitation qualifications.

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Chapter 4

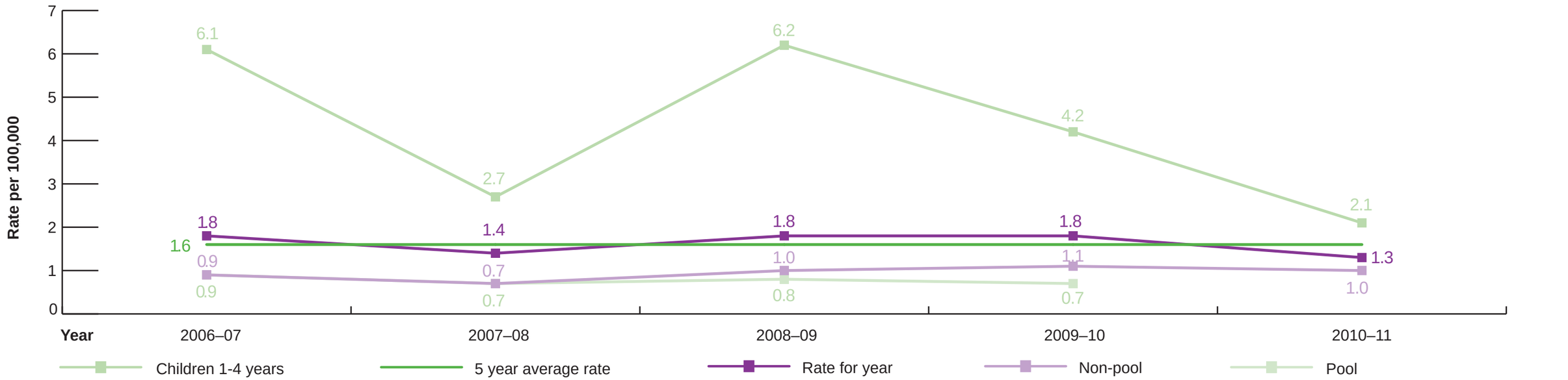
Drowning

Table 4.1: Summary of drowning deaths of children and young people in Queensland, 2006–2011

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All drowning deaths											
Drowning	18	1.8	14	1.4	19	1.8	19	1.8	14	1.3	1.6
Gender											
Female	6	1.2	3	*	10	2.0	6	1.1	6	1.1	1.2
Male	12	2.3	11	2.1	9	1.7	13	2.4	8	1.5	2.0
Aboriginal and Torres Strait Islander status											
Indigenous	0	0.0	2	*	4	5.9	3	*	3	*	*
Non-Indigenous	18	1.9	12	1.3	15	1.5	16	1.6	11	1.1	1.5
Known to the child protection system											
Known to the child protection system	3	*	2	*	7	6.9	8	6.2	2	*	4.3
Age category											
Under 1 year	1	*	0	-	0	0.0	3	*	1	*	*
1–4 years	13	6.1	6	2.7	14	6.2	10	4.2	5	2.1	4.2
5–9 years	2	*	5	1.8	1	*	4	1.4	3	*	*
10–14 years	1	*	0	0.0	2	*	2	*	3	*	*
15–17 years	1	*	3	*	2	*	0	0.0	2	*	*
Pool drownings											
Pool drownings	9	0.9	7	0.7	8	0.8	7	0.7	3	*	0.6
Public pools	*3*	*	*2*	*	*1*	*	*2*	*	*1*	*	*
Private pools	*6*	*0.6*	*5*	*0.5*	*7*	*0.7*	*5*	*0.5*	*2*	*	*0.5*
Age category											
Under 1 year	0	0.0	0	-	0	0.0	0	0.0	0	0.0	0.0
1–4 years	7	3.3	5	2.3	8	3.5	4	1.7	2	*	8.4
5–9 years	1	*	1	*	0	0.0	3	*	0	0.0	*
10–14 years	1	*	0	0.0	0	0.0	0	0.0	1	*	*
15–17 years	0	0.0	1	*	0	0.0	0	0.0	0	0.0	*
Non-pool drownings											
Non-pool drownings	9	0.9	7	0.7	11	1.0	12	1.1	11	1.0	1.0
Static inland waterways	*3*	*	*0*	*0.0*	*1*	*	*0*	*0.0*	*1*	*	*
Rural water hazards	*2*	*	*4*	*0.4*	*2*	*	*5*	*0.5*	*0*	*0.0*	*
Dynamic inland waterways	*1*	*	*3*	*	*4*	*0.4*	*1*	*	*3*	*	*
Bathtubs	*3*	*	*0*	*0.0*	*1*	*	*2*	*	*1*	*	*
Beach/Ocean	*0*	*0.0*	*0*	*0.0*	*2*	*	*1*	*	*0*	*0.0*	*
Other	*0*	*0.0*	*0*	*0.0*	*1*	*	*3*	*	*6*	*0.6*	*
Age category											
Under 1 year	1	*	0	0.0	0	0.0	3	*	1	*	*
1–4 years	6	2.8	1	*	6	2.6	6	2.5	3	*	1.9
5–9 years	1	*	4	1.4	1	*	1	*	3	*	*
10–14 years	0	0.0	0	0.0	2	*	2	*	2	*	*
15–17 years	1	*	2	*	2	*	0	0.0	2	*	*

Data source: Queensland Child Death Register (2006–11)
** Rates have not been calculated for numbers less than 4.*
– These data were not available at the time of publication.
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates that were not published in previous reports have been re-calculated based on the denominator data used for the preparation of the relevant report.
3. Rates are calculated per 100,000 children (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
4. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 ears prior to their death.
5. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
6. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 4.1: Drowning deaths, 2006–2011



Data source: Queensland Child Death Register 2006–2011
Notes: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.
2. Rates relating to children aged 1–4 years are calculated per 100,000 children aged 1–4 years in Queensland.
.

Drowning: findings, 2010–11

Between 1 July 2010 and 30 June 2011, 14 children and young people drowned at rate of 1.3 deaths per 100,000 children and young people aged 0–17 years in Queensland. The rate of death from drowning has remained relatively stable across the 5 year period.

Findings presented here are based on the number of children who drowned whose deaths were registered with the Registry of Births, Deaths and Marriages in 2010–11. These figures will differ from the number of child drownings that *occurred* during this period. The analysis of deaths by date of death registration is in accordance with national datasets managed by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, as well as child death datasets managed by other Australian states and territories.

Table 4.2 illustrates the age categories and gender breakdown for all drowning fatalities.

Table 4.2: Drowning deaths by gender and age category

Age category	Female	Male	Total	Rate per 100, 000
	n	*n*	*n*	
Under 1 year	0	1	1	*
1–4 years	2	3	5	2.1
0–4 years total	***2***	***4***	***6***	***2.0***
5–9 years	3	0	3	*
10–14 years	0	3	3	*
15–17 years	1	1	2	*
Total	**6**	**8**	**14**	**1.3**
Rate per 100,000	**1.1**	**1.5**	**1.3**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people in each age/gender category in Queensland.
2. Total rate of death is calculated per 100,000 children and young people aged 0–17 years in Queensland.

Gender

Male children died from drowning at a rate of 1.5 per 100,000 male children aged 0–17 years in Queensland, compared with 1.1 per 100,000 female children.

This finding is consistent with all previous Commission findings, with the exception of the 2008–09 reporting period when more female children drowned than males.

Age

Drowning occurred most frequently for children 1–4 years of age (5 deaths). This finding is consistent with the findings from all previous reporting periods. Children under 5 years of age have consistently been identified as most at risk from drowning.

Types of drowning-related deaths

Table 4.3 illustrates the different types of drowning-related fatalities by gender.

Table 4.3: Types of drowning-related deaths, by gender

Type of drowning	Female	Male	Total	Rate per 100,000
	n	n	n	
Swimming pool drowning	**0**	**3**	**3**	*****
Non-pool drownings	**6**	**5**	**11**	**1.0**
Bathtubs	1	0	1	*
Dynamic inland waterways (rivers/creeks)	2	1	3	*
Static inland waterway (dam/pond)	0	1	1	*
Other	3	3	6	0.6
Total	**6**	**8**	**14**	**1.3**

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Note: 1. Rates of death are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Aboriginal and Torres Strait Islander status

Three of the 14 children who drowned identified as Indigenous (2 identified as Aboriginal and 1 as both Aboriginal and Torres Strait Islander).

Since the Commission began reporting in 2004–05, the number of Aboriginal and Torres Strait Islander child deaths due to drowning has been consistently low. This is in contrast to research which shows that drowning in the Australian Indigenous population "is quite different from that of the population as a whole, with a very high incidence in children under five years and in the 25 to 34 years age group".[1]

Geographical distribution (ARIA+)

Regional areas recorded the highest rate of drowning death, at 2.9 per 100,000. One death occurred in a remote area. Metropolitan areas recorded no drowning deaths for this reporting period.

Non-pool drownings were more prevalent for children from regional areas of Queensland (2.4 deaths per 100,000). A small number of pool drownings occurred in rural and remote areas. However, in the reporting period there were no pool drownings in metropolitan areas.

Socio-economic status (SEIFA)

The incidence of drowning deaths was greatest in low to very low socio-economic areas (2.5 deaths per 100,000). Two deaths occurred in moderate socio-economic areas.[2] No deaths were recorded for high to very high socio-economic areas.

Children known to the child protection system

Two of the 14 children who drowned were known to the child protection system,[3] which is a significant reduction from the past two reporting periods.

[1] Mackie, I, 1999, Patterns of drowning in Australia, 1992–1997, *Medical Journal of Australia*, 171, 587–90.
[2] Rates have not been calculated for numbers less than 4.
[3] For the purpose of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

Demographics of pool drownings

Three deaths occurred in swimming pools. Two of these children were aged 1–4 years. One child was aged 10-14 years. This finding is consistent with literature, indicating that children under 5 years of age are most vulnerable to drowning.

The number of pool drownings of children in the 1–4 year age category has reduced over the last two reporting periods and is the lowest recorded since reporting began in 2004–05.

All 3 of the children were male.

Circumstances of pool drownings

A number of factors have been identified as increasing the likelihood of children drowning in swimming pools. The main factors are:

- inadequate supervision
- inadequate or no fencing
- lack of gate security
- lack of effective water skills, and
- lack of resuscitation skills.

Table 4.4 provides a summary of the circumstances surrounding swimming pool drownings. Supervision definitions are outlined under the 'Supervision' section of this chapter and relate to toddler drownings only.

Table 4.4: Summary of pool drownings

Age category	Type of pool	Pool fencing	Type of fence	Fencing/gate defects	Supervision
1–4 years	Private – in-ground	Yes	4-sided	**No**	Inadequate Category B
1–4 years	Private – above-ground	No	No fencing	**Yes** Non-compliant with pool fencing requirements.	Inadequate Category A
10–14 years	Public – in-ground	Yes	4-sided	**No**	Not applicable – child over 5 years of age

Data source: Queensland Child Death Register (2010–11)

Location of incident

Two of the 3 pool drownings occurred in private swimming pools – in both cases the incident occurred at the child's home.

The remaining death, involving a male in the 10–14 year age category, occurred in a resort pool. Since 2006–07, a total of 9 children have drowned in public pools in Queensland. The Royal Life Saving Society Australia (RLSSA) has developed a document titled *Guidelines for Safe Pool Operations*[4] for use by public pool operators. The Guidelines have become a minimum standard document, similar to an Australian Standard, providing advice to the aquatics industry on the minimum requirements for particular situations. Pool operators who cannot meet the requirements set out in the guidelines (including supervision) must identify other suitable ways to prevent or minimise the risks of drowning.

[4] Royal Life Saving Society Australia 2007, Guidelines for Safe Pool Operation, Royal Life Saving Society Australia, viewed 26 September 2011, http://www.royallifesaving.com.au/www/html/198-introduction.asp.

Pool fencing

Since 1992, it has been mandatory for all pools in Queensland to comply with the Australian Standard for pool fencing (AS1926 Swimming pool safety). Pool fencing legislation has recently undergone a two-staged transformation where 11 different pool safety standards have now been replaced by the *Queensland Development Code Mandatory Part 3.4*. Under the new standard, from 1 December 2010:

- a pool safety certificate, issued by a licensed pool safety inspector, is required when selling, buying or leasing a property with a pool
- the pool safety standard applies to all pools associated with houses, units, hotels, motels, backpacker hostels, caravan parks, mobile van parks and other forms of short term accommodation
- the pool safety standard applies to indoor pools as well as outdoor pools
- all swimming pools need to be included on the state-based pool safety register by 4 November 2011, and
- safety barriers are mandatory for all portable pools and spas deeper than 300 millimetres.

The new pool safety standard also requires owners to display the latest cardio-pulmonary resuscitation (CPR) sign near their pools.

Pool owners will have until 30 November 2015 to comply with the new pool safety standard, or earlier if their property is sold or leased before then.

Fencing sides

Two children drowned in private pools which were required to meet mandatory fencing standards. Of these 2 cases, 1 of the pools had 4-sided fencing. In the other case the pool was unfenced.

Fencing and gate defects

Of the 2 private swimming pool drownings, 1 had no fencing which means it would not comply with pool fencing legislation.

Pool fencing is an important prevention strategy to decrease the risk of drowning in swimming pools. Fencing should be compliant with the relevant standards and be kept intact and maintained, with a gate that self-latches and closes automatically.

Supervision

Of the 2 pool drownings involving children under the age of 5 years, neither was being actively supervised (that is, they were not within the direct line of sight of an appropriately responsive adult carer) at the time of the incident.

The Commission has developed a model for classifying caregiver supervision in infant and toddler drowning (children aged 0–4 years). The development of this model is based on the following assumptions:

a) line of sight supervision is necessary when the child is known to be in or around water, and
b) the further away the carer is located from the toddler, the lower their level of supervision and capacity to respond.

On this basis, the Commission has classified the supervision of toddler drownings into the following 3 categories.

Intermittent supervision – the child was being intermittently supervised in close proximity to appropriately responsive carers. This includes cases where a child is moving between carers and where the child is not in the direct line of sight, but carers are making concerted efforts to monitor the child in other ways (such as auditory supervision). This *does not* include cases where the child is known to be in or around a water hazard.

Example:
Intermittent supervision

A toddler drowned in a residential swimming pool.

The toddler was playing inside the house while the carer was attending to household chores for approximately 5 minutes in an adjacent room. The carer periodically entered the room to check on the child. At some point the child managed to exit the house and move a chair to the fence to gain enough height to manipulate the child lock and open the gate to gain access to the pool.

The pool was completely fenced and had self-latching gates at all entry points.

Inadequate supervision: Category A – the child was known to be in or around water at the time of the incident and was not in the direct line of sight of an appropriately responsive adult supervisor.

Example:
Inadequate supervision: Category A

A toddler drowned while bathing with a sibling (also aged less than 5 years), who had severe physical disabilities.

The children were left unsupervised in the bath while their carer attended to household chores. The toddler was found deceased by another member of the household.

Inadequate supervision: Category B – the child was left unsupervised, at some distance from an adult carer, for a period of more than 5 minutes duration, and/or the carer was considered inappropriate because of their lack of capacity to respond (for example, they were affected by alcohol or other substances), and/or the environmental barriers to the water hazard were either non-existent or grossly defective. This includes cases where the pool gate had been propped open by supervisors. Carer supervision should be heightened on that basis.[5]

Example:
Inadequate supervision: Category B

A child aged less than 2 years drowned on a rural property.

The child and her sibling (aged under 4 years) had been left unsupervised at the house while the parents engaged in farm-work elsewhere on the property.

The children were left unsupervised for a period of at least half an hour.

In both pool drownings which involved children aged under 5 years, supervision was 'Inadequate'. In both of these cases, the child was left unsupervised for more than 5 minutes. In 1 of the 2 cases, environmental barriers to the pool were not installed.

[4] According to the Royal Life Saving Society Australia, adequate supervision means keeping the child in the direct line of sight or at arm's length and being in a position to quickly respond to the child. However, this presumes that the carer is aware of the proximity of the toddler to the hazard. In households where the pool is not fenced, or the fence is known to be grossly defective, or the gate has intentionally been propped open, the Commission considers that the carer should be aware of the potential for the child to be in, or to quickly move into, close proximity to the water hazard.

Length of time

The length of time that elapsed between when the child was last seen alive and when the child was noticed missing and/or found unresponsive is detailed in Table 4.5.

Table 4.5: Length of time unsupervised or missing

Length of time	Cases
	n
More than 5 minutes but less than 30 minutes	1
Up to 2 hours	1
Total	**2**

Data source: Queensland Child Death Register (20010–11)
Note: 1. Only children aged 0–4 years have been included in this table.

Swimming ability

Two of the 3 children who drowned in pools were reported to have been non-swimmers. The swimming ability of the remaining child was unknown.

Some research has found swimming lessons improve swimming ability in children as young as 2 years of age,[6] while other research has found that children are more developmentally receptive to swimming lessons from 4 years of age onwards.[7] However, swimming lessons should not be seen as the only means of drowning prevention – other safety precautions are essential, including ensuring that pool fencing is compliant and that young children are actively supervised by an appropriate adult.

Season

A significant proportion of the drowning literature reports that children are more likely to drown in swimming pools during the summer months. However, international research has found child drowning in warmer climates to be a perennial public health issue – while the greatest number of deaths occur in the summer months, child drownings occur with comparable frequency in all months.[8] As many areas of Queensland experience warm weather all year round, parents and carers should ensure they do not become complacent during the winter months.

Two of the 3 children drowned in pools during the summer months, with the other occurring during spring.

Resuscitation

Resuscitation was attempted in all pool drownings. Persons attempting resuscitation included parents/carers, neighbours and attending ambulance officers. It is unknown if any of the parents/carers attempting resuscitation were trained.

As positive health outcomes after immersions depend on the early initiation of resuscitation, pool owners, parents and carers should gain current resuscitation qualifications.

[6] Brenner, R & Committee on Injury, Violence and Poison Prevention 2003, Prevention of drowning in infants, children and adolescents, *American Academy of Pediatrics*, 112(2), 440–45.

[7] American Academy of Pediatrics, Committee on Sports Medicine and Fitness and Committee on Injury and Poison Prevention 2000, Swimming programs for infants and toddlers, *Pediatrics*, 105, 868–70.

[8] Lo, M, Hall, K, VanderWerf-Hourigan, L, Vincent, B & Pryor, R 2010, Correlation of pool drowning deaths with number of residential swimming pools by county in Florida 2005–2007, *International Journal of Aquatic Research and Education*, 4, 19–32.

Demographics of non-pool drownings

Table 4.6 illustrates the types and ages for all non-pool drownings.

Table 4.6: Non-pool drownings by type and age category

Type of water hazard	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
	n	*n*	*n*	*n*	*n*	*n*
Bathtubs	0	1	0	0	0	1
Dynamic inland waterways (rivers/creeks)	0	0	1	0	2	3
Static inland waterway (lakes/ dams/ponds)	1	0	0	0	0	1
Other	0	2	2	2	0	6
Total	**1**	**3**	**3**	**2**	**2**	**11**

Data source: Queensland Child Death Register (2010–11)

Gender

Six females and 5 males drowned in non-pool locations (11 deaths). This is inconsistent with previous reporting periods, with the exception of the 2008–09, where males drowned in non-pool locations at more than twice the frequency of females.

Age

Children aged 1–4 years generally die in non-pool drowning incidents at a higher rate than other age categories. The findings for this reporting period support this. In 2010–11, 4 of the 11 children who drowned in non-pool locations were aged under 5. Three were aged 5–9 years, 2 were aged 10–14 years and 2 were aged 15–17 years.

Circumstances of non-pool drownings

January 2011 Queensland Floods

Six of the 11 children drowned during the flash flood events that occurred in the Toowoomba and Lockyer Valley regions during January 2011.

Four of the 6 children were in vehicles being driven by their parents. In all of these cases it appears that the vehicle was being used in an attempt to flee rapidly rising water due to flash flooding. This includes one case in which the child was swept from the arms of personnel attempting to rescue the family from the vehicle. In one of the flood-related drownings involving vehicles, it appears that the driver may have entered water in an attempt to cross a flooded road. One child died when they were swept from a parent's arms after the family home was suddenly inundated due to flash flooding. One child died when their family sought refuge on a stationary vehicle after their home was inundated with water. This vehicle was subsequently swept away by flood waters.

Dynamic inland waterways (rivers/creeks)

Three of the 11 non-pool drownings occurred in a dynamic inland waterway. One child was aged 5–9 years and 2 were aged 15–17 years. Flooding or heavy rainfall was a factor in 2 of these cases. In 1 case the child was known to have epilepsy. It is unknown at this point if their condition was a factor in their death.

Static inland waterways (lakes/ponds)

One child drowned in a pond. The child was aged under 1 year and was intermittently supervised.

Bathtubs

One child drowned in a bathtub. The child was aged 1–4 years and was inadequately supervised (Category A). The child was known to have epilepsy. It is unknown if their condition was a factor in their death.

Supervision

Two children were not in the direct line of sight of an appropriately responsive adult supervisor at the time of the incident. Supervision was considered inadequate in 1 of the 2 cases of non-pool drownings involving children aged under 5 years.

In 1 case, the child was left unsupervised for more than 5 minutes (Inadequate Category A).

In 1 case, the child was being intermittently supervised and was not known to be in or around water at the time of the incident.

Length of time

The length of time that elapsed between when the child was last seen alive and when the child was noticed missing and/or found unresponsive is detailed in Table 4.7.

Table 4.7: Length of time unsupervised or missing

Length of time	Cases
	n
Up to 25 minutes	1
30 minutes or more but less than 1 hour	1
Total	**2**

Data source: Queensland Child Death Register (2010–11)
Note: 1. Only children aged 0–4 years have been included in this table.

As shown in Table 4.7, both of the children aged 0–4 years who drowned in non-pool locations were left unsupervised for more than 5 minutes, with the actual length of time ranging from 10 minutes up to and including 30 minutes.

Season

The vast majority of non-pool drownings occurred in summer (10 of the 11 non-pool drownings). One drowning occurred in winter.

Resuscitation

Resuscitation was attempted in 3 of the 11 non-pool drownings. Of the 3 cases where resuscitation was attempted by parents/carers or other witnesses, 1 was known to be trained.

Queensland Ambulance Service data

Analysis of injury data can provide a more complete view of the risks to children posed by water hazards. The Queensland Ambulance Service (QAS) has provided data on the number of ambulance responses to immersion incidents involving children in 2010–11.

Table 4.10 shows the total number of QAS responses, and includes both fatal and non-fatal injuries.

Table 4.10: Immersion incidents 2009–10

Age category	Immersion incidents 2009–10	Immersion incidents 2010–11
	n	*n*
Under 1 year	22	28
1–4 years	68	91
5–9 years	16	12
10–14 years	27	13
15–17 years	17	29
Total	**150**	**173**

Data source: Queensland Ambulance Service (2009–10)
Note: 1. Figures include both fatal and non-fatal immersion incidents.

In line with the child death data presented in this report, immersion incidents were most common in the 1–4 year age category. However, the second-highest number of immersions occurred in the 15–17 year age category. This is in contrast to the Commission's findings for fatal drownings since 2004. Child death data has historically seen very few fatal drowning incidents in children over the age of 5 years. As reported in 2009–10, this may indicate that while immersion incidents still occur in older age categories, they are much less likely to be fatal than those involving children under the age of 5.

In 2010–11, there was again an increase in the number of immersion incidents involving children under the age of 5 years. Twenty-eight immersion incidents of infants occurred compared with 9 in 2008–09 and 22 in 2009–10. Ninety-one immersion incidents of children aged 1–4 years occurred compared with 81 in 2008–09 and 68 in 2009–10.

The increase in the total immersion incidents reported by the QAS in 2010–11 may have been influenced by the flood events in Queensland in December 2010 and January 2011.

Supporting child death and injury prevention initiatives

Queensland Flood Inquiry

In April 2011 the Commission for Children and Young People and Child Guardian made a submission to the Queensland Floods Commission of Inquiry. The Commission of Inquiry released its interim report on 1 August 2011, with the final report to be delivered on 24 February 2012. The Commission's submission is available on www.ccypcg.qld.gov.au.

Queensland Government Swimming Pool Safety Improvement Strategy

Since 2008, the Commission has been engaged as a key stakeholder in the Queensland Government's Swimming Pool Safety Improvement Strategy. This initiative involved a comprehensive review of Queensland's swimming pool safety laws and resulted in a range of legislative changes aimed at improving the safety of residential pools for young children. During 2010–11 the Commission has continued to provide advice and supporting child death data to the Department of Infrastructure and Planning in implementing the proposed strategy.

Key achievements of the strategy include:

- the introduction of uniform fencing standards for all residential pools, regardless of their date of construction
- extension of fencing laws to include hotels, motels, caravan parks and indoor pools
- removal of local government exemptions for pool fencing, except in the case of disability
- mandatory reporting of immersion incidents of young children by hospitals and ambulance staff
- provisions for alerting home buyers and lessees to the compliance or otherwise of the pool fence with legislation, and
- increased government spending on awareness-raising campaigns.

The Commission is highly supportive of moves to introduce uniform fencing standards for residential pools. Since 1983, a total of 225 children under the age of 5 years have drowned in residential pools in Queensland.[9] Since 1992 it has been mandatory for all pools to comply with the relevant Australian Standard for fencing. Since that time, a number of upgrades or changes to pool fencing requirements have been implemented. Figure 4.2 illustrates the number of drowning deaths of children under 5 years of age, mapped against the points in time at which changes to fencing requirements were introduced.

As can be seen in Figure 4.2, the years prior to 1992 experienced high numbers of toddler drownings, followed by a marked decrease in deaths subsequent to the introduction of pool fencing legislation. However, this was a short-term decrease, with deaths again peaking in 1996.

Changes to pool fencing requirements were introduced in 1998, 2003 and 2006. While the initial mandate for fencing in 1992 was followed by a clear decline in deaths in the following years, the same cannot be said of changes introduced in subsequent years, although the combined effect has been to keep the rate at approximately half (of pre-1992).

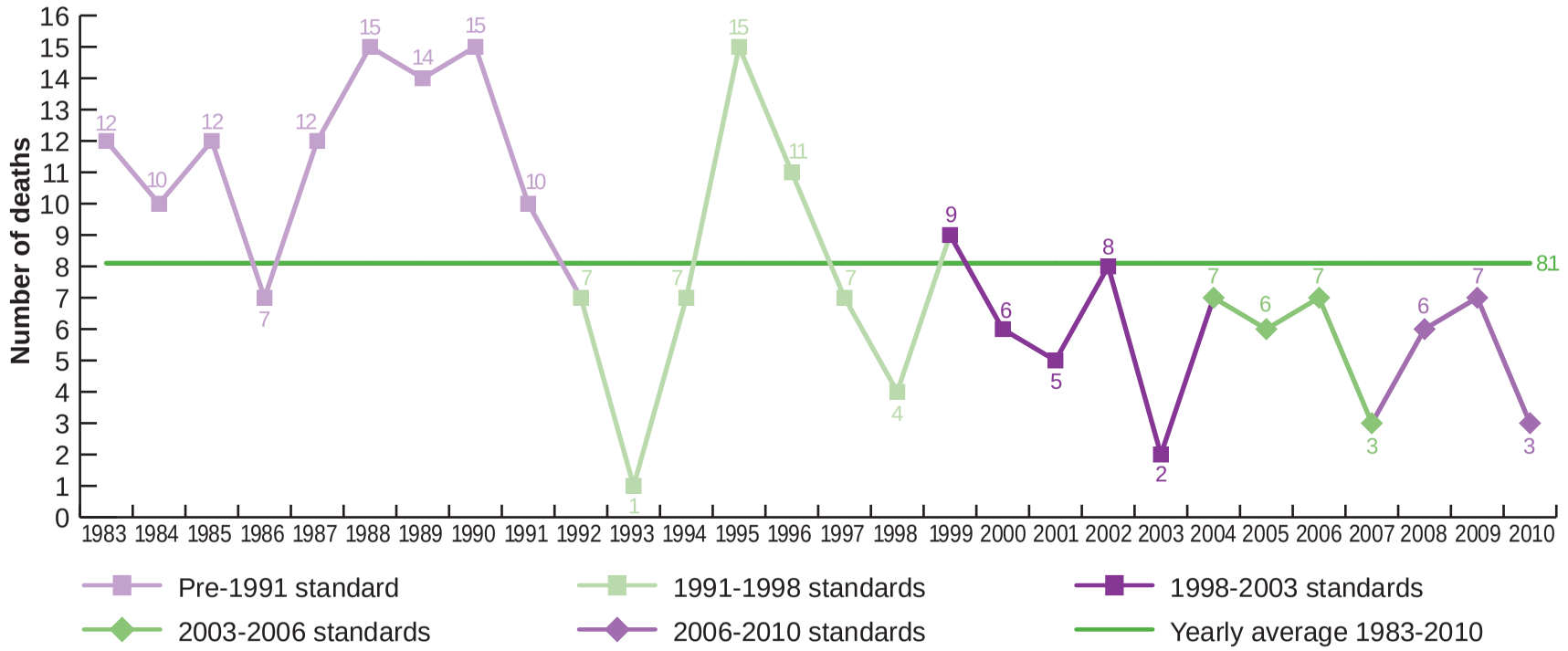
However, the extent to which reductions in drowning are the result of the improvements to fencing requirements, as opposed to a reflection of improved community awareness (or a combination of the two), cannot be determined. The Commission has consistently identified adult supervision as the key to preventing toddler drowning. It is possible that education campaigns associated with the introduction of legislative changes have raised parental awareness of drowning risks and subsequently increased vigilance around residential pools. This may explain the substantial decrease in drowning deaths following the overhaul of fencing laws in 1992, and the absence of this effect with later, more minor changes to requirements.

Despite this, Figure 4.2 clearly shows that the introduction of pool fencing laws has had a major impact on the number of toddler drowning deaths each year. Since 1992, the vast majority of reporting periods have seen drowning deaths below the average for the 18 year period.

The Commission anticipates that the introduction of uniform fencing requirements and mandatory reporting of immersion incidents in late 2010 will continue to have a positive impact on the number of toddler drownings, and will continue to monitor long-term trends over the coming years.

[9] Commission for Children and Young People and Child Guardian, *Queensland Child Death Register 2004–2010; Queensland Injury Surveillance Unit 2008, Injury Bulletin: Domestic pool immersion in Queensland children under 5 years of age*, 104, p.2.

Figure 4.2: Drowning deaths of children aged 0–4 years by applicable pool standard, 1983–2010



Data source: Queensland Injury Surveillance Unit 2008, Injury Bulletin: Domestic pool immersion in Queensland children under 5 years of age, No.104; Queensland Child Death Register 2004–2011.

Note: 1. The above data represents the number of deaths which occurred in each calendar year. These figures will therefore not align with the summary of drowning deaths presented in Table 4.1 of this report which are based on date of death registration by financial year.

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Part III: Non-intentional injury-related deaths

Chapter 5

This section provides details of child deaths from other non-intentional injury.

Key findings

- In 2010–11, 4 children and young people died in a non-intentional injury-related incident, other than a drowning or transport incident at a rate of 0.4 per 100,000 children aged 0–17 years. This is the lowest number of deaths from other non-intentional injury-related deaths in all reporting periods to date.
- The greatest number of non-intentional injury deaths occurred in the 15–17 year age category, in contrast to previous findings which recorded greater numbers of deaths from non-intentional injury in children aged 1–4 years.
- The non-intentional injury-related deaths in 2010-11 were accidental threats to breathing, accidental suffocation and strangulation in bed, fire and electrocution.

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Chapter 5

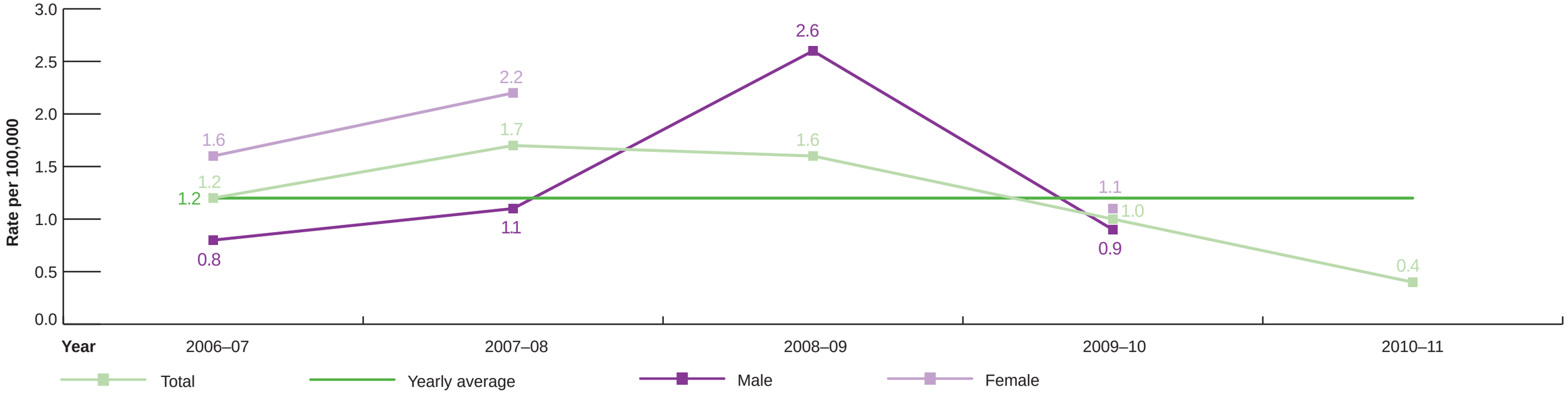
Other non-intentional injury-related deaths

Table 5.1: Summary of other non-intentional injury-related deaths of children and young people in Queensland, 2006–2011

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
Other non-intentional injury deaths											
Other non-intentional injury deaths	12	1.2	17	1.7	17	1.6	11	1.0	4	0.4	1.2
Gender											
Female	8	1.6	11	2.2	3	*	6	1.1	2	*	1.2
Male	4	0.8	6	1.1	14	2.6	5	0.9	2	*	1.2
Aboriginal and Torres Strait Islander status											
Indigenous	1	*	2	*	1	*	2	*	1	*	*
Non-Indigenous	11	1.2	15	1.6	16	1.6	9	0.9	3	*	1.1
Known to the child protection system											
Known to the child protection system	3	*	6	6.6	6	5.9	4	3.1	3	*	4.3
Age category											
Under 1 year	3	*	5	8.8	3	*	4	6.0	1	*	*
1–4 years	5	2.3	6	2.7	8	3.5	3	*	0	*	1.9
5–9 years	0	0.0	2	*	4	1.4	0	*	0	*	*
10–14 years	0	0.0	2	*	0	0	0	*	1	*	*
15–17 years	4	2.3	2	*	2	*	4	2.2	2	*	*
Fire											
Deaths from fire	1	*	5	0.5	4	0.4	0	*	1	*	0.2
Deaths from other injuries											
Other injuries	11	1.1	12	1.2	13	1.2	11	1.0	3	*	1.0

Data source: Queensland Child Death Register (2006–11)
** Rates have not been calculated for numbers less than 4.*
[a] These figures have been amended subsequent to the publication of the 2009–10 Child Death Annual Report due to updated data.
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates that were not published in previous reports have been re-calculated based on the denominator data used for the preparation of the relevant report.
3. Rates are calculated per 100,000 children (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
4. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
5. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
6. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 5.1: Other non-intentional injury-related deaths, 2004–2010



Data source: Queensland Child Death Register (2004–2010)
Note: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in each gender category in Queensland.

Other non-intentional injury-related deaths: findings, 2010–11

The child deaths discussed in this chapter are those unintentional deaths that fall outside the scope of the non-intentional injuries covered earlier in this report (that is, transport incidents and drowning).[1]

Four children died in non-intentional injury-related incidents[2] in Queensland between 1 July 2010 and 30 June 2011, a rate of 0.4 per 100,000 children aged 0–17 years in Queensland.

Gender and age breakdowns are provided in Table 5.2.

Table 5.2: Non-intentional injury-related deaths by gender and age category

Age category	Female	Male	Total	Rate per 100,000
	n	*n*	*n*	
Under 1 year	1	0	1	*
10–14 years	0	1	1	*
15–17 years	1	1	2	*
Total	**2**	**2**	**4**	**0.4**
Rate per 100,000	*	*	**0.4**	

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children in each age/gender category in Queensland.
2. Total rate of death is calculated per 100,000 children and young people aged 0–17 years in Queensland.

Gender

An equal number of male and female children died from non-intentional injuries (2 deaths each).

Research has found that male children are more likely than female children to suffer injury-related deaths, with suggested reasons for these gender differences including a greater degree of risk-taking behaviour by boys, and caregivers displaying a more permissive attitude towards boys' behaviour. While the Commission's findings have generally supported this trend, the 2006–07 and 2007–08 reporting periods recorded a higher number of female deaths from non-intentional injury.

Age

The greatest number of non-intentional injury-related deaths occurred among young people in the 15–17 year age category. This is consistent with the previous reporting period.

Prior to 2009–10, children aged 1–4 years consistently recorded high numbers of deaths from non-intentional injury. Children's risk of injury, and death from injury, is reportedly greater at this age because of young children's rapidly expanding motor skills coupled with an undeveloped perception of risk.

Aboriginal and Torres Strait Islander status

One Aboriginal and Torres Strait Islander child died as a result of non-intentional injury during this period. This child died as a result of accidental threats to breathing.

Geographical distribution (ARIA+)

Three children living in regional areas died as a result of non-intentional injury.[3] This is consistent with findings from the previous reporting periods. The remaining death was a child living in a remote area.

Research has found rates of injury deaths to be higher for children living in regional and remote areas than in metropolitan areas.

[1] Refer to Appendix 5.1 for a comprehensive outline of categories of death constituting 'other non-intentional injury-related deaths'.
[2] For the purposes of this chapter, other non-intentional injury-related deaths will be referred to as deaths caused by 'non-intentional injury'.
[3] Rates have not been calculated for numbers less than 4.

Socio-economic status (SEIFA)

Two children who died were living in moderate socio-economic areas, with the remaining 2 deaths being children living in low to very low socio-economic areas.[4]

Children known to the child protection system

Three of the 4 children were known to the child protection system.[5] Children known to the child protection system are a vulnerable and at-risk cohort who often experience a range of risk factors due to the complex circumstances in their lives.

Members of the community should be encouraged to continue reporting any concerns about the safety of children. If there is a reason to suspect a child in Queensland is experiencing harm, or is at risk of experiencing harm, it is important that risk factors be assessed by child protection experts.

Circumstances of non-intentional injury-related deaths

Types of non-intentional injury-related deaths

Table 5.3 outlines the types of non-intentional injury-related deaths that occurred, by gender and age category.

Table 5.3: Types of non-intentional injury-related deaths by gender and age category

Age category	Female	Male	Total
	n	*n*	*n*
Accidental threats to breathing	**1**	**1**	**2**
Under 1 year	1	0	1
10–14 years	0	1	1
Electrocution	**0**	**1**	**1**
15–17 years	0	1	1
Fire	**1**	**0**	**1**
15-17 years	1	0	1
Total	**2**	**2**	**4**

Data source: Queensland Child Death Register (2010–11)

Accidental threats to breathing

Two children died as a result of accidental threats to breathing. One child was aged under 1 year and died when strangled with a mosquito net that fell over the child's cot. One child aged 10–14 years died as a result of asphyxia after inhaling a volatile substance.

Fire

One child aged 15–17 years died in a residential house fire. Children playing with lighters is considered a likely cause in this incident. This fire fatality occurred during winter. Smoke alarms were known to be present at the time the fire occurred.

Electrocution

One child aged 15–17 years died as a result of electrocution after coming into contact with overhead electrical wires along a railway line.

Place of incident

One of the 4 deaths from non-intentional injuries occurred at the child's home. This is in contrast to the findings both from the literature and from previous Commission research which state that the majority of non-intentional child injuries occur at home.

One death occurred at the home of a friend or relative, while the other 2 occurred in public areas such as shopping centres and railway lines.

[4] Rates have not been calculated for numbers less than 4.

[5] For the purpose of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

Part IV: Intentional injury-related deaths

Chapter 6

This section provides details of child deaths from suicide.

Key findings

- There were 21 suicides of children and young people during 2010–11.
- During this reporting period one nine year old suicided, which is the first death of a child that age the Commission has registered.
- Suicide accounted for over one third of deaths by external (non-natural) causes among children and young people aged 10–17 years (41%), and was the leading external cause of death for 15–17 year olds and the second leading external cause for 10-14 year-olds.
- Over the past 5 years an average of 19 young people have suicided each year in Queensland, representing a rate of 4.0 deaths per 100,000 children and young people aged 10-17 years.
- A third of children and young people who took their own lives were identified as Aboriginal and/or Torres Strait Islander (7 cases). The rate of suicide among Aboriginal and Torres Strait Islander children and young people was more than 7.5 times that of non-Indigenous youth.
- Seventeen children and young people who suicided had, or were suspected to have, mental health issues (81%). Of these, 7 young people had contact with a doctor or health professional in the 3 months prior to death. Depression was the most common mental health issue cited.
- Seventeen of the 21 children and young people (81%) were identified as having previous suicidal thoughts and/or behaviours including suicidal ideation, attempted suicide and engaging in self-harming behaviour.
- In 13 cases the child or young person stated or implied their intent prior to their death. Six of the 13 youth stated or implied their intent in the 24 hours immediately preceding their death. In 7 cases the child or young person wrote a suicide note.

Take threats seriously – most children who suicided stated or implied their intent, or engaged in previous suicidal behaviour, prior to their death. It is important that all threats or talk of suicide are taken seriously.

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Chapter 6

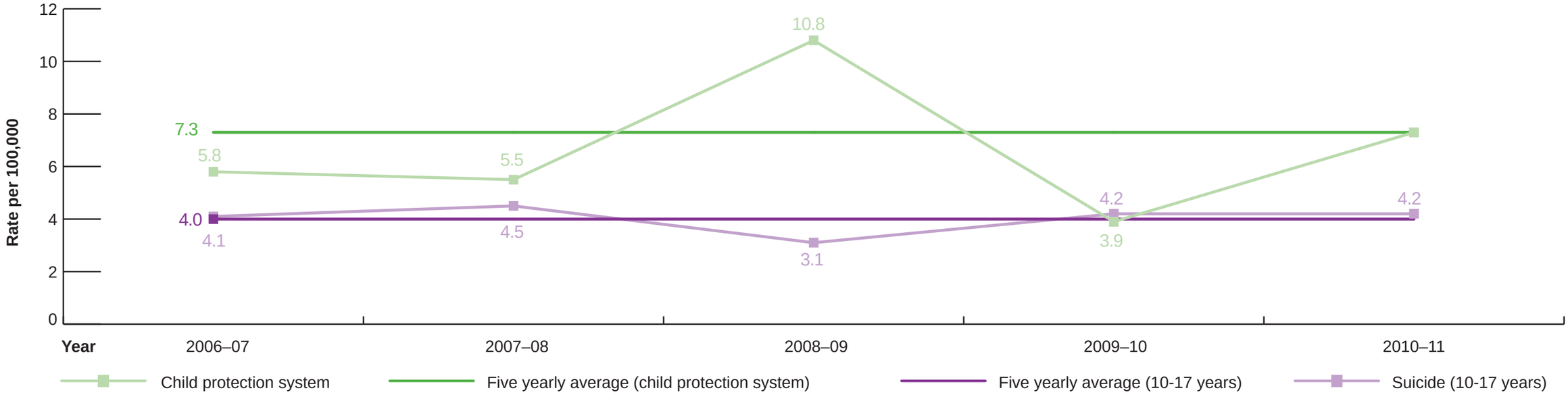
Suicide

Table 6.1: Summary of suicide deaths of children and young people in Queensland, 2006-2011

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All suicide deaths											
Suicide	19	1.9	21	2.0	15	1.4	20	1.9	21	2.0	1.8
Gender											
Female	7	3.1	6	2.6	6	2.6	6	2.6	10	4.3	3.0
Male	12	5.1	15	6.2	9	3.7	14	5.7	11	4.5	5.0
Aboriginal and Torres Strait Islander status											
Indigenous	6	21.1	5	17.1	7	23.5	3	*	7	23.3	18.8
Non-Indigenous	13	3.0	16	3.6	8	1.8	17	3.8	14	3.1	3.1
Known to the child protection system											
Known to the child protection system	5	5.8	5	5.5	11	10.8	5	3.9	11	7.3	7.3
Age category											
10–17 years	19	4.1	21	4.5	15	3.1	20	4.2	20	4.2	4.0
5–9 years	*0*	*	*0*	*	*0*	*	*0*	*	*1*	*	*
10–14 years	*8*	*2.8*	*0*	*	*1*	*	*2*	*	*4*	*1.3*	*
15–17 years	*11*	*6.4*	*21*	*11.8*	*14*	*7.7*	*18*	*9.7*	*16*	*8.7*	*8.8*
Method of Death											
Hanging	17	–	18	–	9	–	16	–	17	–	–
Jumping in front of moving object	1	–	1	–	2	–	2	–	1	–	–
Gunshot wound	0	–	1	–	2	–	1	–	2	–	–
Poisoning	1	–	1	–	1	–	0	–	0	–	–
Jumping from a high place	0	–	0	–	1	–	0	–	0	–	–
Self-immolation	0	–	0	–	0	–	1	–	0	–	–
Other	0	–	0	–	0	–	0	–	1	–	–

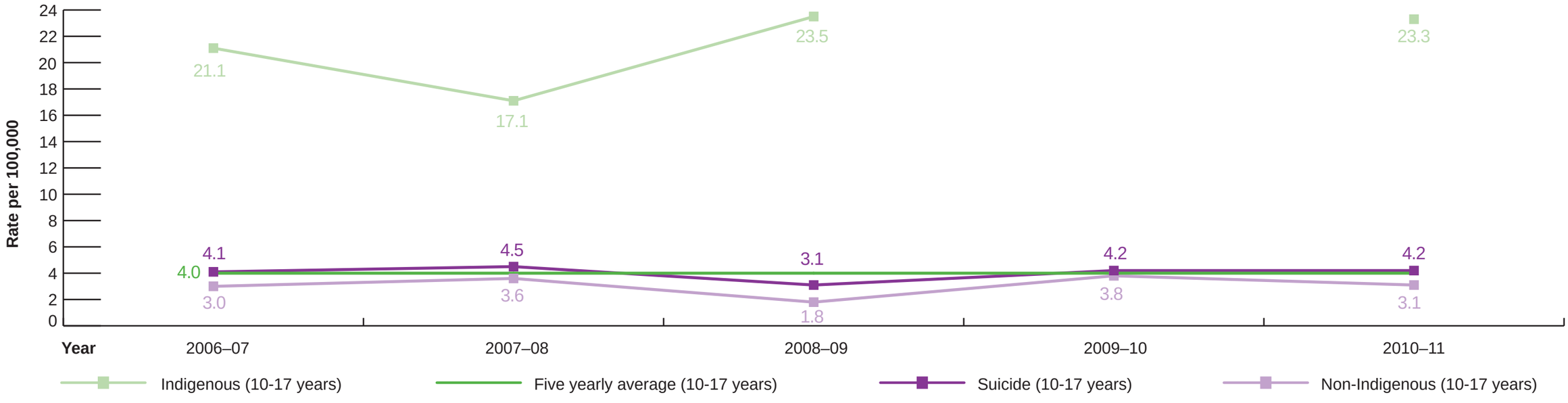
Data source: Queensland Child Death Register (2006–11)
** Rates have not been calculated for numbers less than 4.*
– These data were not available at the time of publication.
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. All rates have been calculated based on the most up-to-date denominator data available to the Commission.
3. Overall suicide rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.
4. All other rates, except known to the child protection population, are calculated per 100,000 children aged 10–17 years in Queensland in each year.
5. The number of children known to the child protection system represents the number of children aged 0-17 years whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
6. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
7. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 6.1: Suicide of children known to the child protection system (0–17 years), 2006–2011



Data source: Queensland Child Death Register 2006–2011
Note: 1. Suicide rates are calculated per 100,000 children and young people aged 10–17 years in Queensland, and per 100,000 children and young people aged 0–17 years known to the child protection system.

Figure 6.2: Indigenous and non-Indigenous suicide (10–17 years), 2006–2011



Data source: Queensland Child Death Register 2006–2010
Notes: 1. Rates are calculated per 100,000 Aboriginal and Torres Strait Islander and per 100,000 non-Indigenous children and young people aged 10–17 years in Queensland.
2. Rates are not calculated for numbers less than 4. Consequently, a rate could not be calculated for Indigenous suicide in 2009-10.

Defining and classifying suicide

In Queensland, a high standard of proof is generally needed for a suicide to be classified as such. In the past, the substantial evidence required for suicide classifications often resulted in deaths that would ordinarily, in clinical or research situations, be categorised as suicides not meeting the threshold for a legal classification. Consequently, cases where suicide was suspected but intent was unclear (that is, the deceased did not leave a suicide note and did not state their intent before death), were often coded as accidents. This resulted in childhood and adolescent suicide being under-reported in official statistics, with a large proportion mistakenly recorded as accidental deaths.[1]

The Commission has endeavoured to reduce the likelihood of suicides being undercounted by examining all cases where police have indicated that a death is a suspected suicide.[2] In addition, to enable further categorisation of these deaths, the Commission has developed a comprehensive suicide classification model (see Appendix 6.1).

Suicide classification model

The Commission's suicide classification model is used to classify all cases of suspected suicide into one of three levels of certainty. In classifying these deaths, the Commission considers a number of factors, including whether intent was stated previously, the presence of a suicide note, witnesses to the event, previous suicide attempts and any significant precipitating factors or life stressors.

Information used to classify suicide certainty is based on data available to the Commission at the time of reporting. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), autopsy and coronial findings, toxicology reports, child protection system records and, for finalised cases, police briefs of evidence to the coroner (which can include witness statements, supplementary Form 1s, additional police reports and suicide notes).

Levels of classification are as follows:

- **Beyond reasonable doubt:** The available information refers to at least one significant factor that constitutes a virtually certain level of suicide classification, or coronial investigations have found that the death was a suicide.
- **Probable:** The available information is not sufficient for a judgement beyond reasonable doubt, but is more consistent with death by suicide than by any other means. Risk factors for suicide have been identified and/or the method and circumstances surrounding the death are such that intent may be inferred.
- **Possible/undetermined:** The police have indicated (on the Form 1) that the case is a suspected suicide but, because of a lack of information on the circumstances of the death, there is a substantial possibility that the death may be the result of another cause, or is of undetermined intent.

In the reporting period, 18 deaths were classified by the Commission as 'beyond reasonable doubt' and 3 deaths were categorised as 'probable'. No deaths were classified as 'possible/undetermined'.

[1] In 2009, in line with the Commission's 2005–06 recommendation, the Australian Bureau of Statistics (ABS) revised their processes in relation to classifying suicide.

[2] As identified in the Police Report of Death to a Coroner (Form 1). In circumstances where the Commission is notified of cases where a child may have suicided, but this information was not recorded on the Form 1, these cases will be included in this chapter. In 2010–11, there were no cases included in the analysis that had not been identified by police as a suspected suicide.

Suicide: findings, 2010–11

Twenty-one children and young people were suspected of suiciding during the 2010–11 reporting period. Table 6.2 illustrates the gender and age breakdowns for all youth suicides.

Table 6.2: Suicide by gender and age category

Age at death	Female	Male	Total	Rate per 100,000
	n	n	n	
5–9 years	**0**	**1**	**1**	*****
9 years	0	1	1	*
10–14 years	**2**	**2**	**4**	**1.3**
10 years	1	0	1	-
13 years	1	1	2	-
14 years	0	1	1	-
15–17 years	**8**	**8**	**16**	**8.7**
15 years	4	3	7	-
16 years	3	0	3	-
17 years	1	5	6	-
Total 10–17 years	**10**	**10**	**20**	**4.2**
Rate per 100,000	**4.3**	**4.5**	**4.2**	

Data source: Queensland Child Death Register 2010–11
** Rates have not been calculated for numbers less than 4.*
- Rates have not been calculated for single year of age.
Notes: 1. Rates are calculated per 100,000 children and young people in each age/gender category in Queensland.
2. Total rate of death is calculated per 100,000 children and young people aged 10–17 years in Queensland.

Gender

In contrast to previous years, female and male children and young people suicided at approximately the same rate in 2010–11.

Research has previously identified gender differences in youth suicide as most likely due to the greater likelihood of males experiencing multiple risk factors, such as co-morbid mood and alcohol abuse disorders, and higher levels of aggression, as well as males choosing more lethal suicide methods compared with those chosen by females. This has been contrasted with higher suicidal ideation and attempt rates amongst adolescent females.

The Commission is concerned with this increase in the rate of suicide among female children and young people, and will closely monitor this trend during the 2011–12 reporting period.

Age

Sixteen deaths involved the suicide of adolescents aged 15–17 years. Suicide remains the leading external cause of death for young people aged 15–17 years in Queensland, occurring at a rate of 8.7 per 100,000 young people in this age group. A further 4 children and young people suicided in the 10-14 year age category, representing the second leading external cause of death. A child aged 9 years also suicided in this reporting period.

The highest number of suicides occurred among young people aged 15 years (7 deaths), with a further 6 deaths occurring among 17 year-olds.

The number of suicide deaths involving younger children, including 1 child aged 10 years and another aged 9 years, remains concerning. Since the Commission commenced registering all deaths

of children and young people in Queensland in 2004, this is the first year that the suicide of a child under 10 years of age has been reported. Subsequent analysis in this chapter will incorporate this child into the 10–17 year age group.

Aboriginal and Torres Strait Islander status

A third of the children and young people who took their own lives were identified as Aboriginal and/or Torres Strait Islander (7 deaths). The rate of suicide among Aboriginal and Torres Strait Islander children and young people was more than 7.5 times that of non-Indigenous youth, with a rate of 23.3 deaths per 100,000 Aboriginal and Torres Strait Islander youth compared to 3.5 per 100,000.

The Commission's research continues to identify the high rate of suicide among Aboriginal and Torres Strait Islander children and young people. Since 2006 Aboriginal and Torres Strait Islander youth aged 10–17 years have died at a rate approximately 6 times that of the non-Indigenous population.

In terms of prevention, of critical importance is the need to differentiate between the distinct factors associated with Aboriginal and Torres Strait Islander children and young people compared with non-Indigenous suicides. Details of the Commission's research on this issue will be discussed in the Reducing Youth Suicide in Queensland (RYSQ) final report, due to be released in 2011–12.

Geographical distribution (ARIA+)

The greatest number of youth suicides occurred in regional areas (9 deaths). However, the highest rate of suicide was in remote areas with a rate of 20.7 deaths per 100,000 young people aged 10–17 years (5 deaths in total).[3]

Socio-economic status (SEIFA)

Children and young people living in moderate socio-economic areas suicided at a rate of 11.2 youth per 100,000 aged 10–17 years, compared with 3.6 per 100,000 for young people living in low to very low socio-economic areas and 1.6 per 100,000 for young people living in high to very high socio-economic areas.

Children known to the child protection system

Of the 21 children and young people who died as a result of suicide, 11 were known to the child protection system.[4] However it is noted that 1 of these children only became known to the Department of Communities subsequent to the suicide incident which ultimately caused their death.

The rate of suicide for children and young people known to the child protection system is greater than that for all youth in Queensland,[5] with 7.3 deaths per 100,000 children, compared with 2.0 suicides per 100,000 for all Queensland children aged 0–17 years.

An increased risk of suicide has been identified among children and young people known to child protection agencies. This is because children known to these agencies may often be living in circumstances that are characterised by substance abuse, mental health problems, lack of attachment to significant others, conduct disorder or a history of abuse, all of which are risk factors for suicide and heighten the importance of increasing community capacity to identify potential concerns and make the necessary referrals to the service system established to assess the risk.

From a research perspective, increasing community capacity to connect at-risk children and young people with support services represents an opportunity to implement new findings about risk factors in assessment and case management frameworks. In that respect, it is preferable that children and young people who are at-risk continue to come to the attention of the child protection system, which

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[3] Caution must be exercised when making comparisons and interpreting rates because of the small number of deaths analysed. An increase or decrease of 1 or 2 deaths across the course of a year may have a significant impact on findings when small numbers are involved.

[4] For the purpose of this report, a child is deemed to have been known to the child protection system if, within 3 years before the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

[5] Rates of children in the child protection population are calculated on the total child protection population aged 0–17 years as age breakdowns are unavailable. These are compared with rates of children and young people in the total Queensland population aged 0–17 years.

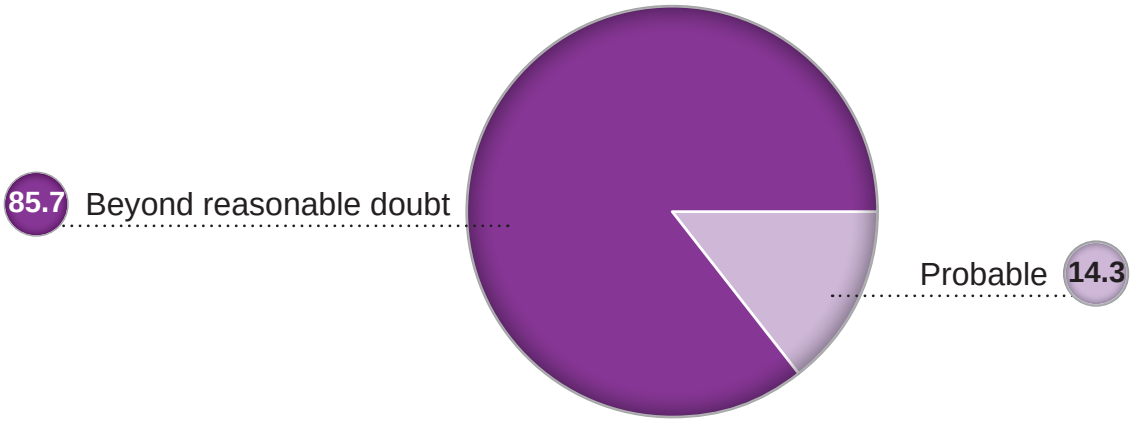
then provides an opportunity for assessment based upon an increasing understanding of the risk factors at play.

Through the RYSQ project, the Commission hopes to present its evidence in a way that helps strengthen assessment frameworks and identify points where intervention can be targeted. This should help agencies explore the potential for partnerships, to better identify risks and provide effective and co-ordinated services and supports. The Commission considers the child protection system to be a key stakeholder of the RYSQ project.

Suicide classification

Figure 6.3 shows the breakdown of suspected suicide deaths by their assessed probability as confirmed suicides. Eighteen cases were classified by the Commission as beyond reasonable doubt, with only 3 classified as being of probable likelihood.

Figure 6.3: Percentage of suspected suicide deaths by classification



Data source: Queensland Child Death Register (2010–11)

Circumstances of death

Method of death

Table 6.3 presents the methods of suicide used by children and young people by gender. Hanging was the most frequently used method for both males and females (17 deaths). Other suicide methods included gunshot (2 deaths), jumping in front of a moving object (1 death), and asphyxiation/inhalation of gases (1 death). These findings are consistent with those of all previous Child Death Annual Reports.

Hanging

Despite the fact that hanging is the single most common mode of suicide for children and young people in Queensland, there are currently no clear interventions to reduce the use of this method. Hanging is a mode of suicide to which it is virtually impossible to restrict access, because of the easy availability of hanging ligatures. Therefore, the method that accounts for the greatest number of youth suicides is also the least amenable to change. The available research suggests that the prevention of suicide by hanging will continue to rely upon a wide-ranging approach to reducing risk factors in suicide generally.

Table 6.3: Method of suicide death by gender

Age at death	Female	Male	Total
	n	*n*	*n*
Hanging	8	9	17
Gunshot	0	2	2
Jumping in front of a moving object (e.g. train or car)	1	0	1
Asphyxiation/Inhalation of gases	1	0	1
Total	**10**	**11**	**21**

Data source: Queensland Child Death Register (2010–11)

Coronial findings

At the time of reporting, coronial findings had been finalised for 4 of the 21 suicides. Table 6.4 shows the coroner's findings for each of these cases, and the classification assigned by the Commission using the suicide classification model.

Table 6.4: Coronial findings and classifications of suspected suicides

Coronial findings	Intent clearly stated in findings	Suicide classification
Hanging	No (but implied)	Beyond reasonable doubt
Hanging	Yes	Beyond reasonable doubt
Gunshot wound to head	No (but implied)	Beyond reasonable doubt
Hanging	No (but implied)	Beyond reasonable doubt

Data source: Queensland Child Death Register (2010–11)

Situational circumstances and risk factors

This section outlines the factors that may have triggered suicidal behaviour in Queensland youth, where that information is available to the Commission.[6] The numbers may therefore under-represent the true number of circumstances and risk factors for some of the children and young people who took their own lives during 2010–11.

Suicidal behaviours in children and young people are often not the result of a single cause, but are multiplicative and frequently occur at the end point of adverse life sequences in which several interacting risk factors combine, resulting in feelings of hopelessness and a desire to 'make it all go away'. It is widely understood, and confirmed by the Commission's research, that a number of common risk factors and adverse life circumstances may lead to suicidal behaviour in children and young people.

Mental health issues and behavioural problems

Seventeen of the 21 children and young people who suicided had, or were suspected to have had, a mental health issue before their death. Depression was the main mental health issue identified (12 cases). In 3 cases, children and young people experienced schizophrenia or possible psychosis, and in a further case a child was found to have auditory hallucinations. Other mental health and behavioural problems identified included attention-deficit hyperactivity disorder, conduct disorder, attachment disorder, Asperger's syndrome, autism, borderline personality disorder and dyspraxia.[7]

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[6] Section 147 of the *Commission for Children and Young People and Child Guardian Act 2000* provides that a government entity may provide the Commissioner with information reasonably required to perform the Commission's child death research functions under Chapter 6, Part 2 of the Act. As the identification of suicide risk factors requires full case records from a number of government agencies, the Commission has previously negotiated agreements with the agencies responsible for health, police, coroners, education, child protection, housing and emergency services to gain access to further risk factor information in some cases.

[7] Each young person may have experienced more than one mental health problem (co-morbid disorders). Therefore, numbers may not sum accurately.

Five of the 17 children and young people identified to have experienced mental health and/or behavioural issues were noted to have co-morbid conditions.

Of these 17 young people, 7 had contact with a doctor or mental health professional in the 3 months prior to death and a further 3 children had been in contact with health professionals in the years prior to their death but were not noted to have had any recent mental health contact.

Seven of the young people were recorded as having been prescribed medication for their mental health issue at the time of their death. However, 3 of these were noted to have been non-compliant with their medication at the time of death and in all other cases it was unknown whether children were compliant. In 1 additional case, a young person was noted to have been taken off their medication by a health professional in the weeks prior to their suicide.

In 5 cases, children were suspected of having a mental health issue based on the statements of family and friends. Table 6.5 outlines the number of children with confirmed or suspected mental health issues, and the sources of information on which this assessment has been based.

Table 6.5: Mental health issues

Mental health issues	
Known mental health issue	**12**
Known to have accessed mental health provider	10
Currently or previously prescribed medication for mental health issue	9
Suspected mental health issue	**5**
No mental health issue identified	**4**
Total	**21**

Data source: Queensland Child Death Register (2000–11)

Notes: 1. 'Known mental health issue' will not sum accurately where young people had both accessed mental health and were prescribed or previously prescribed medication.

2. 'Suspected mental health issue' refers to information from family members or friends that believed the young person to be experiencing a mental health issue.

3. Young people were recorded as not having a mental health issue where the Commission did not have information to indicate otherwise. This is not an absolute finding in regards to the young person's mental health.

Research suggests that mental health problems most frequently associated with youth suicide include depression, anxiety, substance dependence and antisocial behaviour, with multiple or co-morbid conditions suggested to occur frequently in young people who suicide. Early identification and treatment of mental health and behavioural problems are essential in preventing child and adolescent suicides.

In addition, a family history of mental illness was identified in 6 cases.

Previous suicidal behaviour

Previous suicidal behaviour and/or thoughts of suicide were identified for 17 children and young people. Six young people had previously attempted suicide and of these 3 had attempted suicide on several occasions. Thirteen young people were recorded as having experienced suicidal ideation.[8] A total of 5 young people had previously engaged in self-harming behaviour, such as cutting.[9]

Research suggests that a previous suicide attempt is the single most important risk factor predicting youth suicide. The findings of this report highlight the presence of previous suicidal behaviour and/or thoughts as a key risk factor for consideration in youth suicide prevention strategies.

[8] 'Suicidal ideation' refers to the explicit communication of having thoughts of suicide.

[9] Each young person may have experienced more than one suicidal behaviour. Therefore, numbers may not sum accurately.

Intent stated or implied (orally or written)

In 13 cases, children and young people stated or implied their intent to a family member, friend, boyfriend or girlfriend, or to unknown persons online. All 13 young people communicated their intent verbally; some also stated or implied their intent to suicide via mobile phone text message (1 death) or in an online forum (2 deaths). Six of the young people stated or implied their intent in the 24 hours immediately preceding the incident.

Suicide notes were found in 7 cases. Four of these young people had also stated or implied intent prior to their suicide.

The fact that the majority of these children and young people stated their intent before suiciding highlights the importance of taking threats or talk of suicide seriously. Parents, carers and others need to recognise that children know enough to attempt suicide, regardless of whether or not they appreciate the finality and permanence of death.

Studies estimate that approximately 80% of children and young people who complete suicide communicate suicidal thoughts and feelings, or their intent to kill themselves, to someone before their death. However, it is often difficult to tell what some of the signs may mean, or indications may be so subtle that they go unrecognised. Significant changes in behaviour may be easier to identify. Knowledge of risk factors for suicide may help parents, friends and families to intervene and take appropriate action.

In some cases the desire to die may be so strong that even when interventions are initiated they are unsuccessful. Documented interventions by health professionals (in the three months prior to death were noted in 7 cases[10] and yet the individuals still took their own lives. It is essential to recognise the potential for suicide among children and to take all threats of suicide seriously.

History of childhood abuse

Four of the young people had a history of childhood abuse. All 4 were noted to have experienced emotional abuse or neglect. Three of the young people were victims of physical abuse and 1 was also a victim of sexual abuse. Perpetrators of the abuse were typically from within the family, being either the child's parent, step-parent or guardian. All 4 children who had a history of abuse were also known to the Department of Communities within the 3 years before their deaths, and also came from families that had a history of domestic violence.

Research found that children and young people who are abused in childhood are at a significantly greater risk of suiciding compared to children with no history of abuse, with some research finding a direct link between abuse and suicidal behaviour. Likewise, the available research indicates that family violence may also influence childhood suicide behaviours.

Precipitating incidents and stressful life events

Precipitating incidents

Precipitating incidents were identified in 16 of the 21 suicides.[11] The Commission's body of evidence since 2004 shows that precipitating incidents are identified in the vast majority of suicides involving children and young people.

For 8 of the young people, an argument with a significant other preceded the suicide. This included arguments with:

- a parent (4 cases)
- a boy/girlfriend (2 cases)
- another family member (2 cases), and
- friends (1 case).

[10] Interventions counted were specifically in relation to mental health problems and suicide risk, and included counselling and contact with mental health services.

[11] Each young person may have experienced more than one precipitating incident prior to their death. Therefore, numbers may not sum accurately.

Three young people had a recent (or anticipated) relationship breakdown with either a boy/girlfriend or parent in the hours/days prior to their suicide. As in previous years, arguments and relationship breakdowns with significant others were a common precipitating incident prior to a suicide.

Precipitating incidents identified among children and young people who suicided also included residing in an unstable living situation and/or living away from home (4 cases), school stressors and problems (3 cases), recent offence-related contact with police and/or a fear of being placed in youth detention (3 cases) and boy/girlfriend problems (2 cases). In a further 3 cases it was noted that the young person underwent a significant change in personality in the days prior to suicide (as reported by family and friends).

Other precipitating incidents identified among children and young people who suicided in 2010–11 included:

- recent bereavement by the death of a family member
- being the victim of a recent sexual assault
- custody issues
- hopelessness, loneliness and isolation
- medication change
- drug withdrawal
- possible miscarriage, and
- recent parental separation.

These findings are consistent with research which identifies that precipitating incidents most commonly associated with suicide are arguments with partners, family or friends; relationship breakdowns; bereavement as a result of a death; and disciplinary troubles at school or with police.

Other stressful life events

A number of long-term stressors[12] were identified for 18 of the children and young people who took their own lives. More than one life stressor was identified for half of these children and young people (9 cases).

Ongoing school problems was the most frequently identified life stressor among children who suicided with issues including truancy, suspension, exclusion and school attendance refusal identified among 5 youth. Parental substance use, parental psychopathology and offence-related contact with police/youth justice authorities were identified as a life stressor in 4 cases each, with poor parent-child relationships and unstable living situations identified in a further 3 cases each. Transition or a move from country of origin to Queensland was identified as a key stressor for 2 young people who suicided, with both of these young people also experiencing loneliness and isolation as a result of the move. The death of a parent and parental divorce/separation was a key life stressor for young people who suicided (2 cases each). Other stressful life events identified among children and young people who suicided included disability, unemployment, physical assault, and ongoing sibling conflict.

Young people who suicide have often experienced a higher rate of adverse or stressful life events in the period preceding the suicide, compared with other people of the same age. Further, evidence suggests that stressful events, or an accumulation of stressors, are particularly likely to provoke suicidal behaviour in vulnerable individuals.

Of particular note are persistent findings of transition and instability in the lives of children and young people who suicide. Situations of transition may include:

- completion of primary school and transition to high school
- completion of high school and transition to employment, further study or unemployment
- a recent change in schools
- moving a distance away from a previous home, including moving interstate or overseas, and

[12] 'Stressful life event' refers to life stressors that generally occurred more than 6 months prior to death and were considered a contributing factor but not identified as an immediate 'trigger' or precipitating incident for the suicide. In addition, stressors mentioned here do not include other risk factors already examined in other sections of this report, such as domestic violence and mental health problems.

- a transition into or out of care, or between different carers (including in relative, foster care or self placement).

The Commission will continue to explore the issue of transition amongst children and young people who suicide.

Alcohol, drug and substance use

Ten of the children and young people who suicided were reported to have been known alcohol, drug and/or substance users.[13] [14]

Consistent with the findings from previous Child Death Annual Reports, alcohol was the most frequently cited substance used (7 cases). Four young people were noted to have used cannabis/marijuana, with 2 also reported to have used inhalants (such as petrol or paint).[15] One young person was identified to have been a substance abuser/dependent.

Five of the children and young people were recorded as having used alcohol and/or drugs before their death. Of those, 1 young person was identified to be intoxicated at the time of their suicide, while another was found to have consumed antidepressant and antipsychotic drugs beyond safe therapeutic levels. Toxicology results remain outstanding for 1 of the 5 children who allegedly used substances before their death.

Research suggests that use of alcohol and other drugs is correlated to the risk of suicide. Increased risk could be attributed, in the short term, to the indirect effects of intoxication on behaviour.

Contagion

Contagion refers to the process by which a prior suicide or attempted suicide facilitates or influences suicidal behaviour in another person. Contagion was identified as a key risk factor for 3 of the 21 children and young people who suicided during this period. In an additional 3 cases contagion was identified as a potential influencing factor in the suicide of the young person. Table 6.6 below illustrates the different types of contagion influences identified among children and young people who suicided during the current reporting period.

Table 6.6: Contagion influences

Contagion influences	
Contagion a clear influencing factor	**3**
Completed suicide of a parent/carer	2
Completed suicide of a community member	1
Attempted suicide of a family member	2
Contagion a likely factor	**3**
Parent/carer threatened suicide previously	2
Parent/carer made pseudo suicide attempt	2
Alleged suicide pact	1
No contagion identified	**15**
Total	**21**

Data source: Queensland Child Death Register (2010–11)
Note: 1. Contagion sub-headings will not sum accurately where young people had more than one contagion influence.

[13] Previous or current use of alcohol or drugs identified by friends, family members or in toxicology findings.
[14] Each young person may have used more than one substance prior to their death. Therefore, numbers may not sum accurately.
[15] Also known as “chroming”.

There is considerable evidence to suggest that the suicide of one person may trigger suicidal behaviour in those associated with that person, or in vulnerable people who become aware of the suicide. This can occur in a number of ways, including:

- seeing the person who completed suicide and being involved in the aftermath
- having talked with or seen the person on the day of the suicide
- belonging to the family of the person
- being in the same school or a neighbouring school
- learning of the attempted or completed suicide of a role model or respected community member, and
- reading or hearing about the death in the media.

These findings indicate that a suicide or attempted suicide can provide a model for subsequent suicides by means of identification and imitation, demonstrating the far-reaching impact that suicide has on others.

The contagion process that leads to suicide clusters among youth is something that requires heightened recognition. Some young people, especially those who may already be experiencing difficulties, may identify with the suicide victim, raising the notion of suicide as an option. It is therefore essential that any postvention response involves not only those children who were directly known to the suicide victim, but also those who may not have known the young person but who may have heard about the suicide. The occurrence of contagion-related deaths reinforces the importance of having detailed suicide prevention, intervention and postvention guidelines available, and the need for co-ordinated postvention responses.

Table 6.7 illustrates a number of circumstances and risk factors common to children and young people who suicided in Queensland. As shown, many of the youth experienced multiple factors that place individuals at a higher risk of suicidal behaviours.

Other significant factors

Place of incident

Sixteen of the 21 suicides occurred at the young person's place of residence. Of these, 5 took place inside the young person's bedroom, 3 inside a bathroom and 8 outside of the house in the yard or in another out-building or structure. The places where the 5 remaining suicides occurred were:

- home of friend/acquaintance (2 cases)
- homeless/respite shelter
- railway tracks, and
- recreation area/bushland.

Day of incident

The 21 suicide deaths of children and young people were spread across a range of different days of the week.

Table 6.7: Summary of characteristics of all children and young people who suicided in 2010–11

Demographics					Known risk factors						
Gender*	Age category	Aboriginal or Torres Strait Islander status	Regional/ remote	Low SES	Mental health issues	Previous suicidal behaviour/ thoughts	History of childhood abuse	Precipitating incident	Alcohol/ drug use	Contagion	Known to child protection system
5-9 years	***1***	***0***	***1***	***0***	***1***	***1***	***0***	***1***	***0***	***1***	***1***
M	5-9		✓		✓	✓		✓		✓	✓
10-14 years	***4***	***2***	***3***	***2***	***3***	***3***	***1***	***3***	***2***	***1***	***4***
M	10-14	✓	✓	✓	✓	✓		✓	✓		✓
F	10-14	✓	✓	✓		✓	✓	✓	✓	✓	✓
M	10-14				✓	✓		✓			✓
F	10-14		✓		✓						✓
15-17 years	***16***	***5***	***10***	***5***	***13***	***13***	***3***	***12***	***8***	***4***	***6***
F	15-17	✓	✓		✓			✓	✓		✓
F	15-17		✓		✓	✓			✓		
M	15-17	✓		✓	✓	✓	✓	✓		✓	✓
F	15-17							✓	✓		
M	15-17		✓	✓	✓	✓					
M	15-17		✓		✓	✓		✓	✓	✓	
F	15-17				✓	✓		✓			
M	15-17		✓			✓		✓	✓	✓	
F	15-17		✓	✓		✓				✓	
F	15-17				✓	✓					
M	15-17	✓	✓		✓	✓	✓	✓			✓
M	15-17				✓			✓	✓		
F	15-17		✓	✓	✓	✓		✓	✓		✓
M	15-17	✓	✓		✓	✓		✓			
M	15-17	✓		✓	✓	✓		✓	✓		✓
F	15-17		✓		✓	✓	✓	✓			✓
Total	**21**	**7**	**14**	**7**	**17**	**17**	**4**	**16**	**10**	**6**	**11**

Data source: Queensland Child Death Register (2010–11)

✓ *= Yes, the child had this risk factor.*

Note: 1. Low SES refers to children and young people who had been classified as residing in either a low or very low socio-economic area

Reducing Youth Suicide in Queensland (RYSQ) project

The Commission has consistently identified child and adolescent suicide as a key concern in Queensland. On average, 19 young people suicide each year in Queensland, which for the past seven years has made it either the leading or second leading cause of death for 10–14 and 15–17 year olds.

In response, the Commission developed an in-depth project reviewing the suicides of Queensland children and young people.

The *Reducing Youth Suicide in Queensland* (RYSQ) project has involved a detailed review of the lives and deaths of children and young people who died by suicide in Queensland between 1 January 2004 and 31 December 2007.

The project has aimed to provide a solid and contemporary evidence base about suicide risk factors to better inform prevention efforts targeted at children and young people.

The Commission's Final Report on the project will be released in 2011–12. The Commission will continue to support the work of key stakeholders in identifying options for improving prevention and early intervention strategies through its maintenance of the Child Death Register and provision of data and trend information.

Impacted Children Project

Through the Commission's analysis of youth suicide, a number of Queensland regions experiencing high levels of contagion and cluster suicides among their youth populations have been identified. In response to the Commission's findings, the Queensland Police Service initiated the development of the 'Impacted Children' project. The overarching objective of this project is to facilitate timely service delivery to children and young people impacted by suicide by promoting cross-agency communication.

The Impacted Children Project Steering Committee, chaired by the Queensland Police Service, and established to oversee the development and scope of the project, consists of several government and non-government agencies. Representatives include:

- Queensland Health
- Department of Education and Training
- Department of Communities
- Queensland Catholic Education Commission
- Brisbane Catholic Education
- Association of Independent Schools Queensland, and
- the Commission.

The project aims to structure a whole-of-government co-ordinated postvention strategy to reduce the incidence of contagion and cluster youth suicides. Information sharing between relevant agencies is designed to assist in the identification of 'impacted children' and the delivery of co-ordinated postvention support services. The project has been piloted at two key regional centres in Mackay and Toowoomba, where localised hubs were formed by relevant officers of the partner organisations, who convene to identify what postvention supports, if any, are required in their community in the wake of a child or youth suicide. The success of the pilot project has been confirmed through positive evaluation by the Australian Institute for Suicide Research and Prevention.

The Queensland Police Service is currently developing an outcomes paper arising out of the pilot process. In the future, it is hoped that similar local hub networks will be established across the state. An information pack will be developed for distribution to police officers providing advice on what steps to take in the event of the suicide of a child or young person in their region or local community.

The Commission commends this project and the positive outcomes that have been achieved to date. Over the coming year, the Commission will be consulting with other relevant stakeholders in support

of a multi-agency approach to assist the Queensland Police Service in putting into place suitable postvention response strategies throughout Queensland.

Joint Select Committee on Cyber-Safety

In 2010 the Commonwealth Government announced the formation of the Joint Select Committee on Cyber-Safety to investigate the online environment in which children and young people engage, including their safety and wellbeing while doing so. During 2010–11, the Commission provided a submission to the Committee highlighting the challenges presented by social networking sites in responding to the deaths of children and young people.

Some sites may contain unsafe or inaccurate content, and may incite or support inappropriate online behaviour towards other users. The Commission recommended the development of guidelines for managing online behaviour following the suicide of a young person, including education initiatives to help manage risks of memorial pages and the moderation and review of these pages.

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Part IV: Intentional injury-related deaths

Chapter 7

This section provides details of child deaths from assault and neglect.

Key findings

- Between 1 July 2010 and 30 June 2011, assault and neglect accounted for the deaths of 5 children and young people in Queensland.
- Three of the victims of fatal assault and neglect were aged under 1 year and another was aged 1 year. The research literature and the Commission's own evidence consistently show that the youngest children are at the highest risk of fatal assault and neglect.
- In 2010–11, 1 child died as a result of a domestic homicide in which the perpetrator later suicided. A review of murder-suicide cases since 2004 shows that 10 Queensland children have died in circumstances where the perpetrator subsequently suicided or attempted suicide.

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Chapter 7

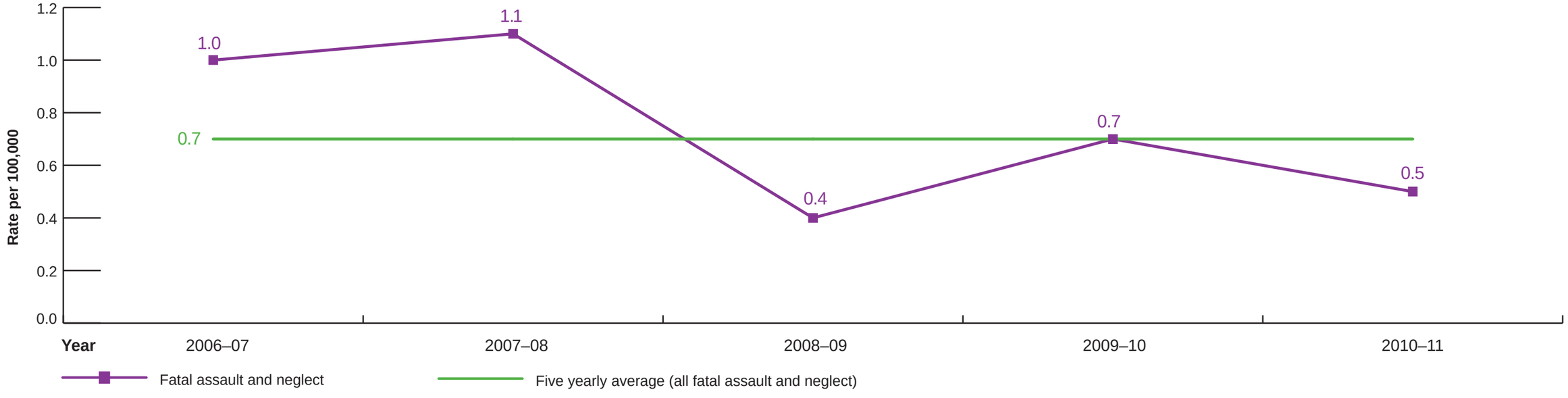
Fatal assault and neglect

Table 7.1: Summary of deaths from assault and neglect of children and young people in Queensland, 2006–11

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All assault and neglect deaths											
Fatal assault and neglect	10	1.0	11	1.1	4	0.4	8	0.7	5	0.5	0.7
Gender											
Female	5	1.0	4	0.8	2	*	5	1.0	1	*	*
Male	5	1.0	7	1.3	2	*	3		4	0.7	0.8
Aboriginal and Torres Strait Islander status											
Indigenous	2		2	*	1	*	1	*	1	*	*
Non-Indigenous	8	0.9	9	0.9	3		7	0.7	4	0.4	0.6
Known to the child protection system											
Known to the child protection system	7	8.1	9	9.9	2	*	4	3.1	3	*	4.9
Age category											
Under 1 year	3	*	5	8.8	0	*	1	*	3	*	*
1–4 years	3	*	3	*	2	*	1	*	2	*	*
5–9 years	0	*	1	*	1	*	1	*	0	*	*
10–14 years	0	*	2	*	0	*	2	*	0	*	*
15–17 years	4	2.3	0	*	1	*	3	*	0	*	*
Method of assault											
Physical assault without weapon	2	–	7	–	1	–	2	–	0	–	–
Blunt force trauma/object	1	–	1	–	0	–	1	–	1	–	–
Stabbing	2	–	1	–	1	–	3	–	0	–	–
Smothering/suffocations	0	–	0	–	0	–	0	–	0	–	–
Carbon monoxide poisoning	1	–	0	–	0	–	0	–	0	–	–
Sexual assault	1	–	2	–	0	–	0	–	0	–	–
Neglect	1	–	0	–	2	–	0	–	0	–	–
Other/unknown	2	–	0	–	0	–	2	–	4	–	–
Victim-offender relationship											
Perpetrator family member	5	–	11	–	4	–	3	–	2	–	–
Perpetrator non-family member or unknown	5	–	0	–	0	–	5	–	3	–	–

Data source: Queensland Child Death Register (2006–11)
** Rates have not been calculated for numbers less than 4.*
– These data were not available at the time of publication.
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Total rates are calculated per 100,000 children (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
3. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
4. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
5. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 7.1: Deaths from assault and neglect, 2006–2011



Data source: Queensland Child Death Register (2006–2011)
Notes: 1. Rates are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Defining fatal child assault and neglect

The Commission defines *fatal assault* as the death of a child resulting from an act or acts of violence perpetrated by another person.

Further, the Commission defines *fatal neglect* as the death of a child resulting from a failure to provide essential care necessary to the child's survival. This may involve acts or omissions on the part of a caregiver that are either deliberate or extraordinarily irresponsible or reckless.

Taken together, *fatal assault and neglect* is a cause of death which accounts for all cases where a child under the age of 18 years is killed by another person, through act or omission.

In formulating these definitions, the Commission acknowledges that assault and neglect are not mutually exclusive concepts and that both can occur concurrently in a child's life. Assault and neglect can also be either acute or chronic in nature.

Categories of fatal child assault and neglect

The Commission's ongoing research in this area has led to the development of a revised classification system for deaths from assault and neglect. The Commission is now able to organise assault and neglect deaths into 8 major event categories: neonaticide; fatal child abuse; fatal neglect; domestic homicide; peer homicide; intimate partner homicide; acquaintance homicide; and stranger homicide.

The categories are primarily based upon the different developmental stages in the lives of children and young people aged 0 to 17 years, from infancy and early childhood, where children are entirely dependent upon others for their survival, through to adolescence, where young people develop a range of new social networks. Fatal assault and neglect scenarios can also be considered in terms of the relationship between the perpetrator and the child victim. The categories of neonaticide, fatal child abuse, fatal neglect and domestic homicide are, by definition, familial; the categories of peer homicide, intimate partner homicide, acquaintance homicide and stranger homicide are essentially non-familial.

Neonaticide

The term neonaticide is defined as the killing of an infant within 24 hours of birth. It is to be differentiated from infanticide, which is commonly defined as the killing of an infant under the age of one year by a parent. Neonaticide is typically characterised by an attempt to conceal birth by disposing of the foetal remains.

The Commission's definition does not limit neonaticide to acts or omissions involving mothers of new-born infants, there being evidence to show that fathers and step-fathers are often complicit in this category of offence.

Fatal child abuse

The category of fatal child abuse describes deaths from physical abuse perpetrated by a parent or caregiver against a child who is reliant upon them for care and protection. For this reason, victims of fatal child abuse are predominantly infants, toddlers or preschool-aged children.

Care must be taken in drawing attention to any clear division between chronic patterns of violence and apparent "one-off" assaults, as it is frequently impossible to determine with any certainty whether an ostensible isolated assault was not preceded by other acts of abuse.

Fatal neglect

Fatal neglect is the ultimate manifestation of the wider social problem of parental/caregiver neglect. It is most likely to involve those younger children who are wholly reliant upon their primary caregivers for the necessities of life, such as food, medical attention and adequate supervision.

The Commission acknowledges that the problem of child neglect occurs across a broad spectrum.

For example, it is necessary to differentiate between intentional or extraordinarily irresponsible or reckless acts and forms of neglect which may arise from social problems such as chronic poverty or the absence of family support networks.

As such, it is not appropriate to construct a fixed definition of what constitutes neglect. The nature and extent of any neglect can only be determined in light of the full circumstances of each particular case.

Domestic homicide

Domestic homicides are premeditated events where there is a clear intent to kill on the part of the perpetrator. Such events are usually characterised by evidence of a breakdown in the parental relationship and/or acute mental illness in one or both parents. In this category, child victims of any age may be involved.

It is common in cases of domestic homicide for a perpetrator to suicide subsequent to their killing one or more family members. These incidents are often referred to as murder-suicides.

Peer homicide

The category of peer homicide accounts for lethal peer-to-peer confrontations that most commonly occur in public places. Peer homicide closely resembles adult homicide, with confrontational violence occurring between friends, acquaintances or strangers.

Intimate partner homicide

Some young people die at the hands of their intimate partners. The body of evidence gathered by the Commission since 2004 shows that in intimate partner homicide, the victim is often a female in the 15–17 year age group and the perpetrator an older, adult male.

Acquaintance homicide

In some cases children are killed by an adult known to – but not intimately connected with – either the victim or their family. Perpetrators may include neighbours, family friends or a person who has interacted with a child in an on-line context.

Acquaintance homicide is an important category to differentiate from domestic homicide, where there is an unambiguous familial association, and stranger homicide, where there is no prior association whatsoever between perpetrator and victim.

Stranger homicide

Stranger homicide involves those child deaths that occur at the hands of an adult person who is unknown to them.

The Commission will commence applying these revised categories of fatal assault and neglect in the 2011–12 reporting period.

Fatal assault and neglect: findings, 2010–11

Between 1 July 2010 and 30 June 2011, 5 children died as a result of assault and neglect in Queensland. In all 5 deaths, the primary mechanism was assault-based.

A sixth Queensland child who died as a result of assault and neglect during the reporting period was killed in New South Wales after being abducted from this state by a parent. As the child's death did not occur in Queensland, it does not form part of this analysis.

Table 7.2: Fatal assault and neglect by victim gender and age category

Age category	Female *n*	Male *n*	Total *n*
Under 1 year	0	3	3
1–4 years	1	1	2
5–9 years	0	0	0
10–14 years	0	0	0
15–17 years	0	0	0
Total	**1**	**4**	**5**

Data source: Queensland Child Death Register (2010-11)

Age and gender

Three children who died were male infants under 1 year of age and another male child was 1 year of age when he died. The female child was aged 3 years and died as a consequence of injuries received when she was an infant.[1]

Research continues to show that the very youngest children are most at risk from fatal assault and neglect, due to their small size, vulnerability and total dependence upon their carers for survival.

Aboriginal and Torres Strait Islander status

One Aboriginal and Torres Strait Islander young person died as a result of assault during this reporting period.

Geographic distribution (ARIA+)

Four of the children who died were living in regional areas.

Socio-economic status (SEIFA)

Three of the children who died were living in low to very low socio-economic areas.

Children known to the child protection system

Of the 5 children who died as a result of assault and neglect, 3 were known to the child protection system due to the complex interplay of risk factors present in their life.[2]

It is preferable that all children in circumstances placing them at risk of assault or neglect come to the attention of the child protection system, which then provides an opportunity for assessment based upon the risk factors at play. Research into these risk factors is critical in building upon the understanding of how they should be assessed and the most appropriate service response.

Members of the community should be encouraged to continue reporting any concerns about the safety of children.

[1] As this child was residing in foster care subsequent to the assault which led to her death, the case is not included in ARIA or SEIFA calculations for this chapter.

[2] For the purpose of this report, a child is deemed to have been known to the child protection system if, within three years prior to the child's death, the Department of Communities, Child Safety Services became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.

Circumstances of fatal assault and neglect

Category of event

Table 7.3 classifies the deaths according to the major categories of event.

Table 7.3: Category of event by perpetrator and age category

Age category	Perpetrator	Charges
Fatal child abuse		
Under 1 year	Father	Yes
Under 1 year	Unknown	No
1–4 years	Unknown	No
1–4 years	Unknown	No
Domestic homicide		
Under 1 year	Mother	Not applicable – perpetrator deceased in same incident

Data source: Queensland Child Death Register (2010–11)

Two male infants under 1 year of age were the victims of fatal child abuse. In one case, while the exact mechanism of injury in unknown, the victim's father was charged with homicide after an autopsy examination revealed extensive skull and rib fractures. In the other instance the victim suffered an inflicted traumatic head injury, however a perpetrator has yet to be identified.

One male child aged 1 year was the victim of fatal child abuse. The child received head and abdominal injuries. A perpetrator has yet to be identified.

The female child aged 3 years died as a consequence of abusive injuries she suffered as an infant. A perpetrator has yet to be identified.

One male infant under 1 year of age was the victim of domestic homicide. His mother subsequently suicided.

Method of assault

Table 7.4 shows the method of assault or neglect.

Table 7.4: Method of assault or neglect by age category

Method of assault	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
	n	*n*	*n*	*n*	*n*	*n*
Blunt force injury	1	0	0	0	0	1
Gunshot	1	0	0	0	0	1
Unspecified	1	2	0	0	0	3
Total	**3**	**2**	**0**	**0**	**0**	**5**

Data source: Queensland Child Death Register (2010–11)

Victim-offender relationship

Two of the children who were fatally assaulted were killed by a parent, while the available evidence suggests that the other 3 child victims were all assaulted in familial situations.

Research has established that the greatest risk of fatal assault and neglect to young children is from family members, usually a parent, and that killings by people unknown to the child are relatively rare.

Location

Four incidents occurred on residential premises which were the victim's own home. For the female child who died from sequelae of assault, the location of the original incident is unknown.

The international research literature and the Commission's own findings both show that child deaths from assault and neglect are most likely to occur in the family home.

Murder-suicide in Queensland, 2004–11

Domestic homicide cases where the perpetrator subsequently suicides are commonly termed murder-suicides. While relatively rare, murder-suicides involving children and young people are signal events which highlight the importance of building community capacity to help recognise when families may be in trouble.

During 2010–11, the Commission recorded a greater than usual number of murder-suicide events. As a result, it has analysed all such incidents that have occurred since 2004.[3]

Between January 2004 and June 2011, a total of 10 children and young people from Queensland died in 8 domestic homicide incidents where the perpetrator either subsequently suicided, or there is recorded evidence of an attempt at suicide. In 2 of the incidents, the perpetrator killed 2 children before suiciding.

Table 7.5: Murder followed by suicide or attempted suicide, Queensland 2004–2011

Child	Year	Victim Age	Victim Gender	Perpetrator relationship	Method of assault
1	2004	Under 1 year	Female	Mother	stabbing / asphyxiation
2	2004	1–4 years	Female	Father	suffocation
3	2004	Under 1 year	Male	Father	suffocation
4	2004	Under 1 year	Male	Father	assault by gases
5	2004	1–4 years	Male	Step-father	assault by gases
6	2005	15–17 years	Female	Mother	assault by sharp object
7	2006	1–4 years	Female	Mother	carbon monoxide poisoning due to fire
8	2009	10–14 years	Female	Step-father	gunshot
9	2010	Under 1 year	Male	Mother	gunshot
10	2011	1–4 years	Male	Step-father	unknown

Data source: Queensland Child Death Register (2004-11)

Notes: 1. Data presented here is by date of death. The death of one child who died in 2011 was not registered in the 2010-11 reporting period; it will be reported on in 2011-12.

2. Another Queensland child who died as a result of a murder suicide in 2011 was killed in New South Wales after being abducted from this state by a parent. As the child's death did not occur in Queensland, it does not form part of this analysis.

3. In one case the perpetrator attempted suicide only.

[3] It is important to note that the analysis in this section is based on date of death, not date of death registration as reported throughout this publication.

The table shows that 6 children died at the hands of their fathers or step-fathers and 4 children died at the hands of their mothers.

Five of the victims were female children and 5 males. Four victims were under 1 year of age and a further 4 were aged between 1 and 4 years.

Of the 8 perpetrators, 5 were biological parents of the child victim/s (2 fathers; 4 mothers). Two male perpetrators were currently or recently involved in the child's life in the role of step-father. The remaining perpetrator was biological father to one victim and step-father to another.

While a review of the previous Australian literature on murder-suicide reveals that perpetrators are typically expected to be males,[4] the evidence gathered by the Commission shows that domestic homicide followed by suicide can involve either male or female perpetrators.

Nine of the 10 child victims were known to the Department of Communities, Child Safety Services within the three years prior to their deaths. This highlights the need for support services to be targeted at those families that are experiencing disruption and hardship due to chaotic social circumstances.

The Commission is committed to working with all of its stakeholders to prevent child deaths occurring in circumstances of domestic homicide and murder-suicide. In particular, the Commission will continue to actively share its evidence base so as to assist in the development of better prevention initiatives.

The Fatal Child Maltreatment project

In 2010–11, the Commission continued research into the problem of fatal child maltreatment. As a result of the Commission's research in this area and analysis of maltreatment-related deaths since 2004, it has developed a revised set of categories for fatal assault and neglect as discussed earlier in this chapter. This represents a significant development in the research literature, expanding on the definitions previously in use.[5]

The Commission intends to release more detailed information about the revised classification system in 2012, along with an analysis of data on maltreatment-related deaths in Queensland.

[4] See for example: Carcach, C & Grabosky, P 1998, *Murder-Suicide in Australia*, Australian Institute of Criminology Trends and Issues in Crime and Criminal Justice 82, Canberra; Lawrence, R 2004, Understanding fatal assault of children: a typology and explanatory theory, Children & Youth Services Review, 26, 837-852; Mouzos, K 2000, *Homicidal Encounters: A Study of Homicide in Australia, 1989-1999*, Australian Institute of Criminology Research and Public Policy Series 28, Canberra.

[5] These definitions were based primarily on Lawrence (2004).

Part V: Sudden unexpected deaths in infancy

Chapter 8

This section provides details of sudden unexpected infant deaths in Queensland.

Key findings

- In 2010–11, there were 55 cases of sudden unexpected death in infancy (SUDI), a rate of 82.2 deaths per 100,000 infants. Although this is the greatest number of SUDI deaths recorded in any reporting period to date, the rate of death has been relatively consistent over the past five years.
- Nearly 60% of SUDIs were awaiting an official cause of death at the time of reporting. Of the 23 SUDIs with an official cause of death, 17 were attributed to Sudden Infant Death Syndrome (SIDS) and undetermined causes (73.9%).
- Aboriginal and Torres Strait Islander infants continue to be over-represented in SUDI statistics. In 2010–11, Aboriginal and Torres Strait Islander infants died suddenly and unexpectedly at 3.3 times the rate of non-Indigenous infants. The rate of SUDI for Indigenous infants this year was however, an improvement on 2009-10.
- Children known to the child protection system are an at-risk cohort who experience a range of risk factors. Infants known to the child protection system died suddenly and unexpectedly at 1.8 times the rate of all Queensland children (9.3 per 100,000 children known to the child protection system in 2010–11 compared with an average of 5.1per 100,000). However, this was below the yearly average for the past five years (10.8 per 100,000 children known to the child protection system).
- The Commission has finalised collaborative arrangements with Queensland Health to facilitate the clinical review of select SUDI cases and will commence work on the first triennial SUDI report in 2011-12.

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Chapter 8

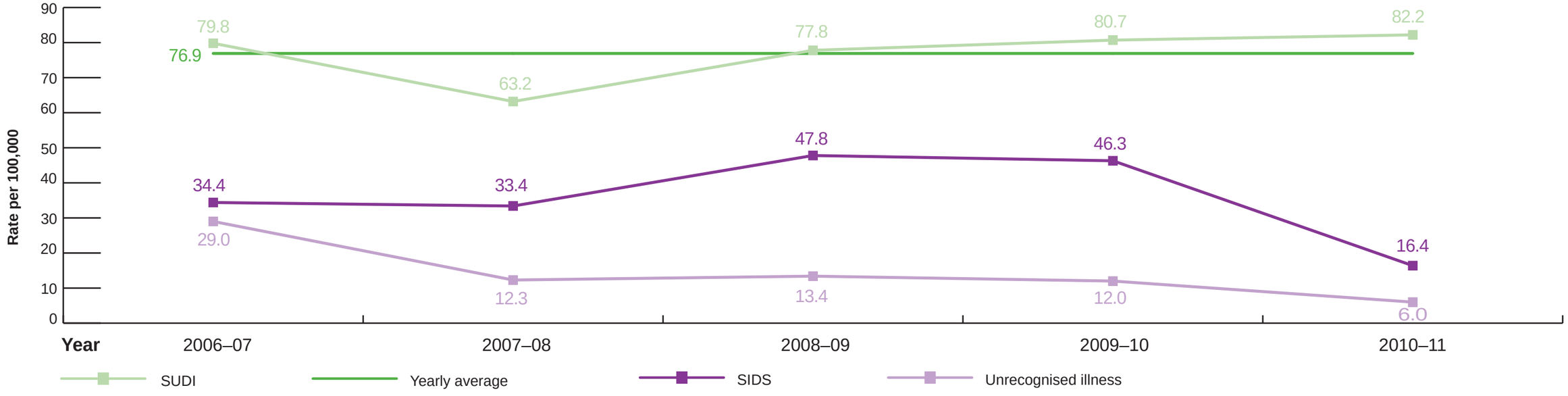
Sudden unexpected deaths in infancy

Table 8.1: Summary of sudden unexpected deaths in infancy in Queensland, 2006–2011

	2006-07		2007-08		2008–09		2009–10		2010–11		Yearly average
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Rate per 100,000
All Sudden Unexpected Deaths in Infancy (SUDI)											
Sudden unexpected deaths in infancy	44	79.8	36	63.2	48	77.8	54	80.7	55	82.2	76.9
Gender											
Female	14	52.3	18	65.6	21	70.1	15	46.3	21	64.8	59.4
Male	30	105.8	18	61.0	27	85.2	39	112.9	34	98.5	93.4
Aboriginal and Torres Strait Islander status											
Indigenous	11	286.1	8	199.9	6	146.0	18	425.5	10	236.4	257.9
Non-Indigenous	33	64.3	28	52.9	42	73.0	36	57.4	45	71.8	63.9
Known to the child protection system											
Known to the child protection system	12	13.9	8	8.8	13	12.8	8	6.2	14	9.3	10.8
All Queensland children	44	4.4	36	3.5	48	4.6	54	5.0	55	5.1	4.5
Unexplained SUDI											
Unexplained SUDI	26	47.1	26	45.6	37	60.0	45	67.2	49	73.2	59.4
Sudden infant death syndrome	*19*	*34.4*	*19*	*33.4*	*32*	*51.9*	*31*	*46.3*	*11*	*16.4*	*36.3*
Undetermined causes	*7*	*12.7*	*7*	*12.3*	*4*	*6.5*	*7*	*10.5*	*6*	*9.0*	*10.1*
Cause of death pending	*0*	*1.0*	*0*	*0.0*	*1*	*0.0*	*7*	*10.5*	*32*	*47.8*	*13.0*
Explained SUDI											
Explained SUDI	18	32.6	10	17.6	11	17.8	9	13.4	6	9.0	17.5
Unrecognised infant illness	*16*	*29.0*	*7*	*12.3*	*9*	*14.6*	*8*	*12.0*	*4*	*6.0*	*14.3*
Sleep accident	*2*	*	*3*	*	*2*	*	*1*	*	*1*	*	*
Other	*0*	*0.0*	*0*	*0.0*	*0*	*0.0*	*0*	*0.0*	*1*	*	*

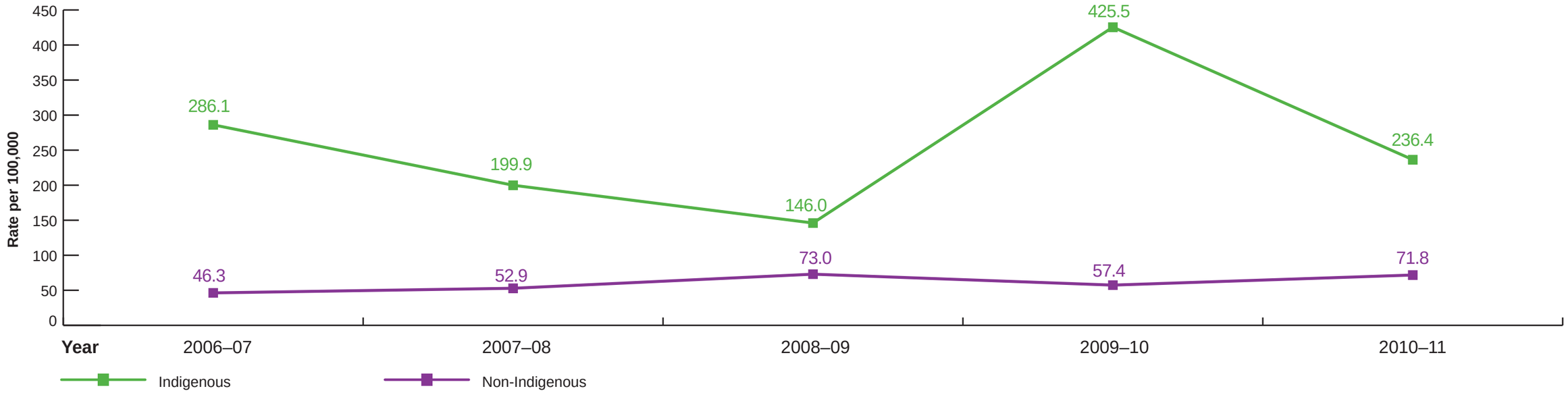
Data source: Queensland Child Death Register (2006–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Data presented here are current in the Queensland Child Death Register as at June 2011, and thus may differ from those presented in previously published reports.
2. Rates are calculated per 100,000 infants under the age of 1 year (in the age/gender/Indigenous status bracket stated) in Queensland in each year.
3. The number of children known to the child protection system represents the number of children whose deaths were registered in the reporting period who were known to the Department of Communities in the 3 years prior to their death.
4. Rates of SUDI for 'all Queensland children' are calculated per 100,000 children and young people aged 0–17 years in Queensland, instead of per 100,000 infants under the age of 1 year, in order to provide a comparable rate for children known to the child protection system.
5. Due to space constraints, 5-yearly average rates have been provided here (2006-11). An expanded copy of this table containing data since 2004 is available online at www.ccypcg.qld.gov.au.
6. Five-yearly rate averages have been calculated using the estimated resident population data at June 2008, the closest available data to the mid-point of the 5 year period.

Figure 8.1: Sudden unexpected deaths in infancy – major causes, 2006–2011



Data source: Queensland Child Death Register (2006–11)
Notes: 1. Rates are calculated per 100,000 infants under 1 year of age in Queensland.
2. The apparent decline in deaths due to SIDS and Unrecognised illness shown above is likely to be due to the large number of deaths awaiting an official cause of death.

Figure 8.2: Sudden unexpected deaths of Aboriginal and Torres Strait Islander infants, 2006–2011



Data source: Queensland Child Death Register (2006–11)
Note: 1. Rates are calculated per 100,000 Aboriginal and Torres Strait Islander and per 100,000 non-Indigenous infants under 1 year of age in Queensland.

The classification of sudden unexpected deaths in infancy

Sudden unexpected deaths in infancy (SUDI) is a research classification and does not correspond with any single medical definition or categorisation. Rather, the aim of this grouping is to report on the deaths of apparently normal infants who would be expected to thrive yet, for reasons often unknown, do not survive. Grouping deaths in this way assists in the identification of possible risk factors and associations for sudden infant death and, most significantly, those factors that may be preventable or amenable to change.

The Commission classifies a death as SUDI using the Police Report of Death to a Coroner (Form 1), which includes a narrative providing a summary of the circumstances surrounding the death as initially reported.[1]

The Commission has adopted the following working criteria for the inclusion of cases in the SUDI grouping – deaths of infants less than 1 year of age that:

- were sudden in nature
- were unexpected, with no previously known condition that was likely to cause death, and
- have no immediately obvious cause of death.

The SUDI grouping includes deaths associated with infections or anatomical or developmental abnormalities not recognised before death, sleep accidents due to unsafe sleep environments, and deaths that initially present as sudden and unexpected but are revealed by investigations to be the result of non-accidental injury. It also includes deaths due to Sudden Infant Death Syndrome (SIDS) and infant deaths where a cause could not be determined.[2]

Sudden unexpected deaths in infancy: findings, 2010–11

In the 2010–11 reporting period, there were 55 cases of SUDI, a rate of 82.2 deaths per 100,000 infants (0.9 per 1000 live births). The rate of SUDI deaths has remained relatively stable since 2006–07, as outlined in Figure 8.1.

Of the deaths identified as meeting the criteria for SUDI, 58.2% were awaiting an official cause of death at the time of reporting (32 deaths). Of the 23 cases with an official cause of death:

- 4 were fully explained after a post-mortem examination as a consequence of an illness or condition, the severity of which was not recognised before death
- 1 was determined to be the result of a sleep accident
- 1 was determined to be the result of non-accidental injury
- 11 were attributed to SIDS, and
- 6 were from undetermined causes.

Male infants died suddenly and unexpectedly at 1.5 times the rate of female infants. Research has consistently identified males to be more at risk of death from SIDS.

Twenty-three of the 55 cases of SUDI occurred while the infant was sharing a sleep surface with one or more people (41.8%), with shared sleeping considerably more common among Indigenous than non-Indigenous families (60.0% of Indigenous infants were sharing a sleep surface at the time of death compared to 37.8% of non-Indigenous infants). Research has found that shared sleeping is significantly more common among Indigenous families. Research has also found the general prevalence of shared sleeping to be increasing.

As in previous years a considerable number of deaths appear to have occurred in chaotic, poor households, characterised by significant social problems where multiple independent risk factors for SIDS and other SUDI converge. The link between chaotic circumstances and death will be further explored in the Commission's first triennial SUDI report.

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[1] In Queensland, section 8 of the *Coroners Act 2003* requires that all violent or unnatural/unusual deaths be reported to a coroner. All unexpected infant deaths fall within that description. All cases of SUDI require a comprehensive investigation, which should include a full autopsy, examination of the death scene and review of the clinical history.

[2] Cases of SUDI that were explained at post-mortem are counted and discussed in the chapter appropriate to their cause of death. Cases of SUDI found at autopsy to be caused by accidental suffocation in bed are counted in Chapter 5, *Other non-intentional injury-related deaths*. Deaths found at autopsy to be caused by previously unrecognised illnesses or congenital anomalies are counted in Chapter 2, *Deaths from diseases and morbid conditions.*

Death certification

Queensland Health has advised that paediatric autopsies are among the most complex undertaken. Within the specific context of SUDI, following the development of a new definition of SIDS in 2004 (termed the San Diego definition)[3] all cases of SUDI optimally require the performance of a complete autopsy (including toxicologic, microbiologic, radiologic, vitreous chemistry and metabolic screening studies). There is also an additional focus on establishing that there is no evidence of unexplained trauma, abuse, or unintentional injury before a classification of SIDS can be assigned. This frequently involves more extensive gross and microscopic examination during autopsy than in cases of explained infant and child deaths.

Queensland Health also reports an increase in the number and complexity of autopsies that are performed since the introduction of the *Coroners Act 2003*, which has led to more in-hospital deaths being designated reportable.[4] These autopsies are frequently more complex due to the presence of multiple co-morbidities.

The above factors contribute to a high proportion of SUDI cases (58.2% in 2010–11 pending death certification). The Commission hopes to see a general reduction in the timeframes for death certification in paediatric autopsies in coming years. In any event the Commission will address reporting on the issue through development of a triennial SUDI report scheduled for release in 2014–15.

SUDI epidemiological analysis and triennial SUDI report

As part of its child death mandate, the Commission analyses all SUDIs and has reported on these deaths in the 7 annual reports it has released to date. Between 2004–05 and 2008–09, the Commission analysed and reported in considerable detail on all sudden and unexpected infant deaths in its Annual Reports. However, the continued reporting of this level of detail on SUDI on an annual basis remains limited by the short statutory timeframe governing the release of the annual report and associated delays with infant autopsies being available within this reporting timeframe.

Notwithstanding these issues, the Commission's SUDI evidence base has been of significant benefit to stakeholders, including community organisations such as SIDS and Kids as well as government stakeholders such as Queensland Health. Recommendations contained in the *Annual Report: Deaths of children and young people, Queensland 2004-05* addressed the need for improvements in the delivery of safe sleeping messages to new and expectant parents.

With a comprehensive 7 year dataset established, the Commission acknowledges that this very complex group of deaths would benefit from more detailed epidemiological analysis, to be conducted retrospectively upon the receipt of all relevant information. In response, in 2010–11 the Commission finalised arrangements with Queensland Health for the provision of expert clinical advice in select cases of SUDI. Review of deaths under this agreement will commence in 2011–12. It is the Commission's intention to collate and analyse the clinical advice provided and release a dedicated and detailed review of SUDI triennially.

The Commission thanks Queensland Health for its co-operation in facilitating the review of this important subset of child deaths.

[3] See Krous, H.F., Beckwith, B., Byard, R., Rognum, T.O., Bajanowski, T., Corey, T., Cutz, E., Hanzlick, R., Keens, T.G. & Mitchell, E.A. 2004, Sudden infant death syndrome and unclassified sudden infant deaths: A definitional and diagnostic approach, *Pediatrics*, 114(1), 234-238.

[4] Under section 7(3)(a) of the *Coroners Act 2003* a reportable death includes a death that was not reasonably expected to be the outcome of a health procedure.

Part VI: Child death prevention activities

Chapter 9

Details the prevention activities undertaken by the Commission in 2010–11 and updates the progress of previous recommendations.

Key findings

- Providing child death data to 42 external stakeholders to inform their work in preventing child deaths and injuries.
- Contributing data to inform research into low-speed vehicle run-overs in Queensland, as published in the *Injury Prevention* journal.
- Submitting evidence to inform the Queensland Floods Commission of Inquiry
- Providing ongoing support and advice to the Department of Infrastructure and Planning in regards to the implementation of the Queensland Government's Swimming Pool Safety Improvement Strategy.
- Participating as a member of, and providing supporting evidence for, the Queensland Police Service Impacted Children Project addressing suicide contagion.
- Progression of research projects into suicide and the deaths of children from injury in rural areas of Queensland.

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Chapter 9

Child death prevention activities

Child death prevention activities: 2010–11

Under sections 143 and 145 of the *Commission for Children and Young People and Child Guardian Act 2000* (the Act), the Commission must maintain a register of all child deaths in Queensland; analyse the information contained in the register; and conduct research to identify trends and patterns to help reduce the likelihood of child deaths. Section 144 of the Act also allows for the use of information from the Child Death Register by persons conducting research to help reduce the likelihood of child deaths.

In 2010–11 the Commission has again welcomed the opportunity to share its data and analyses to inform the development of numerous child death and injury prevention initiatives. These are detailed below.

Data requests

Now in its seventh year of operation, the Queensland Child Death Register (the Register) is a highly authoritative, comprehensive and contemporary data source for monitoring and reporting on the incidence of child death in Queensland. It is also increasingly being accessed to support research into ways child deaths may be prevented.

The child death review process undertaken by the Commission is valuable over and above traditional statistical reporting. It probes beyond causes of death to examine social and situational risk factors as gathered from the analysis of autopsies, coronial, child protection and police files, as well as other relevant data sources.

As the custodians of this unique child mortality dataset, the Commission recognises the value of this strong evidence base in developing prevention initiatives. The Commission encourages access to the Register by stakeholders to inform their work in preventing child death and injury.

The Register may be accessed at no cost to organisations or individuals conducting genuine research.[1] Stakeholders wishing to access the Register to support their research, policy or program initiatives should complete an application form, available on the Commission's website: www.ccypcg.qld.gov.au or email data@ccypcg.qld.gov.au.

In 2010–11 the Commission received 42 requests for access to the Register from external stakeholders. This is an increase from 26 requests received in 2009–10. Requests included:

- data regarding drowning deaths for provision to the Department of Infrastructure and Planning; Royal Life Saving Society Australia; Workplace Health and Safety Queensland; and Kidsafe Queensland
- information and data regarding motorcycle and quad bike fatalities to support research and prevention initiatives conducted by the National Centre for Health Information Research and Training; Department of Communities, Sport and Recreation Services; and Royal Children's Hospital
- regional breakdowns of child mortality data to assist in research and program development by Queensland Health; SIDS and Kids Queensland; and the Australian Institute of Suicide Research and Prevention
- data on low-speed vehicle run-overs to support research conducted by the University of Queensland and Royal Children's Hospital, and
- product-related deaths for research conducted by the National Centre for Health Information Research and Training.

[1] 'Genuine research' is defined by the Commission as research relating to childhood mortality or morbidity with a view to increasing knowledge of incidence, causes and risk factors relating to same. Genuine research includes policy/program initiatives to reduce child death or injury.

Table 9.1: Purpose of data request by type of data requested, 2009–10

Type of data requested	Purpose of data request			
	Research	Public education/ reporting	Policy/ program development	Total
Drowning	0	6	7	13
Transport	5	0	2	7
Other non-intentional injury-related deaths	1	0	3	4
Suicide	1	2	1	4
All deaths	3	0	1	4
Diseases and morbid conditions	0	0	2	2
Interstate residents	0	2	0	2
Children known to the child safety system	0	2	0	2
Sudden unexpected deaths in infancy	1	1	0	2
Aboriginal and Torres Strait Islander status	0	0	1	1
Fatal assault and neglect	0	1	0	1
Total	**11**	**14**	**17**	**42**

Data source: Commission for Children and Young People and Child Guardian, Queensland (2010–11)

In order to measure the usefulness of the Commission's death data, the purposes for which it is used and the efficacy of our data request procedures, the Commission collects feedback from all recipients of child death data.

Throughout the year, the Commission received consistently positive feedback from stakeholders granted access to the Child Death Register. In particular, stakeholders indicated the data was both timely and useful in advancing child death prevention initiatives. A number of agencies also commented on the quality of the information and the service provided.

> ***"The data are well presented, easy to understand and a really rich source of information"***
>
> National Centre for Health Information Research and Training

> ***"The information requested was provided in a timely and professional manner. Many thanks to [the Commission] for taking the time to respond to my requests."***
>
> Department of Communities

An important initiative for the Commission in 2010–11 was the publication of findings from research conducted by the Burns and Trauma Research Group, Royal Children's Hospital. This research was based on data extracted from the Child Death Register regarding low-speed vehicle run-over incidents between 2004 and 2008. Findings of the study, published in the *Injury Prevention* journal, identified that four-wheel drive vehicles were involved in almost half of these fatalities; drivers of the vehicles were commonly parents, and were reversing the vehicle at the time of the incident. The article also reinforced the value of the Commission's Child Death Register as an evidence-base for research and prevention initiatives.

> ***"[The Commission's] child death review is able to provide fields of data that would be otherwise unavailable…A custodian who collates such sensitive data from a number of sources, and then makes these data readily accessible to researchers, is a pioneering effort in database management"***
>
> Griffin, B, Watt, K, Wallis, B et al. 2011, 'Paediatric low speed vehicle run-over fatalities in Queensland', *Injury Prevention*, 17, i10-i13.

In 2011–12 the Commission will continue to promote data from the Child Death Register to recognised stakeholders and genuine researchers as an evidence base to inform prevention initiatives.

Policy submissions

During 2010–11 the Commission completed 10 policy submissions based on evidence from the Child Death Register. These included:

- providing support for the Department of Communities, Sport and Recreation Services regarding off-road motorcycling management strategies
- providing feedback to the Australian Building Codes Board regarding proposed changes to the Building Code to reduce the risk of slips, trips and falls in buildings
- providing feedback on the Queensland Government Suicide Prevention Action Plan
- continuing the provision of data and feedback on the implementation of the Queensland Government Swimming Pool Safety Improvement Strategy, and
- providing feedback to the Department of Transport and Main Roads on improving recreational boating safety.

The Commission has engaged with a number of policy and program initiatives to advocate for the best interests of Queensland children. Areas of particular emphasis for the Commission are discussed below.

Queensland Floods Commission of Inquiry

Between December 2010 and January 2011, Queensland experienced flooding of unprecedented proportions: 78% of the state was declared a disaster zone, with 2.5 million people affected. Thirty-five people died in these events, including children and young people. On 17 January 2011, the Premier announced an independent inquiry into the chain of events leading to the floods, the state's response, and the aftermath of these horrific events.

In April 2011 the Commission submitted evidence before the Inquiry, which addressed the Commission's response to establishing the safety and wellbeing of children in out-of-home care in the wake of the floods, and provided detailed information about the deaths of children in floodwaters since 2004.

The Commission provided evidence from the Queensland Child Death Register, which established that a total of 19 children and young people have drowned in flood-related events in Queensland, including 6 in the flood disaster which occurred in January 2011. Analysis of this data identified that, while the majority of child deaths in the 2010–11 floods were entirely unforeseen, there is evidence that risk-taking behaviour on the part of parents/caregivers and of young people themselves have contributed to a number of deaths since 2004. This includes driving through or swimming/wading in floodwaters. The Commission recommended further examination of community flood education initiatives to increase public awareness of the risks of these activities, including further research into ways to effectively target these messages towards young people.

Further information about flood-related deaths can be found in Chapter 4: Drowning.

Swimming pool safety

Since the inception of the Queensland Government's *Swimming Pool Safety Improvement Strategy* in 2008, the Commission has been a key stakeholder in the review and amendment of Queensland's swimming pool safety laws. The Commission has previously provided a range of supporting data and risk factor information regarding child drowning, and has been an active participant in the development of associated safety initiatives including the mandatory reporting of immersion incidents and the need for educational and awareness-raising campaigns.

During 2010–11 the Commission continued to provide supporting data to the Department of Infrastructure and Planning to assist in the implementation of the legislative reforms.

Committees

The Commission participated as a member of numerous committees in this reporting period, including:

- chairing the Australian and New Zealand Child Death Review and Prevention Group[2]
- participating as a member of the Queensland Injury Prevention Council (QIPC)[3]
- establishing an Advisory Committee involving clinicians from Queensland Health to provide advice on selected cases of sudden unexpected deaths in infancy every 3 years[4]
- participating as a member of the Australasian Mortality Data Interest Group, and
- participating as a member of, and providing data an information to support, the Queensland Police Service 'Impacted Children' Steering Committee in relation to suicide postvention.

Australian and New Zealand Child Death Review and Prevention Group

Most states and territories within Australia, as well as New Zealand, have child death review mechanisms in various forms and stages of development. In recognition of the need to develop nationally comparable data and promote prevention messages across jurisdictions, agencies with child death review functions have convened the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG).

Established in 2005, the aim of this group is to identify and share information about trends and issues in infant, child and youth mortality, and work collaboratively towards national and international reporting. The Commission is the current chair of the ANZCDR&PG.

The group is committed to working collaboratively to maximise the potential for the breadth of knowledge held in each jurisdiction to contribute to national consistency in reporting, particularly in relation to risk factor information and the promotion of consistent prevention messages.

In 2009 the group was recognised by the Commonwealth in the *National Framework for Protecting Australia's Children 2009–2020*. The National Framework seeks to address issues impacting on has endorsed the ANZCDR&PG's work towards identifying national priorities from child mortality data.

Approximately 2000 child deaths are registered each year across Australia, of which around two-thirds are of children who will not reach their first birthday. Infants represent a particularly vulnerable subsection of the child population, being entirely dependent upon those around them to provide the necessities of life, protect them from danger and ensure access to relevant support services. Having systematically reviewed the circumstances of infant deaths over time, the ANZCDR&PG believes that a proportion of infant deaths could potentially be prevented with basic medical, social, psychological or other intervention. Many of the risk factors surrounding infant deaths are modifiable, and therefore amenable to prevention efforts. Through further targeted research utilising the detailed data held at the state and territory level, the ANZCDR&PG hopes to be able to assist the Commonwealth in establishing a national approach to the prevention of infant deaths.

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[2] See also Chapter 10, *National child death statistics*.

[3] The QIPC was established in 2008. The goal of the QIPC is to substantially reduce injury rates and the severity of injuries in Queensland and to demonstrate national leadership in injury prevention activities. The QIPC reports to the Director-General of Queensland Health and provides high-level strategic advice in relation to injury prevention priorities, strategies and activities.

[4] See also Chapter 8, *Sudden unexpected deaths in infancy*.

SUDI epidemiological analysis

The Commission's evidence base regarding sudden unexpected deaths in infancy (SUDI) has been of significant benefit to stakeholders since the Commission commenced its child death review functions in 2004. These include community organisations such as SIDS and Kids as well as government stakeholders such as Queensland Health who have used findings from the Child Death Register to assist in developing staff training modules to ensure the delivery of consistent safe sleeping messages to new and expectant parents.

Between 2004–05 and 2008–09, the Commission analysed and reported on all sudden and unexpected infant deaths in its Annual Reports. However, the continued reporting of SUDI on an annual basis remains limited by external factors. Due to the short statutory timeframe governing the release of the annual report, and the availability of infant autopsies within this timeframe, reporting on SUDI is limited to an analysis of demographic and environmental risk factors.

The Commission acknowledges that this very complex group of deaths would benefit from a more detailed epidemiological analysis, to be conducted retrospectively upon the receipt of all relevant information. In response, in 2010–11 the Commission finalised arrangements with Queensland Health for the provision of expert clinical advice for complex cases, including SUDI. Review of deaths under this agreement will commence in 2011–12. It is the Commission's intention to collate and analyse the clinical advice provided and release a dedicated review of SUDI every 3 years to highlight trends and patterns identified.

Impacted Children Project

Through the routine analysis of youth suicide data, the Commission has identified a number of regions across Queensland experiencing high levels of contagion and cluster suicides among their youth populations. Contagion suicide is defined as the process by which a prior suicide facilitates or influences the occurrence of subsequent suicides. Some young people, especially those who may already be experiencing difficulties, may identify with the victim, raising suicide as an option.

The Commission has identified a high number of such instances in the regional centres of Toowoomba and Mackay. In response to the Commission's findings, in 2009–10 the Queensland Police Service initiated the *Impacted Children Project*, to facilitate timely delivery of postvention support services to young people impacted by suicide. A key strategy of the project is co-ordinated cross-agency communication.

The project was piloted in these Toowoomba and Mackay, where localised hubs were formed by relevant officers of the partner organisations, who convened to identify what postvention supports, if any, were required in their community in the wake of a child or youth suicide. The Commission was involved as an active partner to this initiative, alongside organisations including:

- Association of Independent Schools Queensland
- Brisbane Catholic Education
- Department of Communities
- Department of Education and Training
- Queensland Catholic Education Commission, and
- Queensland Health.

The success of the pilot project has been confirmed through positive evaluation by the Australian Institute for Suicide Research and Prevention.

The Queensland Police Service is currently developing an outcomes paper arising out of the pilot process. In the future, it is hoped that similar local hub networks will be established across the state. An information pack will be developed for distribution to police officers providing advice on what steps to take in the event of the suicide of a child or young person in their region or local community.

The Commission commends this project and the positive outcomes that have been achieved to date. Over the coming year, the Commission will be consulting with other relevant stakeholders in support

of a multi-agency approach to assist the Queensland Police Service in putting into place suitable postvention response strategies throughout Queensland.

Research projects

The Commission continued to progress several research projects in the 2010–11 reporting period.

Keeping Country Kids Safe

The Commission has found that children in country areas are 2.4 times more likely to die as a result of non-intentional injury than those in the city and face a number of risks unique to their environment, such as drowning in dams or quad bike accidents. A key factor associated with these deaths is the unique combination of the home and workplace that occurs on family farms.

The *Keeping Country Kids Safe* initiative aimed to bring together the knowledge, skills and experience of people at all levels – from government agencies through to the agricultural industry and local communities themselves. In 2009, the Commission undertook extensive consultation with the rural sector. The *Keeping Country Kids Safe Discussion Paper*, sharing findings from the Commission's analysis of child death data from 2004–2008, sought input from government and non-government agencies as well as rural industry. The *Keeping Country Kids Safe Community Survey* was also widely distributed to residents throughout rural Queensland, and encouraged farmers to share their views and propose practical solutions to improve safety for children and young people in rural areas.

The Commission has collated and analysed the results of this consultation and will deliver a final project report in 2011–12. This report will detail the views of rural communities, outline key issues identified by government and industry stakeholders and identify some potential future actions in research and prevention efforts directed at reducing death and injury to children in rural areas. The Commission will continue to support research in this area through the provision of detailed datasets to genuine researchers.

Reducing Youth Suicide in Queensland

The Commission's Child Death Annual Reports have consistently identified child and adolescent suicide as a key concern in Queensland. On average, 19 young people suicide each year in Queensland. The repetition of the high numbers and young ages of children suiciding in Queensland reinforced the need for this issue to be further investigated. In response, the Commission commenced working on an in-depth project reviewing the suicides of Queensland children and young people.

The *Reducing Youth Suicide in Queensland* (RYSQ) project involved a detailed review of the lives and deaths of 65 children and young people who died by suicide in Queensland between 1 January 2004 and 31 December 2007. The project aimed to provide a solid and contemporary evidence base to better inform prevention efforts targeted at children and young people, with the aim of reducing youth suicide in Queensland.

The RYSQ Discussion Paper, released in 2009, detailed the preliminary findings of the Commission's analysis of all available case file information for the children and young people who suicided. The Commission consulted with a wide range of key stakeholders from government and non-government agencies, researchers, academics and experts to seek feedback in relation to key discussion points about improving services and preventing youth suicides.

The Commission has collated and analysed the extensive responses of individuals and organisations to the RYSQ Discussion Paper. A total of 235 respondents completed the RYSQ survey, while an additional 48 submissions were received from individuals or key stakeholders. The vast majority of respondents (97%) supported the establishment of a collaborative program that involved sharing information and services between a number of agencies to help better identify, monitor and support children and young people at risk of suicide.

During 2011–12, the Commission will release a final project report detailing the current data, results of consultation, and outlining the potential future actions to support prevention efforts. The Commission will continue to collaborate with researchers to facilitate further exploration of this issue within Queensland.

Recommendations

In accordance with the functions specified under s.145 of the Act, the Commission can make recommendations arising from its analysis of the Child Death Register about the improvement of laws, policies and practices aimed at reducing or preventing child deaths. This year it has not been necessary for the Commission to make any formal recommendations in the annual report. While issues requiring action have arisen throughout the year, the Commission has responded to these as each issue has been identified, including through the Commission's active participation in responding to policy issues and the provision of data to stakeholders seeking to improve research, policy and practice focused on the safety and wellbeing of children and young people.

Monitoring of previous recommendations: 2004–2011

The Commission would like to acknowledge and thank the organisations that have committed their skills and resources to the ongoing implementation of recommendations arising from previous reports.

Table 9.2 below lists recommendations made as a result of findings of the Child Death Annual Reports from 2004–05 to present, and details of their implementation by relevant agencies.

Table 9.2: Implementation of previous Commission recommendations, 2004–2007

Agency	Recommendation	Status
2006–07		
Queensland Health; former Department of Emergency Services, now Department of Community Safety; former Department of Local Government, Planning, Sport and Recreation, now Department of Infrastructure and Planning	Work with the Commission to identify the most appropriate means to promote the importance of supervision for drowning prevention, and provide advice to the government on long-term strategies, including the resource implications, to raise community awareness about the importance of supervision in preventing drowning fatalities to children. ***Reason:*** *Drowning is the leading cause of death for children under 5 years of age, and the Commission has identified a lack of adequate parental and/or adult supervision as a key contributing factor. There is a need to increase the promotion of supervision as a key public health and safety message for the prevention of these incidents. A coordinated cross-agency approach drawing upon the collective expertise of these agencies, assisted by the Commission's contemporary research data, will better inform efforts to promote public health and safety messages aimed at preventing childhood drowning.*	**Implemented** The Queensland Injury Prevention Council (QIPC) was the appropriate mechanism for actioning the Commission's recommendation. The QIPC is currently undertaking a number of injury prevention research projects including in relation to the prevention of childhood drowning.
2005–06		

Agency	Recommendation	Status
Registry of Births, Deaths and Marriages (BDM)	Identify options to provide updated cause of death data to the Commission resulting from the receipt of Autopsy Certificates. ***Reason:*** *Updated cause of death information (from Autopsy Certificates) received by the Registry after the initial provision of information to the Commission should also be supplied in the interests of maintaining accurate public health records.*	**Implemented** The Registry of Births, Deaths and Marriages now provides the Commission with updated cause of death information.
	Maximise the timely capture of deaths reported by the State Coroner in death registration data, and develop an organisational policy/procedure to this effect. ***Reason:*** *The Commission has identified a number of reportable deaths identified by the State Coroner that remained unregistered with the Registry of Births, Deaths and Marriages. The Registrar should investigate using relevant sections of the Births, Deaths and Marriages Act 2003 to register these deaths.*	**Implemented** The policy of the Registrar-General now states that a death can be registered without a death registration application if the coroner has made a finding as to the identity of the person and the location and date of death.
Australian Bureau of Statistics (ABS)	Work with training bodies, mortality coders, Australian child death review teams and coronial system representatives to develop a method of coding intentional self-harm that more accurately reflects the cause of death in the absence of a clear statement of intent from a coroner. ***Reason:*** *Suicides have traditionally been under-reported, partly as a result of the reluctance of coroners to provide clear statements as to whether the injuries leading to death were intentionally self-inflicted. A national approach to the coding of intentional self-harm in such instances is imperative to ensure child suicides are accurately reported.*	**Implemented** In 2006, the ABS convened a Suicide Coding Working Group to assist in improving the quality of national suicide data. Significant changes have now been made by the ABS to improve suicide reporting nationally, including: • no longer automatically coding suicides to accidental when coroners fail to stipulate intent • considering police identification that a death is a suspected suicide and giving greater weight to the presence of risk factors, and • developing guidelines to ensure consistent reporting, and revising causes of death in future publications where a death is reported without coronial findings. These changes will vastly improve the accuracy of suicide reporting nationally.
	Publicly report on suicides of children and young people under 15 years of age. ***Reason:*** *The ABS does not report on suicides for children under 15 years of age. The Commission has identified this as a contributing factor to the under-appreciation of childhood suicide.*	**Implemented** The ABS publication *Suicides Australia*, published in March 2007, contained aggregate information on the suicides of children under 15 years during the period 1995–2005. An additional information paper regarding the quality of external cause of death data was published in April 2007 to explain concerns regarding small numbers when reporting suicides of children. The ABS does not report on deaths of children aged under 15 years as a separate age category, but includes an explanatory note in its publications outlining the low number of child suicides which occur in Australia.

Agency	Recommendation	Status
Former Department of Child Safety, now Department of Communities	Review the Child Safety Practice Manual to determine whether child death reviews may be applied to the deaths of siblings of children known to the department within the previous 3 years. ***Reason:*** *The Commission has identified a number of deaths in which, while the deceased child was not known to the DChS, siblings of the child had been the subject of departmental involvement. In cases where the child was not known* ***only*** *due to an administrative error on behalf of the DChS, there appears to be scope to examine these cases under existing legislative requirements. Where DChS involvement took place before the deceased child's birth or conception, the DChS may wish to consider expanding the scope of the reviews to include such children. Extending current review practice may assist in identifying risk factors and intervention points to inform future practice and policy development.*	**Implemented** The need for reviews in these circumstances will be considered on a case-by-case basis.
2004–05		
Parliamentary Travelsafe Committee	Investigate and report on ways to reduce fatalities and injuries to children from low-speed driveway run-overs in Queensland. ***Reason:*** *Queensland has a significantly higher rate of low-speed run-overs than the rest of Australia. A lead agency needs to take responsibility for initiatives to prevent these fatalities on private properties. A detailed investigation and analysis of the most appropriate strategies for preventing fatalities in Queensland is also required.*	**Implemented** The Parliamentary Travelsafe Committee report of this investigation was tabled in Parliament in September 2007. This report made a number of recommendations to reduce low-speed run-overs in Queensland, all of which have been supported by the target agencies. In accordance with the report recommendations, the Queensland Injury Prevention Council (QIPC) is currently funding further research in relation to the incidence and prevention of low-speed run-overs as one of its key priority areas. During 2010–11 a study of low-speed run-overs funded by the QIPC, and utilising Child Death Register data, was published in the *Injury Prevention* journal.
Queensland Government	Explore and report on options and strategies to assist the rural sector to identify and address risks to children and young people posed by rural hazards. ***Reason:*** *The Commission is concerned about the deaths and injuries to children and young people from quad bikes[5], dams and other rural hazards, and believes that risk factors can be reduced or eliminated.*	**Underway** In 2008–09 the Commission launched the *Keeping Country Kids Safe* initiative, an initiative aimed at developing, in consultation with the rural sector, prevention efforts to reduce death and injury to children in country areas of Queensland. The final project report is due for release in early 2011–12.

[5] In line with the recommendations of a Victorian coronial inquest into deaths as a result of four-wheel motorcycle incidents, the Commission has adopted the term 'quad bike' to describe these vehicles, rather than 'all-terrain vehicles' as used previously. This inquest identified that the description of these vehicles as all-terrain was a 'serious overstatement of their capabilities' which can create an 'impression of invincibility' for riders.

Agency	Recommendation	Status
Queensland Health	Develop and implement a statewide policy, to be followed by all relevant staff including midwives and health workers, in relation to information provided to new and expectant parents about safe sleeping practices (such as the UNICEF UK Baby Friendly Initiative). ***Reason:*** *Health professionals are in a position to educate, promote and influence safe sleeping practices to parents.* Following the development of the above policy, it is recommended that Queensland Health: • develop a training package in relation to the policy, and • develop culturally appropriate communication strategies that convey consistent and appropriate messages about safe sleeping to all new and expectant parents, particularly those at high risk. ***Reason:*** *To ensure consistent messages are being communicated to Queensland Health staff, particularly parents of high-risk infants.*	**Implemented** Queensland Health has developed a comprehensive educational resource package to be delivered to health professionals. In 2010 Queensland Health launched an online training module for nurse educators to further encourage the uptake of this training.

Part VII: National child death statistics: An interstate comparison, 2009 calendar year

Chapter 10

This chapter has been compiled based on child death statistics provided by the following member teams of the Australian and New Zealand Child Death Review and Prevention Group:

- Queensland Commission for Children and Young People and Child Guardian
- New South Wales Child Death Review Team, NSW Ombudsman
- South Australian Child Death and Serious Injury Review Committee
- Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity, and
- Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

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Chapter 10

National child death statistics: An interstate comparison, 2009 calendar year

National child death statistics

In recognition of the need to develop nationally comparable data and multi-jurisdiction prevention messages, agencies with child death review functions have convened the Australian and New Zealand Child Death Review and Prevention Group.

The stated aim of the Australian and New Zealand Child Death Review and Prevention Group is to identify, address and potentially decrease the numbers of infant, child and youth deaths by sharing information on issues in the review and reporting of child deaths and to work collaboratively towards national and international reporting.

At present, child death review functions within agencies throughout Australia and New Zealand are at varying stages of implementation and have individual legislative bases, functions, roles and reporting requirements. The data prepared by these agencies currently differs in some respects, but meaningful comparison is still achievable.

The Australian and New Zealand Child Death Review and Prevention Group is currently progressing a body of work to establish national benchmarks for risk factors associated with child deaths.

Previously, the Commission has used national mortality statistics compiled by the Australian Bureau of Statistics (ABS) and summarised by the Australian Institute of Health and Welfare (AIHW) to provide an overview of rates of child deaths from various causes across Australian jurisdictions. While this data, as published in previous reports, has been useful in establishing basic variances in child death rates between Australian states and territories, the detailed information held by agencies with child death review functions presents a significant opportunity, and will ultimately lead to an ability to compare and contrast risk factors and prevention efforts for different causes of death.

A number of the agencies within Australia are at a stage where it is possible to provide a comparable level of child death data. The following overview represents the second attempt to draw together the data held by member jurisdictions of the Australian and New Zealand Child Death Review and Prevention Group and draw meaningful comparisons. Currently, the jurisdictions with the capacity to share detailed child death data are Queensland, New South Wales, Victoria, South Australia and Tasmania. As other jurisdictions further develop their data collection and reporting capacity, it is hoped that this dataset will evolve to include child death data from all Australian states and territories, as well as New Zealand.

Members of the Australian and New Zealand Child Death Review and Prevention Group are working collaboratively to collect and report consistently on common risk factors for certain categories of child death. As this dataset is under development, the comparative overview provided in the Commission's Child Death Annual Reports will include progressively more discussion of the prevalence of risk factors for death in each jurisdiction. The methodology used in compiling the data in this chapter is outlined in Appendix 10.1.

Due to differences in data collection and reporting processes across the member states, the analysis in this chapter is based upon the 2009 calendar year. This is the most up-to-date national data available for comparison purposes.

All causes of child deaths: 2009

Table 10.1: Number and rate of child deaths by age and jurisdiction

Age category	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
Under 1 year	333	511.9	352	376.3	71	356.7	23	339.6	270	378.7
1–4 years	56	23.5	66	18.3	17	22.3	6	22.7	53	19.3
5–9 years	37	12.9	36	8.2	4	4.2	5	16.2	30	9.2
10–14 years	39	13.1	111	15.1	13	12.9	3	*	36	10.7
15–17 years	54	29.2			24	37.9	14	67.2	53	25.1
Total	**519**	**48.4**	**565**	**34.7**	**129**	**36.4**	**51**	**43.0**	**442**	**36.3**

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people in each age category in each jurisdiction.
2. Total rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.
3. The causes of 7 deaths in Queensland are yet to be finalised and these deaths are not counted in tables 10.3, 10.4 or 10.5. Comparable rates for the 10-14 and 15-17 year age categories for New South Wales are not able to be calculated due to the age breakdowns reported by the New South Wales Child Death Review Team, which consider children aged 10-13 years; 14-15 years; and 16-17 years. The number of deaths of children in these age breakdowns have been grouped together for the purposes of Table 10.1 to show a total figure for children aged 10.17 years in New South Wales.

Children in the under 1 year age category had the highest number of child deaths in all jurisdictions. In general, the rate of death in childhood usually decreases with age until the teen years, when it increases again. In all jurisdictions, numbers and rates of death are second highest in the 15–17 year age category.

Table 10.2 below shows the number and rate of child deaths in each state and territory by gender.

Table 10.2: Number and rate of child deaths by gender and jurisdiction

Gender	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
Female	215	41.2	240	30.3	57	32.9	15	26.0	180	30.3
Male	304	55.2	325	39.0	72	39.8	36	59.1	261	41.7

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
Note: 1. Rates are calculated per 100,000 females and per 100,000 males aged 0–17 years in each jurisdiction.
2. One child death in Victoria was of indeterminate gender.

Males experienced higher rates of death in all jurisdictions at between 1.2 and 2.3 times the rate of females.

Diseases and morbid conditions

Deaths from diseases and morbid conditions are those deaths whose underlying cause is an infection, disease, congenital anomaly or other naturally-occurring condition.

As outlined in Table 10.3 below, deaths from diseases and morbid conditions were highest for infants under 1 year of age in all jurisdictions.

Table 10.3: Number and rate of child deaths from diseases and morbid conditions by age and jurisdiction

Age category	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
Under 1 year	283	435.0	298	318.6	62	311.5	20	295.3	233	326.8
1–4 years	27	11.3	36	10.0	7	9.2	3	*	26	9.5
5–9 years	22	7.7	23	5.2	2	*	4	13.0	17	5.2
10–14 years	25	8.4	55	7.5	10	9.9	2	*	14	4.2
15–17 years	19	10.3			8	12.6	5	24.0	17	8.0
Total	**376**	**35.1**	**412**	**25.3**	**89**	**25.1**	**34**	**28.7**	**307**	**25.2**

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Rates are calculated per 100,000 children and young people in each age category in each jurisdiction.
2. Total rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction. Comparable rates for the 10-14 and 15-17 year age categories for New South Wales are not able to be calculated due to the age breakdowns reported by the New South Wales Child Death Review Team, which consider children aged 10-13 years; 14-15 years; and 16-17 years. The number of deaths of children in these age breakdowns have been grouped together for the purposes of Table 10.1 to show a total figure for children aged 10-17 years in New South Wales.
3. The causes of 7 deaths in Queensland are yet to be finalised and these deaths are not counted in Tables 10.3, 10.4 or 10.5.

External causes

External cause deaths are those resulting from environmental events and circumstances causing injury, poisoning and other adverse effects. Table 10.4 illustrates the number and rate of child deaths from external causes across the five jurisdictions.

Deaths from external causes occurred at a higher rate in Tasmania than in any other state included (11.8 per 100,000). Queensland had the next highest rate of death from external causes, at 9.0 per 100,000.

While Queensland recorded a greater number of transport fatalities (37 deaths) than most other states included, the rate of fatal transport incidents was similar to that of South Australia, which recorded 12 deaths.[1]

Amongst those jurisdictions included in the analysis, Queensland recorded the highest rate of drowning deaths, followed by New South Wales. Youth suicide was most prevalent in Queensland and Victoria, while the rate of fatal assault was highest in South Australia.

[1] Caution must be exercised when making comparisons and interpreting rates because of the small number of deaths analysed.

Table 10.4: Number and rate of child deaths from external causes by jurisdiction

Cause of death	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
Transport	37	3.5	44	2.7	12	3.4	9	7.6	25	2.1
Drowning	22	2.1	11	0.7	3	*	2	*	<10[a]	*
Other non-intentional Injury-related death	16	1.5	13	0.8	2	*	2	*	41	3.4
Suicide	15	1.4	17	1.0	4	1.1	1	*	16	1.3
Fatal assault	6	0.6	7	0.4	7	2.0	0	*	<5[a]	*
Total	**96**	**9.0**	**92**	**5.7**	**28**	**7.9**	**14**	**11.8**	**93**	**7.6**

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
** Rates have not been calculated for numbers less than 4 or less than 10 for Victoria data.*
– Number of deaths not provided.
[a] Figure not specified where number of deaths is less than 10.
Notes: 1. Classification of external cause deaths may differ from state to state. The methodology section in Appendix 10.1 provides further details.
2. Rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.
3. The causes of 7 deaths in Queensland are yet to be finalised and these deaths are not counted in tables 10.3, 10.4 or 10.5.

Deaths from ill-defined and unknown causes of mortality

The deaths of children as a result of unknown or ill-defined causes of mortality, including Sudden Infant Death Syndrome (SIDS) are outlined in Table 10.5 below.

Unexplained deaths of infants

Of specific interest in the study of infant deaths are those certified as due to SIDS or where the cause of death cannot be determined. SIDS is defined as the sudden, unexpected death of an infant under 1 year of age, the cause of which remains unexplained after a thorough investigation (including review of the death scene, clinical history and complete autopsy). While SIDS is, essentially, an undetermined cause of death itself, infant deaths should be specifically certified as 'undetermined' when:

- natural disease processes were detected (insufficient to cause death but precluding a SIDS diagnosis)
- there are signs of significant stress
- non-accidental but non-lethal injuries were present, or
- toxicology screening detects non-prescribed but non-lethal drugs.

Of those jurisdictions included, Queensland recorded the highest rate of unexplained infant deaths (56.9 per 100,000 infants) followed by Victoria (44.9 per 100,000).

Undetermined deaths of children over the age of 1 year

Each year, the deaths of a number of children over the age of 1 are registered for whom a cause of death is unable to be determined. These deaths may occur in any age category, but are most often of children in the 1–4 year age category. The circumstances of these deaths often resemble those of infants, but are precluded from a diagnosis of SIDS as they are over the age of 1.

While historically, undetermined deaths of children over the age of 1 year occur fairly infrequently, 2009 saw an unusually large number of undetermined deaths of children aged 1–17 years, particularly in Victoria. Victoria however uses this category for deaths where the cause of death is yet to be determined at the date of submission of data for this analysis, and therefore the number is likely to be revised downwards when the Annual Report for the Year 2009 is published. (This will be available from www.health.vic.gov.au/ccopmm/index.htm)

Table 10.5: Child deaths from SIDS and undetermined causes by age and jurisdiction

Age category	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
Under 1 year	37	56.9	17	18.2	7	35.2	3	*	32	44.9
1–4 years	2	*	0	0.0	–	–	0	0.0	<10[a]	*
5–9 years	0	0.0	0	0.0	–	–	0	0.0	<10[a]	*
10–14 years	1	*	0	0.0	–	–	0	0.0	<10[a]	*
15–17 years	0	0.0	0	0.0	–	–	0	0.0	<10[a]	*
1–17 years total	**3**	*****	**0**	**0.0**	**5**	**1.5**	**0**	**0**	**10**	**0.9**
Total	**40**	**3.7**	**17[b]**	**1.0**	**12**	**3.4**	**3**	*****	**42**	**3.4**

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
** Rates have not been calculated for numbers less than 4, or less than 10 for Victoria data.*
– Number of deaths not provided.
[a] Figure not specified where number of deaths is less than 10.
[b] This figure represents identified SIDS cases only. New South Wales defines infant deaths (including undetermined deaths) under a broader definition of SUDI and therefore data is not directly comparable. For this reason, summing death categories for New South Wales will not equal the total number of deaths.

Notes: 1. Classification of external cause deaths may differ from state to state. The methodology section in Appendix 10.1 provides further details.
2. Rates are calculated per 100,000 children and young people aged 0–17 years in each jurisdiction.
3. The causes of 7 deaths in Queensland are yet to be finalised and these deaths are not counted in tables 10.3, 10.4 or 10.5.

Deaths of Aboriginal and Torres Strait Islander children and young people

Table 10:6: Number and rate of Indigenous child deaths by jurisdiction

Year	QLD		NSW		SA		TAS		VIC	
	n	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000	*n*	Rate per 100,000
2007	52	77.8	N/A	–	12	98.1	N/A	–	<10	54.4
2008	67	98.8	N/A	–	11	89.2	0	0.0	12	80.8
2009	64	93.1	32	45.9	11	88.4	0	0.0	<10	*

Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
** Rates have not been calculated for numbers less than 10 for Victoria data.*
Note: 1. Rates are calculated per 100,000 Indigenous children and young people aged 0–17 years in each jurisdiction
2. Historical rates differ to those published in the 2010-11 Annual Report due to updated Indigenous population data released by ABS.

It should be noted that some states experience difficulty with the collection of data regarding Aboriginal and Torres Strait Islander status. Challenges are also faced in obtaining accurate population data for Indigenous children and young people to enable the calculation of rates. Therefore, the rates presented in Table 10.6 should be interpreted with caution.

Rates of Aboriginal and Torres Strait Islander child deaths from 2007 and 2008 have also been included in Table 10.6. The Commission hopes to monitor long-term trends in Indigenous child mortality across Australia, in line with the Commonwealth *Closing the Gap* initiative, which aims to reduce disparity in mortality rates between Indigenous and non-Indigenous children. This initiative commenced in 2009, and it is hoped that improvements in the rate of Indigenous child mortality will be observed in future reports. Based on the available data from jurisdictions included, in 2009 Queensland had the highest rate of death for Aboriginal and Torres Strait Islander children and young people, followed by South Australia.

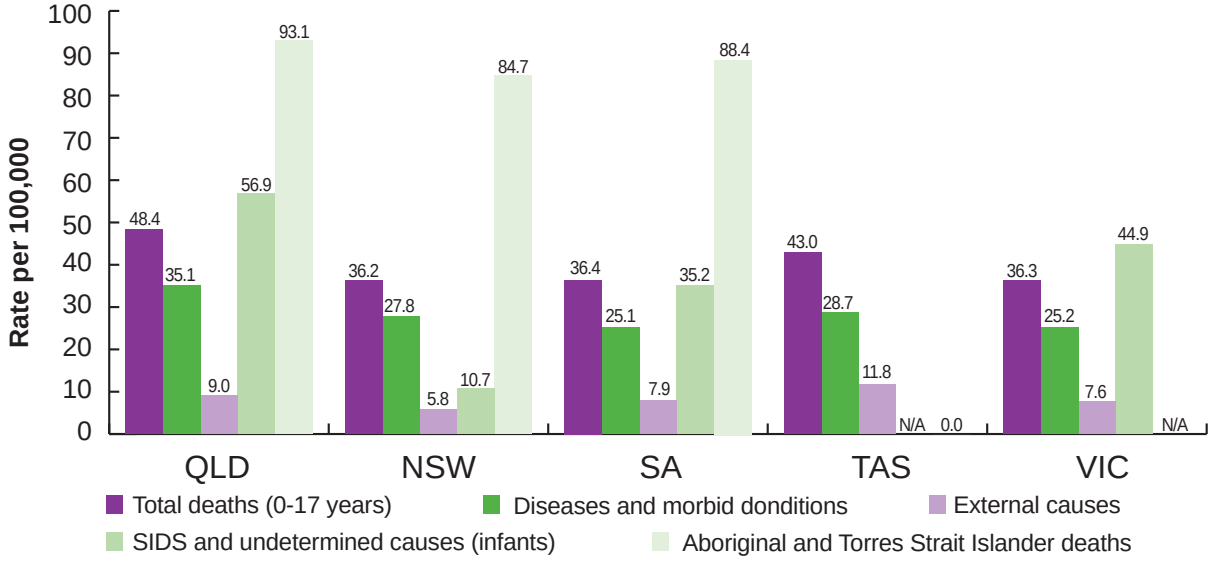
National child death statistics: findings and conclusions

The information presented above is a snapshot of child mortality for contributing Australian states in 2009. Analysis of statistics for 2009 has shown:

- Queensland had the highest rate of child death overall
- Queensland also had the highest rate of death from drowning, youth suicide and unexplained infant death.
- Tasmania had the highest rate of death from transport, and
- Victoria had the highest rate of death from other non-intentional injury, in part reflecting the tragic loss of life from the Victorian bushfires of February 7 2009.

Selected findings are highlighted in Figure 10.1 below.

Figure 10.1: Interstate comparisons – selected findings



Data source: Australian and New Zealand Child Death Review and Prevention Group (2009)
Note: 1. Victorian data in this figure are provisional and subject to change. Full data will be available from the Annual Report for the Year 2009. This will be available from www.health.vic.gov.au/ccopmm/index.htm

The comparison of child death data across jurisdictions as undertaken for the first time in the Child Death Annual Report 2008–09 represented a significant first step in the journey towards developing nationally comparable data. The Commission was pleased to be able to continue this initiative in 2010–11. It is hoped that future years will see the inclusion of data from other states and territories as the development of their child death review mechanisms progress.

Findings from this year have highlighted that, at a national level, further efforts need to be invested in addressing risk factors for sudden unexpected deaths in infancy, external cause deaths and factors and circumstances affecting life expectancy for Aboriginal and Torres Strait Islander children and young people.

While the findings of these early analyses have provided some direction for prevention activities, more meaningful conclusions and specific targeting of prevention initiatives will become more apparent through future analysis of data over multiple years. Long-term data analysis is imperative for the accurate identification of trends and patterns in child mortality. In addition, as the reporting capabilities of review mechanisms throughout Australia continue to develop, the analysis of social, situational and risk factor information is likely to become available to further inform prevention efforts.

The Commission greatly appreciates the efforts of the New South Wales Child Death Review Team, the South Australian Child Death and Serious Injury Review Committee, the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity and the Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity in contributing to this report, and looks forward to continued collaboration in an effort to reduce child mortality from preventable causes.

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Appendix 1.1: Methodology

This chapter provides an overview of the methodology employed by the Commission in producing this report. It also explains the process of maintaining the Child Death Register and the methods used for the analysis of trends and patterns in the data.

Child Death Register

Under the *Commission for Children and Young People and Child Guardian Act 2000* (the Act), the Commission has a statutory obligation to maintain a register of all deaths of children and young people under the age of 18 that are registered in Queensland. The information in the register is required to be classified according to cause of death, demographic information and other relevant factors. The Commission is required to maintain the register of all child deaths from 1 January 2001. In this capacity, the Commission has responsibility for the centralised collection and coding of mortality information for both coronial and non-coronial child deaths.

The Commission analyses information in the Child Death Register to identify and report on patterns of child mortality and make recommendations about policies, practices and procedures aimed at reducing or preventing child deaths.

As the Queensland Child Death Register relies on administrative data sources, a small margin of error is possible. There are no mechanisms available to formally verify the complete accuracy of the datasets provided to the Commission and the information contained in the Child Death Register.

Rates and percentages cited in this report have been quality assured.

The *Annual Report: Deaths of children and young people, Queensland, 2010–11* brings together information from a number of key sources and presents it in a way that facilitates consideration and interpretation of the risk factors associated with the deaths of children and young people in Queensland. The report also allows comparisons to be made between different population subgroups, such as Aboriginal and Torres Strait Islander children and young people and children known to the child protection system. However, as noted throughout the report, caution must be exercised when making comparisons and interpreting rates due to the small number of deaths analysed. An increase or decrease of 1 or 2 deaths across the course of a year may have a significant impact on findings when small numbers are involved.

To support the establishment and maintenance of the register, the Registry of Births, Deaths and Marriages and the Office of the State Coroner both advise the Commissioner of a child's death and provide available relevant particulars.

Registry of Births, Deaths and Marriages

The information contained in the Child Death Register is based on death registration data from the Queensland Registry of Births, Deaths and Marriages. To help the Commission fulfil its child death functions, the *Births, Deaths and Marriages Registration Act 2003* provides that the Registrar must give notice of the registration of all child deaths to the Commissioner.[1] The data provided includes the following information:

- the registration number
- the child's name
- the child's date and place of birth
- the child's usual place of residence
- the child's age
- the child's sex
- the child's occupation, if any

[1] Section 48A (details of stillborn children are not included in the information given to the Commission).

- Aboriginal or Torres Strait Islander status
- the duration of the last illness, if any, had by the child
- the date and place of death
- the cause of death, and
- the mode of dying.[2]

To the extent practicable, this information is provided within 30 days after the death is registered. Where the death is a 'natural death' (that is, due to diseases or morbid conditions) and a Cause of Death Certificate is issued by a general practitioner, only death registration data is available for analysis. In coronial cases, additional information on the death is available.

Office of the State Coroner

In cases of 'reportable' child deaths, coronial information is also available. Section 8 of the *Coroners Act 2003* defines a reportable death as a death where:

- the identity of the person is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- the death was not a reasonably expected outcome of a health procedure
- a Cause of Death Certificate was not issued or is not likely to be issued
- the death occurred in care, or
- the death occurred in custody.

A death in care occurs when the person who has died:

- had a disability (as defined under the *Disability Services Act 1992*) and was living in a residential service provided by a government or non-government service provider or hostel
- had a disability, such as an intellectual disability, or an acquired brain injury or a psychiatric disability, and lived in a private hostel (not an aged-care hostel)
- was being detained in, taken to or undergoing treatment in a mental health service, or
- was a child in foster care or under the guardianship of the Department of Communities.[3]

A death in custody is defined as a death of someone in custody (including someone in detention under the *Youth Justice Act 1992*), escaping from custody or trying to avoid custody.[4]

To help the Commission fulfil its child death research functions, the Coroners Act imposes an obligation on the State Coroner to notify the Commissioner of all reportable child deaths. The information provided by the State Coroner includes:

- the Police Report of Death to a Coroner (Form 1), which includes a narrative giving a summary of the circumstances surrounding the death
- autopsy and toxicology reports, and
- the coroner's findings and comments.[5]

For the major categories of reportable deaths, which include deaths from external causes and sudden unexpected deaths in infancy (SUDI), coronial information is reviewed, with a view to identifying key risk factors.

[2] Section 48B of the Births, Deaths and Marriages Registration Act enables the Registrar to enter into an arrangement with the Commissioner to provide additional data. Aboriginal and Torres Strait Islander status, date of birth and mode of dying are provided by administrative arrangement only.

[3] Section 9 of the *Coroners Act 2003.*

[4] Section 10 of the *Coroners Act 2003.*

[5] Section 45 of the *Coroners Act 2003* provides that the Coroner must give written copies of his/her findings relating to child deaths to the Commissioner. Coroner's findings are the findings of coronial investigations and should confirm the identity of the person, how, when and where the person died, and what caused the death. Section 46 provides that in the case of a child death the Coroner must give written copies of his/her comments to the Commissioner. Coroner's comments may arise from an inquest that relates to public health or safety, or relates to the administration of justice or ways to prevent future deaths.

Access to other data sources

Section 147 of the Commission's Act enables other government entities to enter into an arrangement with the Commission to provide information or documents reasonably needed for the child death research functions. By providing such information, another agency does not contravene any statutory confidentiality provisions.

The Commission has developed agreements with the following agencies:

- Registry of Births, Deaths and Marriages[6]
- Office of the State Coroner[7]
- Department of Communities (including records relating to child safety, housing and youth justice)
- Queensland Police Service
- Department of Community Safety (including records relating to Emergency Services)
- Department of Justice and Attorney-General (including records relating to Workplace Health and Safety Queensland)
- Australian Bureau of Statistics
- Queensland Health, and
- Department of Education and Training.

Access to information held by these agencies provides valuable insights into the lives of, and circumstances leading to the deaths of, some of Queensland's most vulnerable children.

Confidentiality

Accompanying the Commission's privileged access to information is a duty of confidentiality that is specified in legislation. Section 385 (Confidentiality of Other Information) of the Act states:

If a person gains confidential information through involvement in this Act's administration, the person must not –

(a) make a record of the information or intentionally disclose the information to anyone, other than under subsection (4)[8], or

(b) recklessly disclose the information to anyone.

Coding cause of death

The Commission uses the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) to code underlying and multiple causes of death. ICD-10 was developed by the World Health Organisation (WHO) and is designed to promote international comparability in the collection, processing, classification and presentation of morbidity and mortality statistics.

What is the underlying cause of death?

The concept of the underlying cause of death is central to mortality coding and comparable international mortality reporting. The WHO has defined the underlying cause of death as:

- the disease or injury which initiated the train of morbid events leading directly to death, or
- the circumstances of the incident or violence which produced the fatal injury.

Stated simply, the underlying cause of death is the condition, event or circumstances without the occurrence of which the person would not have died.

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[6] The agreement between the Registry of Births, Deaths and Marriages and the Commission has been developed in accordance with the provisions of section 48B of the *Births, Deaths and Marriages Registration Act 2003*.

[7] The agreement between the Office of the State Coroner and the Commission has been developed in accordance with the provisions of section 54A of the *Coroners Act 2003*.

[8] Subsection 4 permits a person to make a record of or disclose confidential information for this Act to discharge a function under another law, for a proceeding in a court or tribunal or if authorised under a regulation or another law.

Qualified mortality coders

Commission staff have undertaken training in ICD-10 mortality coding and are responsible for the coding of all external cause deaths.

In addition, the Commission has entered into a formal arrangement with the Australian Bureau of Statistics (ABS) for the provision of mortality coding services. Qualified ABS mortality coders review all available information for natural cause deaths and code the underlying and multiple causes of death according to ICD-10 cause of death coding regulations. ABS also undertake quality assurance of external cause deaths coded by the Commission.

Classification of external cause deaths

The Commission recognises that ICD-10 carries certain inherent limitations, particularly in regards to recognising contextual subtleties between cases, and in adequately capturing deaths due to:

- dam drowning
- driveway run-overs of toddlers
- four-wheel motorcycle (quad bike) incidents, and
- sudden unexpected death in infancy.

To help overcome the limitations of ICD-10, the Commission primarily classifies deaths according to their circumstances. Based on the information contained in the Police Report of Death to a Coroner (Form 1), such classification enables the Commission to discuss deaths occurring in similar circumstances, even where an official cause of death has not yet been established[9], or where the ICD-10 code does not accurately reflect the circumstances of death.

All reportable deaths are classified as transport, drowning, other non-intentional injury-related deaths, suicide or fatal assault. SUDI are also grouped together for the purpose of analysis.

As outlined above, discrepancies may exist between research categories and ICD-10 figures. The Commission primarily reports by the broad external cause classifications described above. ICD-10 coding is still used to report on deaths from diseases and morbid conditions. Full details of ICD-10 coding for external cause deaths can be found in Appendix 1.2.

Geographical distribution (ARIA+)

The Commission uses the latest version of the Accessibility/Remoteness Index of Australia Plus (ARIA+) to code geographical remoteness.

ARIA+ is a standard distance-based measure of remoteness developed by the National Centre for the Social Applications of Geographic Information Systems (GISCA) and the former Commonwealth Department of Health and Aged Care (now Department of Health and Ageing).

It interprets remoteness on the basis of access to a range of services; the remoteness of a location is measured in terms of distance travelled by road to reach a centre that provides services.[10]

All child deaths are classified according to the ARIA+ index. The analysis of geographic distribution in this report refers to the child's usual place of residence, which may differ from the place of death or the incident location. However, because of the importance of incident location in the prevention of transport-related deaths, the geographical distribution of all deaths falling within this category has also been reported according to the place of incident.

[9] Where cases have not received an official cause of death as established at autopsy, they are unable to be coded according to ICD-10.

[10] ARIA+ is a purely geographic measure of remoteness, which excludes any consideration of socio-economic status, rurality and population size factors (other than the use of natural breaks in the population distribution of urban centres to define the service centre categories).

For the purposes of analysis in this report, the following general categories of remoteness are reported:

- **metropolitan:** includes major cities of Queensland[11]
- **regional:** includes inner and outer regional Queensland[12], and
- **remote:** includes remote and very remote Queensland.[13]

Socio-economic status (SEIFA)

The Socio-Economic Indexes for Areas (SEIFA) developed by the ABS have been used to code disadvantage. The SEIFA Index of Advantage/Disadvantage is used in this report. This index aims to rank geographical areas to reflect both advantage and disadvantage at the same time, effectively measuring a net effect of social and economic conditions.

Variables associated with advantage include the proportion of families with high incomes, the proportion of people with a degree or higher, and the proportion of people with skilled occupations. Variables associated with disadvantage include the proportion of families with low incomes, the proportion of persons with relatively low levels of education and the proportion of people in low-skilled occupations.

To determine the level of advantage and disadvantage, the child's usual place of residence was used for coding the geographic area. For this reason, measures of socio-economic status used in this report are measures of the status of the areas in which children and young people reside, not the socio-economic status of each individual child or their family.

Aboriginal and Torres Strait Islander status

Although the identification of the deaths of Aboriginal and Torres Strait Islander people has improved considerably in recent years, it is not known how many Indigenous deaths are not identified. Therefore, the number of deaths registered as Aboriginal or Torres Strait Islander in a given year is expected to be an undercount of the actual number of deaths of Indigenous people.

The Child Death Register captures Aboriginal and Torres Strait Islander status as recorded both in the death registration data and on the Form 1, or other documentation available to the Commission. Several cases have been recorded where a child has been identified as Indigenous by the reporting officer in completing the Form 1, but family members did not identify as Indigenous when registering the death.

The Commission recognises that, in Queensland, Aboriginal and Torres Strait Islander children and young people aged 0–17 comprise approximately 45.1% of the Aboriginal and Torres Strait Islander population[14], and will continue to work collaboratively with stakeholders in addressing the undercounting of Aboriginal and Torres Strait Islander child deaths.[15]

Children known to the child protection system

The deaths of children known to the child protection system have been analysed as a separate cohort, as the Commission has distinct responsibilities in relation to these child deaths.

In addition to maintaining the Child Death Register and the research and analysis contained in this report, the Commission provides full secretariat support to the Child Death Case Review Committee (CDCRC), an independent committee established to increase accountability and improve effectiveness in decision-making in the child protection system.

[11] Relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.
[12] Significantly restricted accessibility of goods, services and opportunities for social interaction.
[13] Very restricted accessibility of goods, services and opportunities for social interaction.
[14] Commission for Children and Young People and Child Guardian 2009, *Snapshot 2009: Children and young people in Queensland*, Brisbane: Commission for Children and Young People and Child Guardian.
[15] In New South Wales, for example, when an Aboriginal member of the Child Death Review Team can identify the family as an Aboriginal family, the child is coded as Aboriginal (New South Wales Child Death Review Team, 2000–2001 Report, Sydney: New South Wales Commission for Children and Young People, 2001).

Since 1 August 2004, the Department of Communities, Child Safety Services has been required to conduct a review of its involvement in each case where a child known to the child protection system dies within 3 years of the Department's last involvement with the child. The Department of Communities has 6 months from the time it learns of the child's death to provide the CDCRC with a report.

The CDCRC considers this report and makes recommendations about:

- improving policies which impact on services to children known to the child protection system
- improving relationships between the Department of Communities and other agencies involved with the children and their families, and
- whether disciplinary action should be taken against any departmental staff in relation to their involvement with a child.

The CDCRC is a multidisciplinary committee of experts in paediatrics, child health and welfare, and investigations. The Commissioner and Assistant Commissioner are standing members of the CDCRC, with the Commissioner permanently appointed as the chairperson.

The Queensland Child Death Register captures information regarding whether the child was known to the child protection system, or whether their siblings were known to the child protection system.

Due to the complex circumstances present in their lives, children known to the child protection system often experience a range of risk factors and represent a vulnerable and at-risk cohort.

Analysis and reporting

Analysis period

The register was analysed according to date of death registration (rather than date of death). This is in accordance with national datasets managed by the ABS and the Australian Institute of Health and Welfare (AIHW), as well as child death datasets managed by other Australian states and territories.

Reporting period

This report examines the deaths of 465 children and young people aged from birth to 17 years, registered between 1 July 2010 and 30 June 2011.

Yearly average reporting

The Queensland Child Death Register represents a rich source of information which can be used to inform research and prevention activities. A critical element of the Register's effectiveness in this regard is its ability to evolve over time, based upon the receipt of new information relating to individual child deaths. In order to reflect the ever-changing nature of the information contained within the Register, the Commission has re-analysed data pertaining to deaths registered in previous years, to ensure the most current and up-to-date data is presented. The information contained in the first table of each chapter may therefore differ from those presented in previously published reports.

The Commission's information relating to child deaths in Queensland now comprises 7 years worth of data. As the Commission's dataset continues to grow, it will not be practical to display data for each year within the Annual Report. As such, data for the last 5 years only is displayed in the first table for chapters 1-8. As the Commission recognises the value of the information contained in these tables, copies of the tables containing data since 2004 are available online at www.ccypcg.qld.gov.au.

Incidence

This report analyses the rate of death for various sections of the child population in Queensland. These rates show the number of deaths per 100,000 children in each age and/or gender category in the population. Rates allow comparisons over time, across states and internationally.[16]

For infants under 1 year, rates per 1000 live births were also calculated. Births data are based on medium series Queensland Government Population Projections for 2009–10.

Rates were not calculated where cases numbered less than 4 because of the unreliability of such calculations.

Aboriginal and Torres Strait Islander child death rates

The Indigenous death rates used in this report have been calculated using the Queensland Treasury Experimental Indigenous Estimated Resident Population for Queensland Statistical Local Areas, 30 June 2009. This was the latest population data available at the time of publication. In comparing Indigenous child death rates across reporting periods, it should be taken into account that previously published figures were based on ABS experimental estimates and projections of the Indigenous population, rather than those produced by Queensland Treasury as used in this publication.[17]

Rates of death for children known to the child protection system

Rates of death for children known to the child protection system are calculated on the number of distinct children known to the child protection system in the three-year period before the 2010–11 financial year. This data was provided to the Commission by the Department of Communities.

The table below lists the denominator data provided by the Department of Communities for the last 5 reporting periods.[18]

Distinct children known to the child protection system

Reporting period	Number of distinct children known to the child protection system	Percentage increase from previous year	Total number of children	Percentage increase from previous year
2006–07	86,041	22%	1,007,003	3%
2007–08	91,068	6%	1,027,226	2%
2008–09	101,899	12%	1,049,066	2%
2009–10	129,361	27%	1,073,512	2%
2010–11	151,349	17%	1,073,512	0%

Data source: Department of Communities, Performance and Analysis Branch, 5 July 2010.

The denominator data represent the number of distinct children (aged 0–17 years) who have had any of the following forms of contact with the child protection system in the preceding 3 years:

- Child Concern Report[19]
- notification
- investigation and assessment
- order, and/or
- placement.

[16] Rates of death reported in Child Death Annual Reports from 2004–05 to 2006–07 are based on ABS population projections from the 2001 Census. Caution should be exercised in comparing rates across years.

[17] The ABS experimental estimates and projections used in 2004–05 and 2005–06 were based on high series projections, while those used in 2006–07 related to low series projections as per a whole-of-government policy change. Experimental Indigenous estimated resident populations developed by the Queensland Treasury, Office of Economic and Statistical Research were used from 2007–08 onwards. For this reason, caution should be exercised when comparing Indigenous child death rates across reporting periods.

[18] The Department of Communities has improved the methodology used for calculating denominator data. This methodology was employed for denominator data used in all Child Death Annual Reports from 2006–07 onwards. Comparisons should therefore not be drawn between the rates of death in the child protection system presented in these reports and those given in the 2005–06 report. Updated denominator data for the 2005–06 period has been provided and is included in the table above.

[19] Before 2006–07, data regarding Child Concern Reports were not available. The inclusion of Child Concern Reports in the 2006–07 denominator data primarily accounts for the large increase between 2005–06 and 2006–07 figures.

This denominator has increased significantly in recent years, resulting in a consistent reduction in the rate, despite the number of child protection deaths remaining relatively stable.

Historically, a higher proportion of children known to the child protection system have died than children in the overall population. The complexity of the issues faced by families of at-risk children are likely to contribute to the disparity between outcomes for children known to the child protection system and those for other Queensland children. The fact that this group comes to the attention of an established service system means that ongoing analysis of risk factors related to their deaths will be well targeted and will help inform the design of supports and interventions.

Child death rates across Australian states and territories

Chapter 10, *National child death statistics: an interstate comparison 2009*, provides a comparative analysis of child mortality across selected Australian states. Data was supplied by the following members of the Australian and New Zealand Child Death Review and Prevention Group:

- Queensland Commission for Children and Young People and Child Guardian
- New South Wales Child Death Review Team, NSW Ombudsman
- South Australian Child Death and Serious Injury Review Committee
- Tasmanian Council of Obstetric & Paediatric Mortality & Morbidity, and
- Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

Rates are based on population data as at June 2009 in each state and territory, as sourced from the Australian Bureau of Statistics.

Statistics for Indigenous children have also been provided. As discussed earlier, data regarding Aboriginal and Torres Strait Islander people are likely to be an undercount of actual figures. Rates for the deaths of Aboriginal and Torres Strait Islander children were based on experimental estimates at June 2009.

Rates were not published where cases numbered less than 4 because of the unreliability of such calculations. Further detail of the methodology used in compiling Chapter 10 can be found in Appendix 10.1.

Abbreviations and dictionary

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AISRAP	Australian Institute for Suicide Research and Prevention
AMDIG	Australian Mortality Data Interest Group
ARIA+	Accessibility/Remoteness Index of Australia Plus (ARIA+). An index of remoteness derived from measures of road distance between populated localities and service centres. These road distance measures are then used to generate a remoteness score for any location in Australia.
Autopsy	Also ‘post-mortem’. A detailed physical examination of a person’s body after death. An autopsy can be external only, external/internal or external/partial internal.
Births, Deaths and Marriages Registration Act	*Births, Deaths and Marriages Registration Act 2003* (Qld)
Commission for Children and Young People and Child Guardian Act	*Commission for Children and Young People and Child Guardian Act 2000* (Qld)
CDCRC	Child Death Case Review Committee (Qld)

Chaotic social circumstances	For the purpose of this report, a child is considered to have been living in chaotic social circumstances if their familial environment is characterised by persistent disruption, instability and expose to risk relevant to one or more of the following: parental abuse or neglect; domestic violence; mental health problems; itinerancy; poverty.
Child	A person aged 0–17 years
Child known to the child protection system	For the purpose of this report, a child is deemed to have been known to the child protection system if, within three years before the child's death, the Department of Communities, Child Safety Services, became aware of child protection concerns, alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child.
The Commission or CCYPCG	The Commission for Children and Young People and Child Guardian (Qld)
The Commissioner	Commissioner for Children and Young People and Child Guardian (Qld)
Congenital anomalies	Congenital anomalies (ICD-10 Chapter XVII, Congenital malformations, deformations and chromosomal abnormalities) are mental and physical conditions present at birth that are either hereditary or caused by environmental factors.
Contagion	Contagion refers to the process by which a prior suicide or attempted suicide facilitates or influences suicidal behaviour in another person.
Coroners Act	*Coroners Act 2003* (Qld)
CPR	Cardiopulmonary resuscitation
Death in care	A death as defined under section 9 of the *Coroners Act 2003*.
Death in custody	A death as defined under section 10 of the *Coroners Act 2003*.
External causes of death	Pertaining to environmental events and circumstances that cause injury, poisoning and other adverse effects. Broadly, external cause deaths are generally more amenable to prevention than many deaths from disease and morbid conditions.
Fatal assault	The Commission defines fatal assault as the death of a child resulting from an act or acts of violence perpetrated by another person.
Fatal neglect	The Commission defines fatal neglect as the death of a child resulting from a failure to provide essential care necessary to the child's survival. This may involve acts or omissions on the part of a caregiver that are either deliberate or extraordinarily irresponsible or reckless.
GISCA	National Centre for the Social Applications of Geographic Information Systems
HIV	Human Immunodeficiency Virus
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
Indigenous	Refers to children identified as Aboriginal and/or Torres Strait Islander

Neonatal death	A neonatal death is the death of an infant within 0–27 days of birth who, after delivery, breathed or showed any other evidence of life such as a heart beat. This is the definition used by the Australian Bureau of Statistics in all cause of death publications.
Neoplasms (cancers and tumours)	The term 'neoplasm' (ICD-10 Chapter II) is often used interchangeably with words such as 'tumour' and 'cancer'. Cancer includes a range of diseases in which abnormal cells proliferate and spread out of control. Normally, cells grow and multiply in an orderly way to form organs that have a specific function in the body. Occasionally, however, cells multiply in an uncontrolled way after being affected by a carcinogen, or after developing a random genetic mutation. They may form a mass that is called a tumour or neoplasm. A 'benign neoplasm' refers to a non-cancerous tumour, whereas a 'malignant neoplasm' usually refers to a cancerous tumour (that is, cancer). Benign tumours do not invade other tissues or spread to other parts of the body, although they can expand to interfere with healthy structures.
Other non-intentional injury-related deaths	Other non-intentional injury-related deaths include those resulting from a fall; electrocution; poisoning; suffocation, strangulation and choking; fire; and 'other' non-intentional injury-related deaths that are not discussed in Chapter 3 (Transport) or Chapter 4 (Drowning) of this report.
OESR	Office of Economic and Statistical Research (Qld)
QIPC	Queensland Injury Prevention Council
Perinatal condition	Perinatal conditions (ICD-10 Chapter XVI, Certain conditions originating in the perinatal period) are diseases and conditions that originated during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. These include maternal conditions that affect the newborn, such as complications of labour and delivery, disorders relating to foetal growth, length of gestation and birthweight, as well as disorders specific to the perinatal period such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders.
Perinatal period	The perinatal period includes foetuses and infants delivered weighing at least 400 grams or having a gestational age of 20 weeks, whether alive or dead. This is the Australian Bureau of Statistics (ABS) definition of the perinatal period. The ABS has adopted the legal requirement for registration of a perinatal death as the statistical standard as it meets the requirements of major users in Australia. This definition differs from the World Health Organisation's recommended definition of perinatal deaths, which includes infants and foetuses weighing at least 500 grams or having a gestational age of 22 weeks or a body length of 25 centimetres crown–heel.
Police Report of Death to a Coroner (Form 1)	A form completed by the police in accordance with section 7 of the Coroners Act 2003 – Duty to Report Deaths.
Post-neonatal death	A post-neonatal death is the death of an infant 28 or more days but less than 12 months after birth. This is the definition used by the Australian Bureau of Statistics in all cause of death publications.

Postvention	Defined by the American Association of Suicide Prevention as the provision of crisis intervention, support and assistance for those affected by a completed suicide.
Quad bike	Previously referred to as all-terrain vehicles (ATVs), these are four-wheeled motorcycles primarily used for agricultural purposes.
The Registrar	Registrar of the Registry of Births, Deaths and Marriages (Qld)
Registry	Registry of Births, Deaths and Marriages (Qld)
Reportable death	A death as defined under sections 8, 9 and 10 of the *Coroners Act 2003*.
SCD	An unexplained or presumed arrhythmic sudden death, occurring in a short time period (generally within 1 hour of symptom onset) in a child or young person with previously unknown cardiac disease.
SEIFA	Socio-Economic Indexes for Areas 2006. Developed by the Australian Bureau of Statistics using data derived from the 2006 Census of Population and Housing, SEIFA 2006 provides a range of measures to rank areas based on their relative social and economic wellbeing.
SIDS	Sudden Infant Death Syndrome
STI	Sexually transmissible infection
SUDI	Sudden unexpected death in infancy
Toxicology	The analysis of drugs, alcohol and poisons in the body fluids at autopsy.
Undetermined	Death certified as 'undetermined' refer to deaths in which available information is insufficient to classify the death into one of the specific causes of natural or unnatural death. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category. Sudden unexpected deaths of infants are certified as undetermined when insufficient findings are present to support a particular diagnosis but when sufficient abnormal features in the history or at the scene, examination, autopsy or laboratory workshop were found that were not typical of Sudden Infant Death Syndrome.[20]
Undetermined intent	A death where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault.
WHO	World Health Organisation

[20] Mitchell, E, Krous, H, Donald, T & Byard, R 2000, Changing trends in the diagnosis of sudden infant death, *American Journal of Forensic Medicine and Pathology*, 21(4), 311–14.

Appendix 1.2:

Cause of death by ICD-10 mortality coding classification

Deaths from diseases and morbid conditions, 2010–11

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
	n	*n*	*n*	*n*	*n*	*n*
Certain conditions originating in the perinatal period (P00-P96)	146	1	0	0	0	147
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	84	8	3	1	2	98
Neoplasms (C00-D48)	2	7	9	7	9	34
Diseases of the nervous system (G00-G99)	6	1	4	2	3	16
Diseases of the respiratory system (J00-J99)	2	2	1	2	1	8
Endocrine, nutritional and metabolic diseases (E00-E90)	2	2	1	1	2	8
Certain infectious and parasitic diseases (A00-B99)	3	2	0	0	0	5
Diseases of the circulatory system (I00-I99)	1	0	0	3	1	5
Diseases of the digestive system (K00-K93)	0	1	1	1	0	3
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	1	0	0	0	0	1
Mental and behavioural disorders (F00-F99)	0	0	0	0	1	1
Diseases of the genitourinary system (N00-N99)	1	0	0	0	0	1
Diseases and morbid conditions total	**248**	**24**	**19**	**17**	**19**	**327**
Sudden infant death syndrome (R95)	11	0	0	0	0	11
Other ill-defined and unspecified causes of mortality (R99)	6	0	0	0	0	6
SIDS and undetermined causes (infants) total	**17**	**0**	**0**	**0**	**0**	**17**
Other ill-defined and unspecified causes of mortality (R99)	0	0	0	0	1	1
Undetermined >1 total	**0**	**0**	**0**	**0**	**1**	**1**
Total	**265**	**24**	**19**	**17**	**20**	**345**

Data source: Queensland Child Death Register (2010–11)

Deaths from external causes, 2010–11

Cause of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
	n	*n*	*n*	*n*	*n*	*n*
Car occupant injured in transport accident (V40-V49)	0	2	2	4	9	17
Pedestrian injured in transport accident (V01-V09)	1	3	2	1	1	8
Motorcycle rider injured in transport accident (V20-V29)	0	0	0	1	1	2
Water transport accidents (V90-V94)	0	0	0	0	2	2
Event of undetermined intent (Y10-Y34)	0	0	0	0	1	1
Cause of death pending	0	0	0	0	1	1
Transport total	**1**	**5**	**4**	**6**	**15**	**31**
Intentional self-harm (X60-X84)	0	0	1	4	15	20
Cause of death pending	0	0	0	0	1	1
Suicide total	**0**	**0**	**1**	**4**	**16**	**21**
Exposure to forces of nature (X30-X39)	0	2	2	2	1	7
Accidental drowning and submersion (W65-W74)	1	2	0	1	1	5
Cause of death pending	0	1	1	0	0	2
Drowning total	**1**	**5**	**3**	**3**	**2**	**14**
Other accidental threats to breathing (W75-W84)	1	0	0	0	0	1
Exposure to electric current, radiations and extreme ambient air temperature and pressure (W85-W99)	0	0	0	0	1	1
Exposure to smoke, fire and flames (X00-X09)	0	0	0	0	1	1
Cause of death pending	0	0	0	1	0	1
Other non-intentional injury-related death total	**1**	**0**	**0**	**1**	**2**	**4**
Assault (X85-Y09)	2	0	0	0	0	2
Event of undetermined intent (Y10-Y34)	1	1	0	0	0	2
Sequelae of external causes of morbidity and mortality (Y85-Y89)	0	1	0	0	0	1
Fatal assault and neglect total	**3**	**2**	**0**	**0**	**0**	**5**
Total	**6**	**12**	**8**	**14**	**35**	**75**

Data source: Queensland Child Death Register (2010–11)

Appendix 1.3:

Geographic distribution by cause of death

Geographic distribution of child deaths by cause of death, 2010–11

Cause of death	Metropolitan		Regional		Remote		Outside Queensland	Total	
	n	Rate per 100,000	n	Rate per 100,000	n	Rate per 100,000	n	n	Rate per 100,000
Diseases and morbid conditions	**165**	**27.8**	**146**	**34.7**	**19**	**31.7**	**15**	**345**	**32.1**
SIDS and undetermined causes (infants)	4	0.7	10	2.4	3	*	0	17	1.6
Undetermined > 1 year	0	*	1	*	0	*	0	1	*
External causes	**23**	**3.9**	**41**	**9.7**	**9**	**15.0**	**2**	**75**	**7.0**
Transport	15	2.5	13	3.1	2	*	1	31	2.9
Suicide	7	1.2	9	2.1	5	8.3	0	21	2.0
Drowning	0	*	12	2.9	1	*	1	14	1.3
Fire	0	*	1	*	0	*		1	*
Accidental	0	*	2	*	1	*	0	3	*
Fatal assault and neglect	1	*	4	1.0	0	*	0	5	0.5
Cause of death pending	**26**	**4.4**	**16**	**3.8**	**2**	*	**1**	**45**	**4.2**
Total	**214**	**36.1**	**203**	**48.3**	**30**	**50.1**	**18**	**465**	**43.3**

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Eighteen children were not classified as their usual residence was outside Queensland. For further details, see Appendix 1.4.
2. Rates are calculated per 100,000 children and young people aged 0–17 years in metropolitan, regional and remote areas of Queensland.

Appendix 1.4:

Interstate and international residents 2010–11

Interstate and international residents, 2010–11

Case	Cause of death	Gender	Age category	Usual place of residence
1	Diseases and morbid conditions	Male	Under 1 year	New South Wales
2	Diseases and morbid conditions	Female	Under 1 year	New South Wales
3	Diseases and morbid conditions	Female	Under 1 year	New South Wales
4	Diseases and morbid conditions	Male	Under 1 year	New South Wales
5	Diseases and morbid conditions	Female	Under 1 year	New South Wales
6	Cause of death pending	Female	Under 1 year	New South Wales
7	Diseases and morbid conditions	Male	1-4 years	Papua New Guinea
8	Diseases and morbid conditions	Female	5–9 years	Papua New Guinea
9	Diseases and morbid conditions	Female	1–4 years	Papua New Guinea
10	Diseases and morbid conditions	Female	15-17 years	New South Wales
11	Diseases and morbid conditions	Male	Under 1 year	New South Wales
12	Diseases and morbid conditions	Female	Under 1 year	New South Wales
13	Drowning	Male	10-14 years	China
14	Diseases and morbid conditions	Male	Under 1 year	New South Wales
15	Diseases and morbid conditions	Female	Under 1 year	Guernsey
16	Transport	Female	15-17 years	United States of America
17	Diseases and morbid conditions	Male	Under 1 year	New South Wales
18	Diseases and morbid conditions	Female	1-4 years	New South Wales

Data source: Queensland Child Death Register (2010–11)

Appendix 1.5:

Socio-economic status of child deaths by cause of death

Socio-economic status of child deaths by cause of death, 2010–11

Cause of death	Low to very low		Moderate		High to very high		Outside Queensland	Total	
	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Rate per 100,000	Total *n*	Total *n*	Rate per 100,000
Diseases and morbid conditions	**115**	**26.1**	**104**	**47.8**	**111**	**26.7**	**15**	**345**	**32.1**
SIDS and undetermined	8	1.8	5	2.3	4	1.0	0	17	1.6
Undetermined > 1 year	0	*	1	*	0	*	0	1	*
External causes	**42**	**9.5**	**22**	**10.1**	**9**	**2.2**	**2**	**75**	**7.0**
Transport	18	4.1	6	2.8	6	1.4	1	31	2.9
Suicide	7	1.6	11	5.1	3	*	0	21	2.0
Drowning	11	2.5	2	*	0	*	1	14	1.3
Accidental	1	*	2	*	0	*	0	3	*
Fire	1	*	0	*	0	*	0	1	*
Fatal assault and neglect	4	0.9	1	*	0	*	0	5	0.5
Cause of death pending	**22**	**5.0**	**11**	**5.1**	**11**	**2.6**	**1**	**45**	**4.2**
Total	**179**	**40.6**	**137**	**63.0**	**131**	**31.6**	**18**	**465**	**43.3**

Data source: Queensland Child Death Register (2010–11)
** Rates have not been calculated for numbers less than 4.*
Notes: 1. Eighteen children were not classified as their usual residence was outside Queensland. For further details, see Appendix 1.4.
2. Rates are calculated per 100,000 children and young people aged 0–17 years in low to very low, moderate and high to very high socio-economic areas of Queensland.

Appendix 2.1:

Notifiable diseases

Complete Notifiable Conditions Schedule (Public Health Regulation 2005)

acquired immune deficiency syndrome (AIDS)	human immunodeficiency virus infection (HIV)
acute flaccid paralysis	influenza
acute rheumatic fever	invasive Group A streptococcal infection
acute viral hepatitis	Japanese encephalitis
adverse event following vaccination	lead exposure (notifiable) (blood lead level of 10 mg/µL (0.48 µmol/L) or more)
anthrax	legionellosis
arbovirus infections – • **alphavirus infections, including Barmah Forest, getah, Ross River and sindbis viruses** • **bunyaviruses infections, including gan gan, mapputta, termeil and trubanaman viruses** • **flavivirus infections, including alfuy, Edge Hill, kokobera, kunjin, Stratford and and other unspecified flaviviruses (excluding dengue fever, yellow fever, Japanese encephalitis and Murray Valley encephalitis)** • **any other arbovirus infection (excluding dengue fever, yellow fever, Japanese encephalitis and Murray Valley encephalitis)**	leptospirosis
avian influenza	listeriosis
botulism (food-borne)	lyssavirus (Australian bat lyssavirus)
botulism (intestinal – adult)	lyssavirus (Australian bat lyssavirus), potential exposure
botulism (intestinal – infantile)	lyssavirus (rabies)
botulism (wound)	lyssavirus (unspecified)
brucellosis	malaria
campylobacteriosis	measles
chancroid	melioidosis
chikungunya	meningococcal infection (invasive)
Chlamydia trachomatis infection (anogenital)	mumps
chlamydia trachomatis infection (lymphogranuloma venereum)	Murray Valley encephalitis
chlamydia trachomatis infection (non-anogenital)	non-specified mycobacterial disease
cholera	ornithosis (psittacosis)
ciguatera intoxication	paratyphoid
Creutzfeldt-Jakob disease	pertussis
cryptosporidiosis	plague
dengue fever	pneumococcal disease (invasive)
diphtheria	poliomyelitis – wild type and vaccine associated
donovanosis	Q fever

equine morbilivirus (Hendra virus) infection	rotavirus infection
food-borne or waterborne illness in 2 or more cases	rubella, including congenital rubella
food-borne or waterborne illness in food handler	salmonellosis
gonococcal infection (anogenital)	severe acute respiratory syndrome (SARS)
gonococcal infection (non-anogenital)	shiga toxin and vero toxin producing escherichia coli infection SLTEC/VTEC
haemolytic uraemic syndrome (HUS)	shigellosis
haemophilus influenzae type b infection (invasive)	smallpox
Hansen's disease (leprosy)	syphilis, including congenital syphilis
hepatitis A	tetanus
hepatitis B (acute)	tuberculosis
hepatitis B (chronic)	tularaemia
hepatitis B (not otherwise specified)	typhoid
hepatitis C	varicella – zoster virus infection (chickenpox, shingles or unspecified)
hepatitis D	viral haemorrhagic fevers (Crimean-Congo, Ebola, Lassa fever and Marburg viruses)
hepatitis E	yellow fever
hepatitis (other)	yersiniosis

Appendix 5.1:

Inclusions within the other non-intentional injury-related death category

Causes of death included in other non-intentional injury-related death category

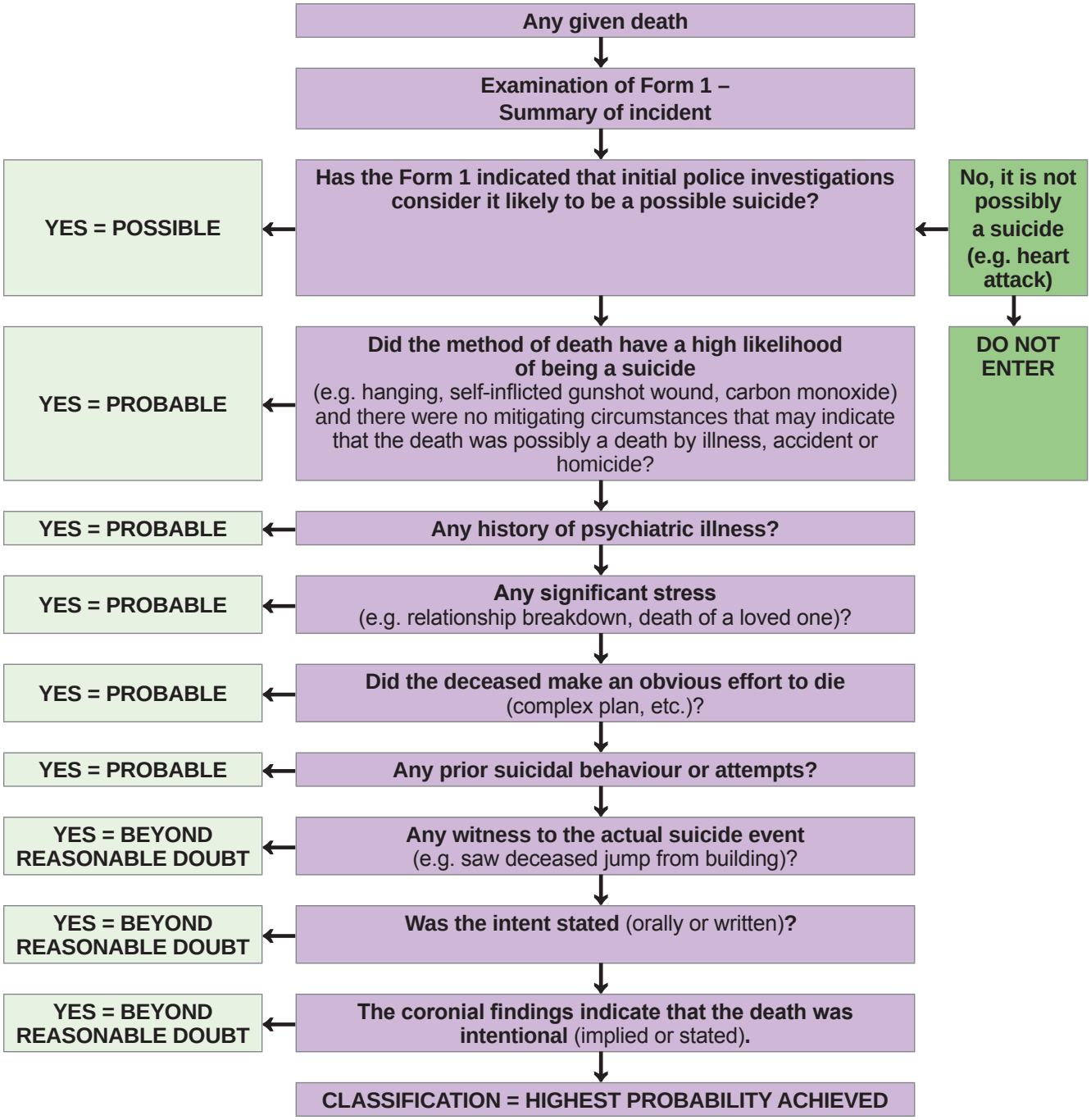
- poisonings
- falls
- non-intentional threats to breathing, including accidental suffocation and strangulation in bed; other accidental hanging and strangulation; threats to breathing due to cave-in falling earth and other substances; inhalation of gastric contents, food or other object causing obstruction of respiratory tract
- exposure to electrical current, and
- fire.

Other inclusions within this category

- misadventure to patients during medical or surgical care
- drugs, medicaments and biological substances causing adverse effects in therapeutic use
- surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
- sequelae with surgical and medical care as external
- lightning
- cataclysmic storms and floods resulting from storms
- exposure to forces of nature (for example, excessive natural heat)
- contact with venomous marine animals and plants
- injury caused by animals
- struck by falling object or striking against or struck by other objects
- striking against or bumped into by another person
- caught, crushed, jammed between objects
- injury caused by machinery (for example, agricultural machinery)
- unintentional injury caused by cutting, piercing instruments or objects
- foreign body entering into or through eye, other orifice or skin
- unintentional injury caused by firearms
- contact with heat and hot substances, and
- late effects of accidental injury (excluding transport accidents).

Appendix 6.1:

Suicide classification model[1]



[1] Modified from De Leo, D & Evans, R 2002, Suicide in Queensland 1996–1998: *Mortality rates and related data*, Australian Institute for Suicide Research and Prevention, Brisbane.

Appendix 10.1:

Methodology for national child death statistics

Data sources

Interstate mortality statistics have been provided by the member teams and committees of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) with the current capacity to share child death data. Consequently, this data is limited to that provided by the:

- Queensland Commission for Children and Young People and Child Guardian
- New South Wales Child Death Review Team, NSW Ombudsman
- South Australian Child Death and Serious Injury Review Committee
- Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity, and
- Victorian Consultative Council on Obstetrics and Paediatric Mortality and Morbidity.

Analysis period

This analysis covers the period 1 January–31 December 2009.

Due to differences in data collection and reporting processes across the member states, the analysis in this chapter is based upon the 2009 calendar year. This is the most up-to-date national data available for comparison purposes.

Date of registration and place of residence

All states provided raw numbers of the deaths of all children from birth up to, but not including, 18 years of age *occurring* in 2009, independent of when these deaths were registered with the Registry of Births, Deaths and Marriages. This is in contrast to the last reporting period where some states provided data on the deaths of children per the date of registration with the Registry of Births, Deaths and Marriages in each state in 2008, irrespective of the child's place of usual residence.

Capturing deaths based on the state in which they occurred can have an impact on rates of deaths. Rates of death in South Australia, for example, may be artificially inflated by the number of deaths of residents from surrounding areas of the Northern Territory occurring within South Australian boundaries. Similar problems are also known to occur in New South Wales.

Population data

The population figures used in the following analysis are estimated resident populations (ERP) for each state, as at June 2009.[1] To ensure comparability of child death rates between states, all rates have been calculated on this population data, and therefore may differ from those previously published in the reports of individual agencies.[2] The table below provides details of the ERP of each state as sourced from the Australian Bureau of Statistics and as used for the calculation of rates of death in the following analysis.

[1] Australian Bureau of Statistics 2010, *Population by age and sex, Australian states and territories, June 2010* (cat. no. 3201.0), Australian Bureau of Statistics, Canberra.

[2] Rates presented here are crude rates rather than adjusted rates as used in some jurisdictions, and may also account for some differences between the rates published here and those published in other reports.

Estimated resident population by age category and state

Age category	Queensland	New South Wales	South Australia	Tasmania	Victoria
Under 1 year	65,055	93,544	19,902	6,772	71,292
1–4 years	238,668	359,702	76,228	26,431	273,979
5–9 years	286,463	440,872	94,164	30,884	325,954
10–14 years	296,915	451,094	100,787	33,594	336,385
15–17 years	184,815	281,870	63,356	20,840	211,477
Total (0–17 years)	**1,071,916**	**1,627,082**	**354,437**	**118,521**	**1,219,087**

Data source: Australian Bureau of Statistics (2009)
Note: 1. Age breakdowns reported by the New South Wales Child Death Review Team consider children aged 10–13 years; 14–15 years and 16–17 years. Population estimates of children in these age breakdowns have been grouped together for the purpose of calculating rates throughout the analysis.

Estimates for the Indigenous child population are based on experimental estimates for 2007 to 2009.[3] It should be noted that these estimates were only available in 5-year age brackets. Therefore, a synthetic estimation technique was undertaken to estimate the proportion of Indigenous children aged 15-17 years within a jurisdiction (from the 15-19 year Indigenous population data provided) based on the underlying assumption that the single year of age distribution for Indigenous children was the same as that for all children within the jurisdiction. The below table provides details of estimates of the Indigenous child population in each state as used in the calculation of death rates in the following analysis. Victoria was unable to provide data for this comparison and was therefore not included in these estimates.

Estimated Aboriginal and Torres Strait Islander child population by state

State	Estimated Indigenous population
Queensland	68,736
South Australia	12,450
Tasmania	8,222
New South Wales	69,676

Data source: Australian Bureau of Statistics (2009)

Data extraction and methodological differences

To assist with comparative research regarding the prevention of child deaths, the ANZCDR&PG has agreed to report under a number of research categories based on the circumstances of death. These research categories capture diseases and morbid conditions and the major external causes of death: transport, drowning, suicide, other non-intentional injury and fatal assault.

However, it is important to recognise that the deaths counted under each category are as per the particular agency's classification. In many cases, agencies have multiple sources of information available concerning children (including health, welfare and education records) and are not limited to the causes of death recorded in post-mortem reports or death certificates. Accordingly, a team or committee's classification for a particular death may vary from the World Health Organisation's International Classification of Diseases (version 10) classifications.

[3] Australian Bureau of Statistics 2009, *Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*, (cat. no. 3238.0), Australian Bureau of Statistics, Canberra.

Notable differences include:

- usual coding of neonatal (0–28 days) deaths according to PSANZ-PDC[4] and PSANZ-NDC[5] rather than ICD-10 by the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- the inclusion of only deaths occurring in 2009 (whether registered in 2009 or 2010) by the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity for ages from 28 days up to (but not including) the 18th birthday
- the inclusion by Victoria of the deaths of all neonates (0–27 days) born in 2009, regardless of whether the death occurred in 2009 or 2010
- South Australia reports on deaths occurring in that years, independent of when they were registered with the Office of Births, Deaths and Marriages
- the exclusion of 36 neonatal deaths as the result of terminations of pregnancy or that were less than 20 weeks gestation from Victorian figures for infant deaths, and
- classification of external cause deaths by the South Australian Child Death and Serious Injury Review Committee according to the following guidelines:
  - **Transport:** includes deaths from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport. Incidents may occur on public highways or places other than a public highway.
  - **Accidents:** excludes deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, accidents most commonly include suffocation, strangulation and choking, falls and poisoning.
  - **Suicide:** the Committee classifies a death as suicide where the intent of the child was clearly established. It also attributes a death to suicide if careful examination of coronial, police, health and education records indicated a probable intention to die.
  - **Fatal assault:** the Committee characterises a fatal assault as 'the death of a child from acts of violence perpetrated upon him or her by another person' (Lawrence, 2004; p. 842).

A number of additional issues affecting data in particular states and territories should also be noted:

- The Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) note that the data provided are provisional only. Final data will be available in the yet to be published *Annual Report for the Year 2009*. This will be available from <www.health.vic.gov.au/ccopmm/index.htm>.
- The Victorian CCOPMM does not specify raw figures where these are equal or less than 10. These are represented by the figure ≤10 throughout the analysis.
- The Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity note that breakdowns by cause of death are currently unavailable for neonatal deaths. All figures pertaining to cause of death breakdowns for infants less than 1 year of age represent infants in the post-neonatal period only.
- The New South Wales Child Death Review Team (CDRT) note that different methodologies have been applied in the calculation of rates in this analysis compared with that used in the New South Wales CDRT reports. While crude rates have been used in this analysis, the New South Wales CDRT report Direct Standardised Mortality Rates.[6]

[4] Perinatal Society of Australia and New Zealand – Perinatal Death Classification.

[5] Perinatal Society of Australia and New Zealand – Neonatal Death Classification.

[6] Details of the methodology used in the calculation of mortality rates used by the New South Wales Child Death Review Team can be found in Chapter 19, Methods, of the Child Death Review Team Annual Report 2009, available at: <http://kids.nsw.gov.au/kids/resources/publications/childdeathreview.cfm>.

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commission for
children and young people
and child guardian

Speaking up for Queensland children

Level 17, 53 Albert Street
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PO Box 15217
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11-773 OCT11

This and the following 2 pages is the annexure marked **"F"** to the affidavit of Elizabeth Fraser affirmed on 8 August 2012 before me

Signed: ……

Forde and CMC Recommendations that relate to current CCYPCG functions

Forde Recommendations that relate to current CCYPCG functions

Recommendation 16
That legislation be enacted to make mandatory the reporting of all abusive situations that come to the attention of departmental employees and persons employed in residential care facilities and juvenile detention centres.

Recommendation 19
That the provision of advocacy services for young people in residential care facilities and juvenile detention centres be required by legislation.

Recommendation 25
That amendments be made to the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996* to ensure the independence of the office of Children's Commissioner, and provisions be made for its attachment for administrative support services to the Premier's Department.

Recommendation 26
That the office of the Children's Commissioner be strengthened by:

- Investing it with the role of Independent Inspector of residential care facilities and juvenile detention centres with wide powers of inspection in relation to such matters as the treatment of residents, preparation for release, morale of residents and staff, quality of health care and education, physical facilities and management;
- Empowering the Commissioner to conduct Inquiries into matters affecting children and young people including the authority to investigate and resolve complaints about the provision of services to children and young people;
- Establishing a comprehensive research function to enable research to be conducted into all matters relating to the rights, interests and wellbeing of children and young people in residential facilities and juvenile detention centres; and
- Providing the Commissioner with the power to monitor the role of the Department in overseeing the care of young people in residential facilities and detention centres.

Recommendation 28
That there be a review of the Official Visitors' program focusing on the legislative base, policy and procedural guidelines, actual practice, and effectiveness of the service.

Recommendation 29
That the Official Visitors' program be maintained and extended with a view to

providing a comprehensive monitoring function of all residential facilities for children and young people, including those not funded by the State but which, nevertheless, provide a similar service and including juvenile detention centres.

Recommendation 30
That visits from Official Visitors be regular and frequent, and the number of Visitors reflect the size of the client base.

Recommendation 31
That Official Visitors be empowered to act as advocates for children and young people in care, by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances.

Recommendation 32
That Official Visitors be provided with complete orientation and training in alternative care practice, standards of residential care, advocacy issues and practice, and developing trusting relationships with young people.

Recommendation 33
That Official Visitors be given access to relevant information about children and young people in care, and that they be bound by the same rules of confidentiality as other Commission and departmental staff.

CMC Recommendations that relate to current CCYPCG functions
Recommendation 5.21
That a position of Child Guardian, to be situated within the Commission for Children and Young People, be established, whose sole responsibility would be to oversee the provision of services provided to, and decisions made in respect of, children within the jurisdiction of the DCS.

Recommendation 5.22
That the powers granted to the Child Guardian be clearly set out in the legislation, and include the powers necessary to investigate complaints and enable proactive monitoring and auditing of the DCS.

Recommendation 5.23
That the Community Visitor Program of the Commission for Children and Young People be extended to cover all children in the alternative care system, including those in foster care. This program should be administered by the Child Guardian.

Recommendation 5.24
That the jurisdiction of the Children Services Tribunal be expanded to allow the Child Guardian to refer decisions of the DCS or non-government organisations to the Children Services Tribunal for merit review, where the Child Guardian thinks it is warranted.

Recommendation 5.26
That, following the establishment of the Department of Child Safety, discussions be held between the State Coroner and the relevant investigative agencies, with a view to developing protocols and other working arrangements directed to determining who is to be the lead investigative agency in different cases and how information can be appropriately exchanged between agencies.

Recommendation 5.27
That a new review body – called the Child Death Review Committee (CDRC) – undertake detailed reviews of the DCS's internal and external case reviews.

Recommendation 5.28
That the jurisdiction of the Commission for Children and Young People be expanded to include the following roles:

- To maintain a register of deaths of all children in Queensland;
- To review the causes and patterns of death of children as advised by investigative agencies;
- Through a Child Death Review Committee, to review in detail all DCS case reviews, whether conducted internally or externally, regarding the deaths of children in care and those who had been notified to DCS, within three years of their deaths;
- To conduct broader research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable; and
- To prepare an annual report to the parliament and the public regarding child deaths.

Recommendation 8.4
That DCS compliance with the Indigenous child placement principle be periodically audited and reported on by the new Child Guardian.

This page is the annexure marked **"G"** to the affidavit of Elizabeth Fraser affirmed on 8 August 2012 before me

Signed: ……

Direct Costs for Community Visitor activities

Average cost per visit to location:	$232.20
Average cost per child visit:	$133.63
Average cost per service delivery issue:	$33.30
Average cost per visit to location in remote region:	$291.23
Average cost per visit to location in non-remote region:	$226.23
Average cost per visit to child in remote region:	$224.48
Average cost per visit to child in non-remote region	$127.07

The above figures are based on the operational data for Community Visitors for the first 6 months of the 2011-12 financial year.

A 'location' is a foster home or residential facility (site) where children who require a visit are placed or residing.

A 'child visit' is a visit to an individual child placed in a location, if several children are placed in a location they are counted as being visited separately.

The 'cost per visit' includes claims made by Community Visitors for arranging a visit, travelling to the location , conducting the visit itself, and time spent writing subsequent child and site reports.

An 'issue' includes time claims made by Community Visitors for advocating on behalf of young people, including raising concerns with relevant service providers, and recording the issue and outcomes.

A 'remote region' is an area away from urban or suburban areas. CVs typically have to travel longer distances to conduct the visit in remote regions.

A 'non-remote region' are the areas near or around urban/suburban areas.

commission for children and young people and child guardian

A better life for Queensland children

Queensland Child Guardian Key Outcome Indicators Update

Queensland Child Protection System 2008-11

Introduction - Key Outcome Indicators Framework (Jigsaw)

Introduction

The Commission for Children and Young People and Child Guardian is responsible for the independent monitoring of the child protection system in Queensland. The *Queensland Child Guardian Key Outcome Indicators Update: Queensland Child Protection System 2008–11* represents the Commission's latest analysis of the performance of the outcomes achieved for Queensland children and young people in need of protection.

This is the first major report released by the Commission in an interactive on-line format and is an important step that evidences a commitment to providing high-quality, up-to-date and readily accessible data and reports on matters pertaining to vulnerable and disadvantaged children. The move to a web-based publication will greatly enhance the Commission's ability to monitor, analyse and report on the performance of the child protection system.

A new feature of the interactive on-line report that assists with this understanding is the Commission's Performance Assessments. These are intended as a summary comment on the current functioning of the child protection system under each of the Key Outcome Indicators. The Commission's Performance Assessments are aimed at identifying strengths and weaknesses in service delivery, which will help service

providers and stakeholders to better identify and action priority areas.

Another feature of the on-line report is the interactive nature of the graphs. Clicking on the legend within the graph enables various elements of the data to be highlighted.

Key Outcome Indicator Framework (Jigsaw)

The Key Outcome Indicators (represented in the Jigsaw below) provide a comprehensive framework for examining the experiences of children and young people in the child protection system. They represent the desired safety and wellbeing outcomes for children and young people who come into contact with the child protection system. The Commission developed this monitoring framework in 2005, and has reported annually on each of these outcome indicators. These annual reports can be accessed at: **http://www.ccypcg.qld.gov.au/resources/publications/reports.html**

Each piece of information that informs these indicators adds value to understanding how children and young people reliant on this service system are faring. Combined, these indicators provide an informative picture about what we hear, what we see and what we have learned about children and young people in the child protection system.

The Commission uses this information to identify and advocate where improvements to service delivery to these children and young people needs to occur. The Commission analyses and publishes this evidence so that stakeholders who are directly responsible for the child protection services can better understand its positive and negative impacts on children and young people and direct efforts where required.

The performance assessments are determined as follows:

Child Guardian Performance Assessment Indicator (Green)

The child protection system is performing well across this key outcome indicator and any areas for improvement are being actioned appropriately.

Child Guardian Performance Assessment Indicator (Amber)

The child protection system is performing satisfactorily across this key outcome indicator. However, scope for improvement exists and the success of action being undertaken may not yet be evident.

Child Guardian Performance Assessment Indicator (Red)

The child protection system is performing below the expected standard and the corrective action being taken has not yet produced the desired result, creating risk of negative outcomes for children and young people.

- For information about the evidence base used by the Commission to inform the Indicators click here
- To view the Department of Communities' child protection data for Queensland click here
- To view the Australian Institute of Health and Welfares' national child protection data click here
- To view a profile of all Queensland children and young people in out-of-home-care click here

Significant gains have been made in relation to the delivery of child protection services since major reforms were undertaken in 2004. As such, scope exists to both recognise where these gains have improved outcomes for children and young people and to highlight where further effort is required.

Effective assessment

Measures	2008–09	2009–10	2010–11
Rate of children subject to Notifications (Departmental data)	20.0	18.3	17.8
Percentage of Investigation and Assessments commenced within the required timeframe (Departmental data)	30%	32%	32%
Percentage of Investigation and Assessments finalised within 60 days (Departmental data)	54%	56%	59%
Percentage of children subject to a Child Concern Report who experience a subsequent Notification within 12 months[1] (Departmental data)	17.2%	15.4%	NA

Performance assessment:

Despite significant efforts across the past eight years, which have succeeded in reducing the Investigation and Assessment backlog, the percentage of matters responded to and completed within Departmental benchmarks remains low and there have been relatively minor improvements evident in Investigation and Assessment response and finalisation rates over the past three years.

Departmental comment:

The Department advises that it is undertaking a range of initiatives to reduce the number of outstanding Investigation and Assessments, as well as developing a number of strategies to improve investigation commencement and completion times. Refer to Appendix E for the full Departmental response.

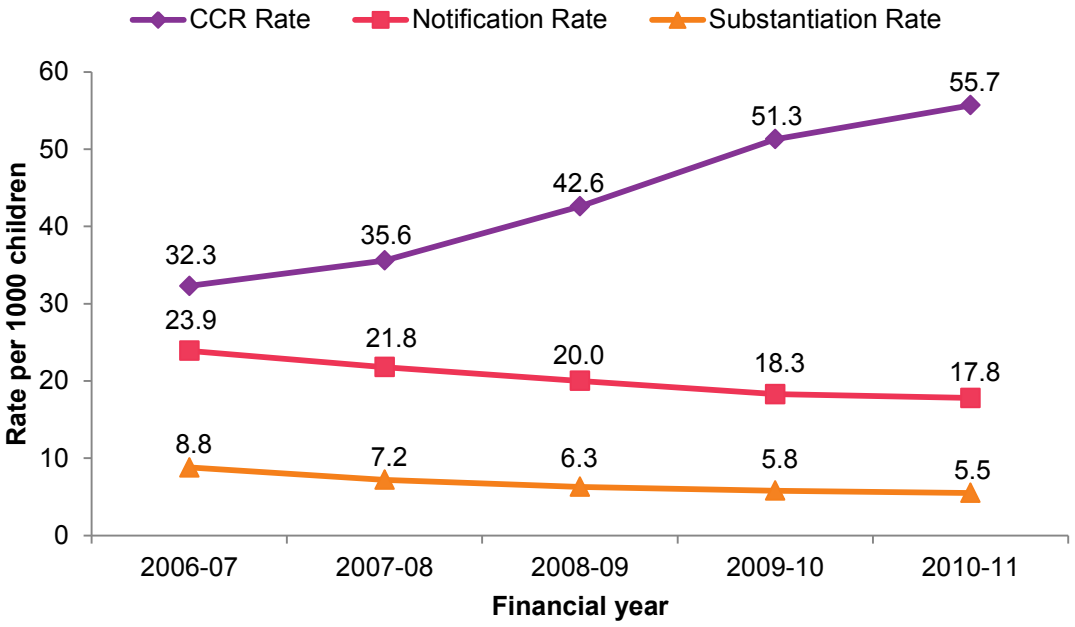
[1] This measure is the proportion of distinct children subject to a child concern report in a financial year who were the subject of a subsequent child concern report or notification within a period of 12 months. Data for 2010–11 will not be available until 12 months after the end of 2010–11.

Child Concern Reports, Notifications and Substantiations

Latest level and trends

There has been an increase in the rates of Child Concern Reports (CCRs) and a steady decrease in the rates of Notifications and Substantiations since 2006–07.[2]

Rate of CCRs, Notifications and Substantiations per 1000 children in 2006–11



[2] The reasons for the differences over time in Notification rates could reflect modifications to assessment and recording practices at intake. For example, in March 2007, the implementation of the Integrated Client Management System (ICMS) meant that any additional concerns received relating to an open investigation were recorded as additional concerns linked to the original Notification. Previously, any new concerns were recorded as an additional Notification.
Historical data was taken from the Child Guardian Report: Child Protection System 2009–10. 2010–11 populations were sourced from ABS Estimated Resident population (Customised report). Note that these are the most current at time of drafting but are preliminary populations and will be subject to change in the future.

Investigation and Assessments commenced within the required timeframe

Latest level and trends

The Investigation and Assessments (I&As) that were allocated an immediate 24-hour response timeframe continued to be prioritised in 2010–11. Achievements against benchmarks for responding to 5 day and 10 day I&As continue to be low.[3]

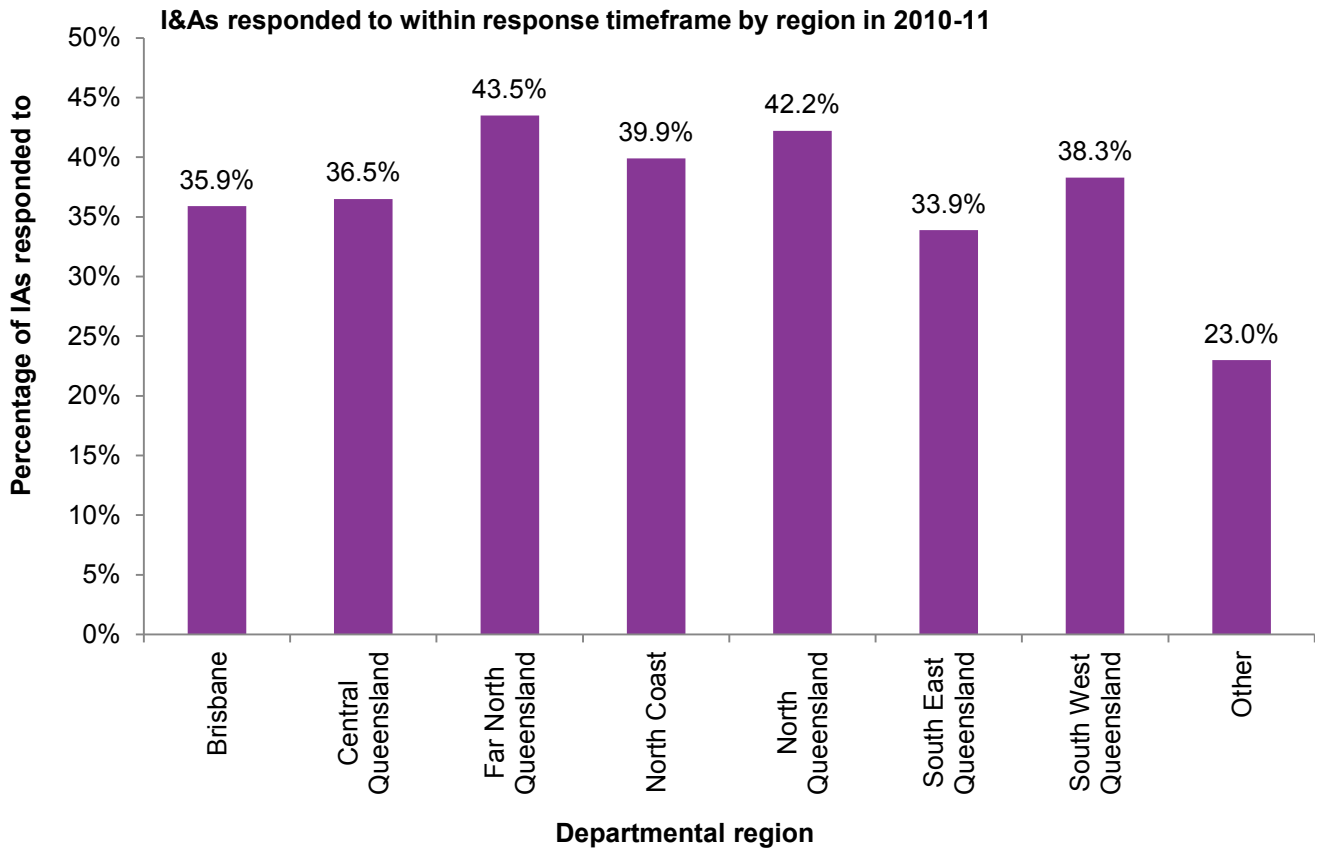
I&As commenced within the allocated response timeframe in 2008–11

Response timeframe	Number of IAs in 2008–09	I&As commenced within response timeframe 2008–09		Number of IAs in 2009–10	I&As commenced within response timeframe 2009–10		Number of IAs in 2010–11	I&As commenced within response timeframe 2010–11	
24-hour	6462	4520	70%	5151	3927	76%	4763	3776	79%
5 days	6258	1159	19%	6203	1380	22%	6238	1439	23%
10 days	10,673	1344	13%	10,531	1620	15%	10,654	1791	17%
All allocated timeframes	**23,393**	**7023**	**30%**	**21,885**	**6927**	**32%**	**21,655**	**7006**	**32%**

[3] The denominator for the 2008–09, 2009–10 and 2010–11 percentages includes all Investigation and Assessments, including those where the commencement date is not recorded (20%), and therefore assumes that none of these notifications have commenced. Removing these from the count would raise the percentage of those commenced within the allocated timeframe to 40% (up from 32%) and those not commenced within the allocated timeframe to 60% (up from 48%).

Regional differences

Far North Queensland and North Queensland had the highest compliance with response timeframes required for all I&As in 2010–11, at 43.5% and 42.2% respectively.[4]



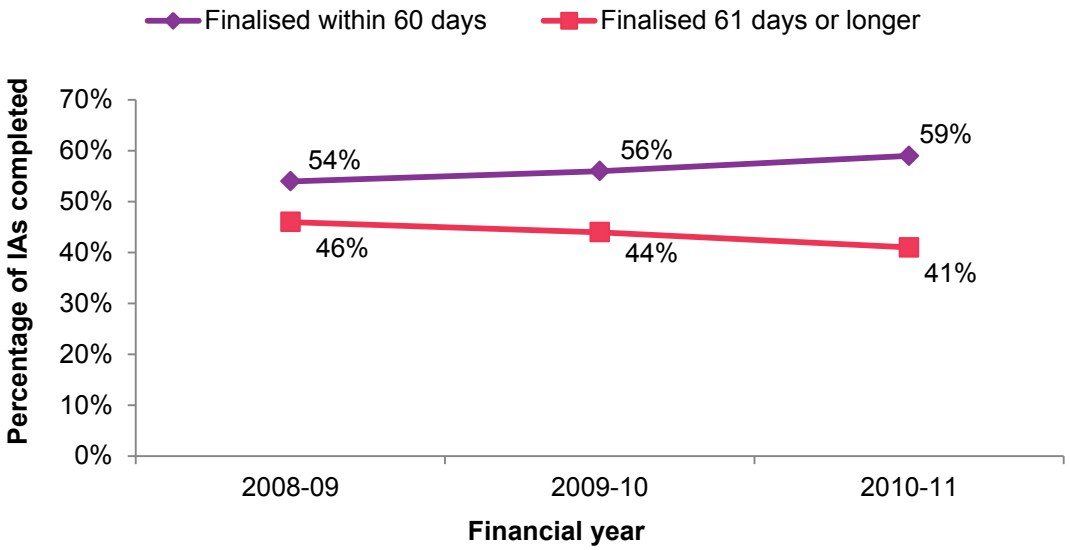
4 „Other' can include units such as the Child Safety After Hours Service Centre or interstate cases.

Investigation and Assessments finalised within 60 days

Latest level and trends

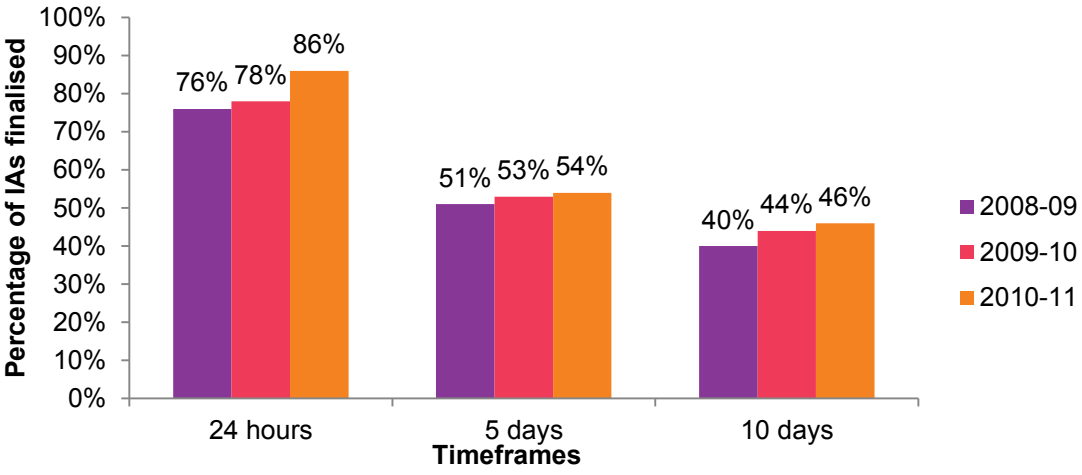
Overall, 59% of I&As were finalised within 60 days (the required completion timeframe) in 2010–11, increasing from 54% in 2008–09.[5]

I&As finalised within 60 days, 2008-11



The majority of 24-hour response I&As were finalised within 60 days (86%); just over half of the 5 day response I&As were completed within 60 days (54%); and just under half of the 10 day response I&As were completed within 60 days (46%). These percentages have increased slightly since 2009–10.

Percentage of I&As finalised within 60 days by response timeframe, 2008-11

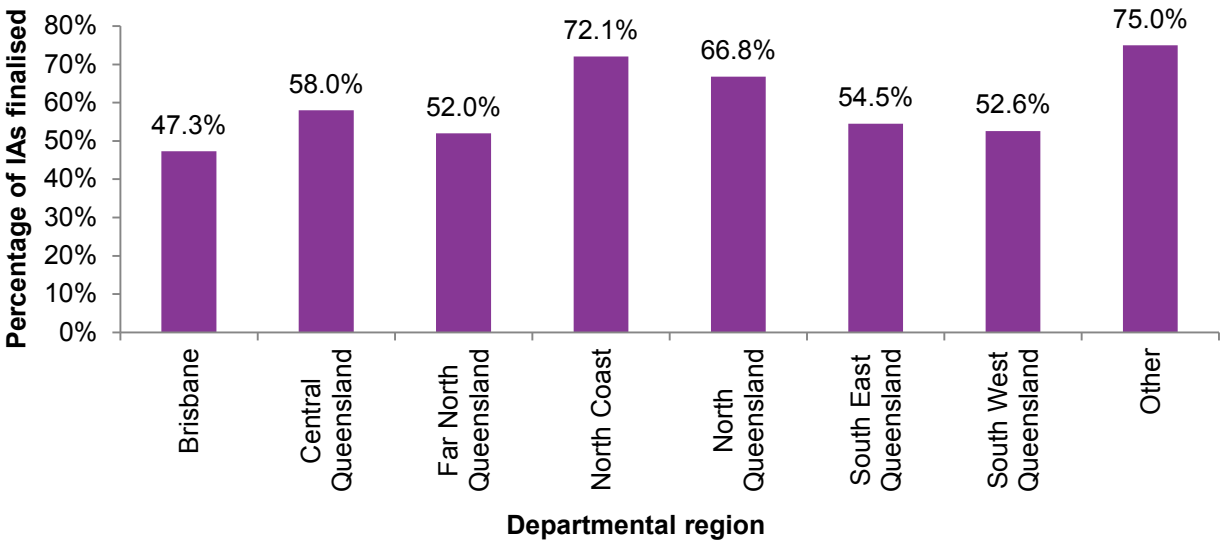


[5] The time taken to complete an Investigation and Assessment is calculated as the number of days between the date the Notification was received and the date the Investigation and Assessment was approved.

Regional differences

Brisbane had the lowest percentage of I&As finalised within 60 days (the required completion timeframe) in 2010–11, at 47.3%.[6]

I&As finalised within 60 days by region, 2010-11



[6] 'Other' can include units such as the Child Safety After Hours Service Centre or interstate cases.

Children subject to a Child Concern Report experiencing a subsequent Child Concern Report or Notification within 12 months

Latest level and trends

More than one in seven children subject to a CCR in 2009–10 were subject to a subsequent Notification within 12 months (15.4%). This is a decrease from 2008–09 where one in six children subject to a CCR were subject to a subsequent Notification within 12 months (17.2%).

Children subject to a subsequent CCR or Notification within 12 months

Distinct children subject to a CCR in 2009–10 and a subsequent CCR within 12 months	
Number	21,403
Percentage	**38.9%**
Distinct children subject to a CCR in 2009–10 and a subsequent Notification within 12 months	
Number	8493
Percentage	**15.4%**
All children subject to a CCR in 2009–10	**55,081**

Appropriate interventions

Measures	2008–09	2009–10	2010–11
Rate (per 1000) of Queensland children in out-of-home care (Australian Institute of Health and Welfare data)	6.7	6.8	7.0
Number of families engaging with Referral for Active Intervention services following referral (Departmental data)	980[7]	1824	1879
Number and percentage of families who exhibit improvements in presenting factors at exit from Referral for Active Intervention services (Departmental data)	484 (95% of those with a completed case plan)	622 (90% of those with a completed case plan)	752 (80% of those with a completed case plan)

Performance assessment:

The rate of Queensland children in out-of-home care (7.0 per 1000) remains below the national average of 7.3 per 1000 children (as at June 2011). Aboriginal and Torres Strait Islander children and young people continue to be over-represented in the child protection system. Further, the percentage of families demonstrating an improvement in primary presenting factors, secondary presenting factors, or both decreased by 10% (from 2009–10 to 2010–11).

Departmental comment:

The Department advises that it is responding to the over-representation of Aboriginal and Torres Strait Islander children in the child protection system through actioning the state government *Blueprint for Implementation Strategy: Reducing the over-representation of Aboriginal and Torres Strait Islander children in Queensland's Child Protection System*, as well as by responding to recommendations arising out of Commission audits of Departmental compliance with the *Indigenous Child Placement Principle* (conducted in 2008 and 2010). Refer to Appendix E for the full Departmental response.

[7] This figure is based on data relating to 10 RAI services in Queensland (the 11th service commenced at the end of 2008-09 and data was not available from this service in the period). Not all of the RAI services commenced regular data entry using the RAI-IS database until January 2009. As a result, annualised estimates have been provided for 2008/09.

Children in out-of-home care

Latest level and trends

As at 30 June 2011, 7.0 per 1000 Queensland children were in out-of-home care.[8]

The table below outlines the rates of children in Queensland subject to different levels of intervention in the child protection system in 2010–11 and the percentage change in the number of children subject to the same level of intervention in 2009–10.

The most noticeable change relates to the 9.9% increase in children subject to a Child Concern Report from 2009–10 to 2010–11.

Representation of children in the Queensland child protection system in 2010–11

Distinct number of children	Number	Rate per 1000	Percentage change (2009–10 to 2010–11)
1. Subject to an Intake	71,164	65.4	6.1%
2. Subject to a Child Concern Report	60,553	55.7	9.9%
3. Subject to a Notification	19,353	17.8	-1.4%
4. Subject to a Substantiation	5941	5.5	-4.5%
5. Subject to an IPA*[9]	1956	1.8	-24.2%
6. Subject to protective orders[10]*	8456	7.8	4.5%
7. Living away from home*[11]	8063	7.4	3.3%

*As at 30 June 2011

[8] Australian Institute of Health and Welfare 2011. *Child protection Australia 2010–11*. Child welfare series no. 53. Cat. No. CWS 41. Canberra: AIHW.
[9] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS) took place. This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.
[10] This measure includes all children subject to short and long-term child protection orders and court assessment orders.
[11] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.

Aboriginal and Torres Strait Islander status

Aboriginal and Torres Strait Islander children were significantly over-represented at each stage of intervention in the child protection system in 2010–11.

Representation of children in the Queensland child protection system, by cultural status, 2010–11

	Aboriginal and Torres Strait Islander children		Non-Indigenous children	
Distinct number of children	**Number**	**Rate per 1000**	**Number**	**Rate per 1000**
1. Subject to an Intake	13,433	191.7	57,731	56.7
2. Subject to a Child Concern Report	10,884	155.3	49,669	48.8
3. Subject to a Notification	4953	70.7	14,400	14.1
4. Subject to a Substantiation	1731	24.7	4210	4.1
5. Subject to an IPA*[12]	744	10.6	1212	1.2
6. Subject to protective orders[13]*	3181	45.4	5275	5.2
7. Living away from home[14]*	3052	43.6	5011	4.9

*As at 30 June 2011

[12] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS) took place. This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.
[13] This measure includes all children subject to short and long-term child protection orders and court assessment orders.
[14] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.

Number of families engaging with Referral for Active Intervention services following referral

Latest level and trends

There has been a 16% increase in the number of families referred to Referral for Active Intervention (RAI) services from 2009–10 (1861) to 2010–11 (2156).

However, the percentage of families demonstrating an improvement in primary presenting factors, secondary presenting factors, or both, decreased 10% from 2009–10 to 2010–11 (90% to 80% respectively).

Families referred and engaged in RAI services, 2009-11

RAI services	2009–10		2010–11	
	Number	Percentage	Number	Percentage
Families referred to RAI services				
Total number referred	1861	-	2156	-
Families engaging with RAI services				
Total number engaging	1824	-	1879	-
Improvement in presenting factors for families exiting from RAI services				
Improvement in primary presenting factors, secondary presenting factors or both	622	90%	752	80%
No change	70	10%	189	20%
Total completing case plans	692	-	941	-

Aboriginal and Torres Strait Islander status

The percentage of families referred to RAI services that were Aboriginal and/or Torres Strait Islander has remained relatively consistent over the past two years (17% in 2009–10 and 16% in 2010–11).

Aboriginal and Torres Strait Islander families referred and engaged in RAI services 2009–11

RAI services	2009–10		2010–11	
	Number	Percentage	Number	Percentage
Families referred to RAI services				
Aboriginal and/or Torres Strait Islander	323	17%	349	16%
Total number referred	1861	-	2156	-
Families engaging with RAI services				
Aboriginal and/or Torres Strait Islander	423[15]	23%	395	21%
Total number engaging	1824	-	1879	-

[15] Families engaging with RAI services may have been referred in the previous year.

Safe out-of-home care

Measures	2008–09	2009–10	2010–11
Percentage of children in out-of-home care subject to a substantiated Matter of Concern[16] (Departmental data)	NA	2.8%	2.3%
Percentage of children and young people who felt safe in their current placement (Commission Views survey data)	97.5% (children) 98.6% (young people) [17]	NA	97.9% (children) 98.4% (young people)[18]
Percentage of Community Visitor reports resulting in an Issue of Concern (Commission Community Visitor data)	NA[19]	1.9%	1.4%

Performance assessment:
Children and young people continue to report feeling safe in out-of-home care and both Matters of Concern and Issues of Concern have decreased.

Departmental comment:

The Department advises that the safety and wellbeing of children in care is paramount and monitored regularly through a range of means. Further, procedures are in place to ensure that concerns identified about children in out-of-home care are actioned in an adequate and timely manner so as to reduce the possibility of any escalation of concerns. Refer to Appendix E for the full Departmental response.

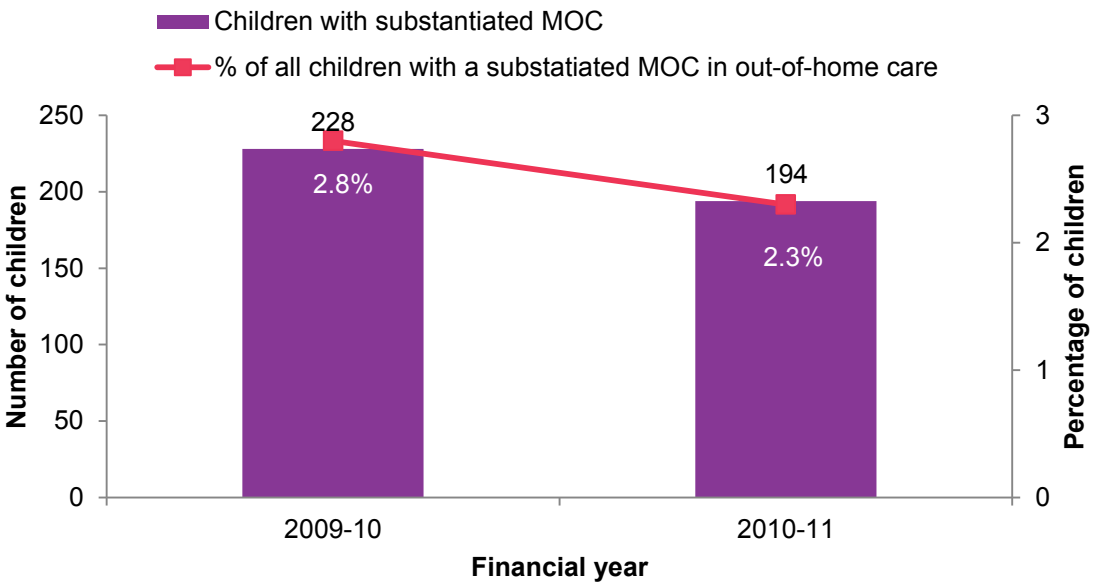
[16] From 2009-10 the department commenced improved reporting for this measure. Prior to 2009-10, the denominator for this measure referred to all children in out-of-home care, not just those children in the custody or guardianship of the Chief Executive to whom the Matter of Concern policy applies. Data for 2008-09 is therefore not comparable to 2009-10 and 2010-11.
[17] Data source: Commission for Children and Young People and Child Guardian. (2010). *Views of Children and Young People in Foster Care Queensland, 2010.* Brisbane.
[18] Data source: Commission for Children and Young People and Child Guardian. (2012) [forthcoming]. *The 2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings.* Brisbane.
[19] Note that the Commission changed its reporting system in November 2009, hence data for 2008-09 is not directly comparable to subsequent years.

Children in out-of-home care subject to a substantiated Matter of Concern

Latest level and trends

There has been a decrease in the number and percentage of children in out-of-home care with a substantiated Matter of Concern (MOC) over the past three years, down to 2.3% in 2010–11.

Number and percentage of children in out-of-home care who had a substantiated MOC, 2008-11

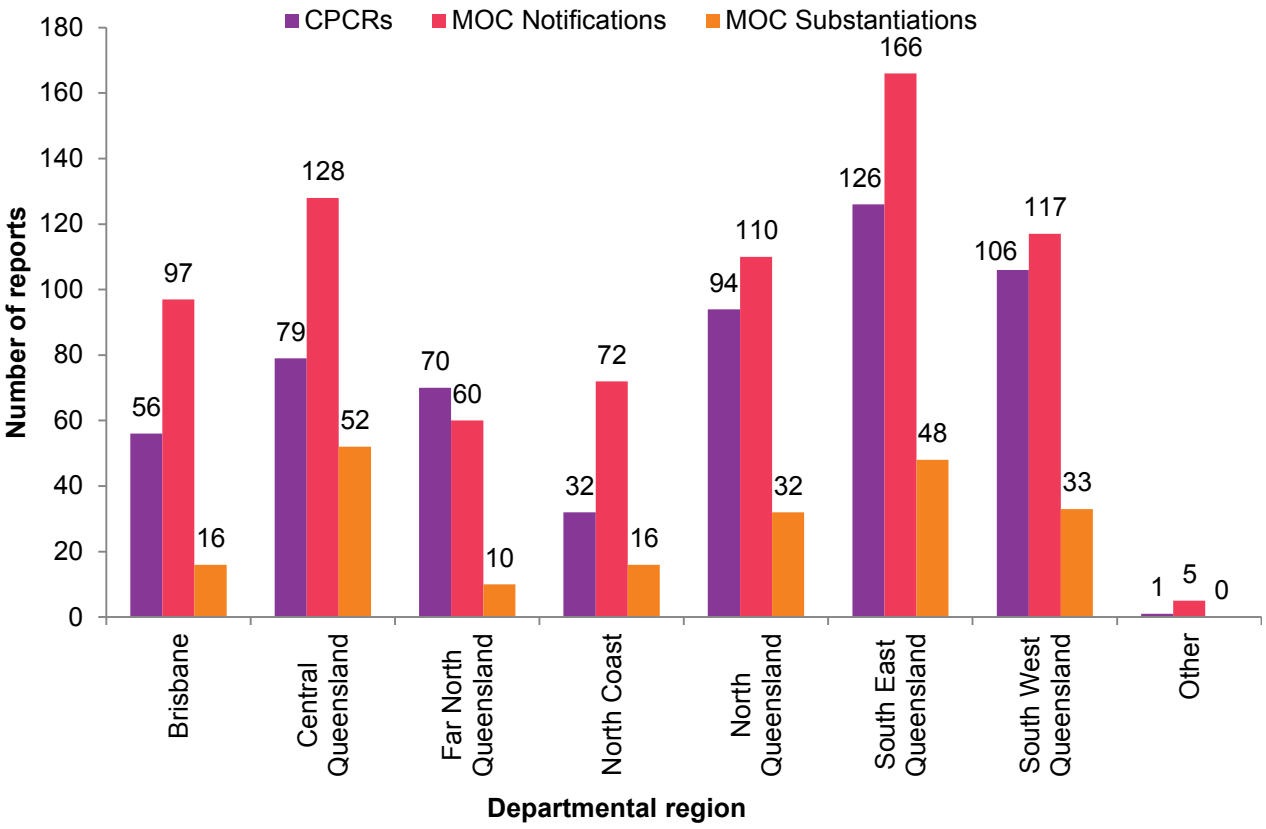


Regional differences

South East Queensland had the highest number of Child Placement Concern Reports (CPCRs) and MOC Notifications in 2010–11, a recurring trend from 2009–10.[20]

Central Queensland had the highest number of MOC Substantiations in 2010–11.[21]

CPCRs, MOC Notifications and MOC Substantiations for each region, 2010-11



[20] South East Queensland had the highest number of children in out-of-home care in 2009–10 and 2010–11.
[21] 'other' can include units such as the Child Safety After Hours Service Centre or interstate cases.

Children who felt safe in their current placement

Latest level and trends

Almost all of the children (97.9%) and young people (98.4%) who responded to the Commission's latest *2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings* reported feeling safe in their current placement.

These findings are consistent with those reported in the *Views of Children in Foster Care, Queensland, 2010* survey (Views survey), where 97.5% of children and 98.6% of young people reported feeling safe in their current placement.

As reported in the 2010 Views survey, the vast majority of young people also reported that their carer treats them well (99.3%) and the rules and discipline are reasonable (95.2%).[22]

Similar proportions of children responded „Yes' to the questions "Is your carer nice to you?" (97.8%) and "Are the rules here fair?" (92.3%).

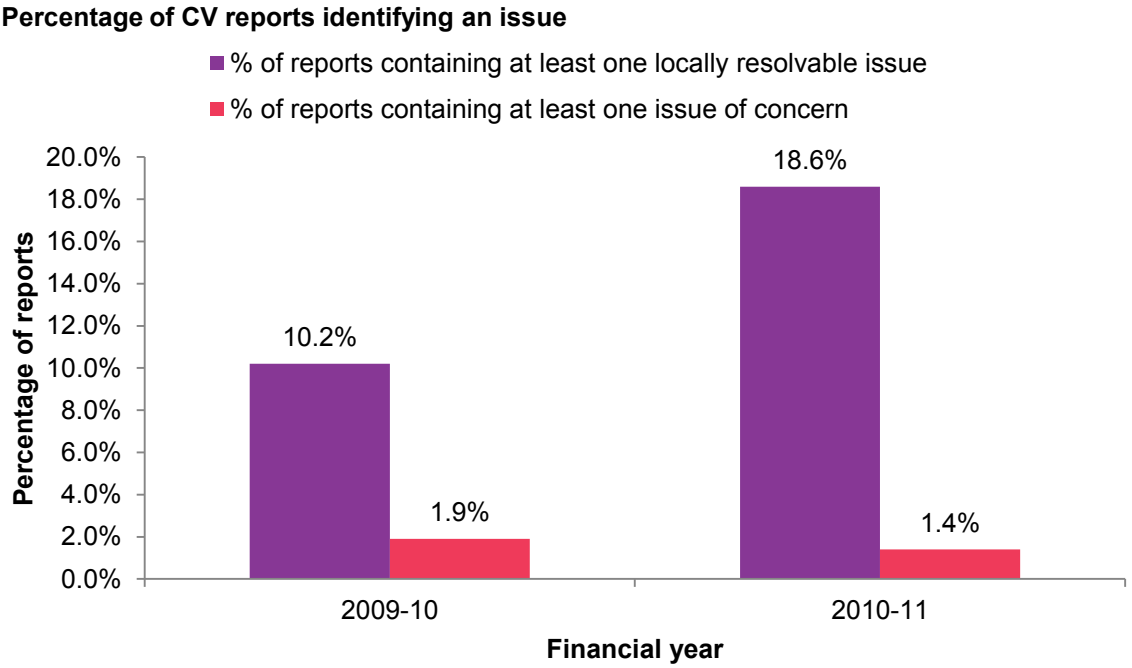
When asked "What is the best thing about their placement?" many children referred to feeling safe.

[22] This section refers to data collected from the Commission's *Views of Children in Foster Care, Queensland, 2010*. Updated data will be released in the forthcoming *2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings* (2012).

Issues of concern identified by Commission Community Visitors

Latest level and trends

In 2010–11, Commission Community Visitors (CVs) completed 40,952 visit reports in relation to 7511 distinct children.[23] 1.4% of visit reports identified a Serious Issue, and 18.6% of visit reports identified a Locally Resolvable Issue.[24]



[23] The figures of 40,952 reports and 7511 distinct children exclude detention centres, so may differ from figures reported elsewhere.

[24] The majority of issues of concern are generated through the CV function, if, as a part of their regular visiting to children and young people in care, they come across significant safety and/or wellbeing issues impacting on the child or young person. The issue is classified as either a Serious Issue or a Locally Resolvable Issue. The distinction between the two classifications is explained below. Serious Issues are those which require immediate referral to a relevant agency (relevant agencies include the Department of Communities (Child Safety), Queensland Police Service and the Crime and Misconduct Commission) under section 25 or Chapter 4 of the *Commission for Children and Young People and Child Guardian Act 2000.* These relate to:

- a child or young person who is or may be in need of protection
- a child or young person who is or may be the victim of a criminal offence, and
- a service delivery issue significantly impacting on a child or young person's wellbeing and development which remains unresolved after two months of advocacy.

Locally Resolvable Issues are those which can be addressed by CVs using their functions as outlined in Chapter 5 of the *Commission for Children and Young People and Child Guardian Act 2000*, and are typically service delivery issues significantly impacting on a child or young person's wellbeing and development. A Locally Resolvable Issue could include instances where a child is significantly impacted by not having access to appropriate dental care, education support or contact with family. Action taken in response to these issues is known as local resolution, which describes a range of activities undertaken by CVs to raise and seek resolution for issues, concerns or grievances impacting on a child or young person's wellbeing or development, with appropriate stakeholders who have the responsibility and capacity to take action to address it.

Best health possible

Measures	2008–09	2009–10	2010–11
Percentage of young people who reported having a health issue that they were concerned about (Commission Views survey data)	12.1%[26]	NA	8.5%[27]
Of these young people, the percentage that reported they had seen someone about their problem[25] (Commission Views survey data)	67.2%	NA	73.3%
Percentage of children who reported having an unmet health need (Commission Community Visitor data)	NA	6%	4%
Number of children in out-of-home care who received National Disability Agreement services (Departmental data)	383	376	NA[28]
Number of children in out-of-home care with a child health passport (cumulative count)[29] (Departmental data)	2645[30]	NA[31]	NA[32]

Performance assessment:
Commission Community Visitors have identified children with unmet health needs. The lack of Departmental child health passport data, indicating health needs assessments and planning are occurring, creates concerns in relation to this indicator.

Departmental comment:

The Department advises that they will continue to ensure that children and young people's health needs, including their dental needs, are met through quality health assessments and planning. They further advise that November 2011 changes to the Integrated Client Management System will lead to the future capture of all health information for children in out-of-home care, including details regarding the development of a child health passport. Refer to Appendix E for the full Departmental response.

[25] Data source: Commission for Children and Young People and Child Guardian. (2010). *Views of Children and Young People in Foster Care Queensland, 2010.* Brisbane.
[26] A total of 1180 surveys were completed by young people in care and analysed in the *Views* data
[27] Data source: Commission for Children and Young People and Child Guardian. (2012). [forthcoming]. *The 2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings.* Brisbane.
[28] Data not available until September 2012.
[29] This is a cumulative count of children who have had a health plan/assessment completed since commencement of the requirement in January 2007, and not a point-in-time count of children with a current health plan.
[30] At 30 June 2009.
[31] The Department is unable to report this data. The Department has advised that in August 2009, new ICMS fields were introduced to capture data on Child Health Passports. However, it will take some time for data from these news fields to be recorded. Once data becomes available, it will be subject to assessment and validation before the measure can be implemented.
[32] Ibid. However, the Department has advised its operational (non-public) data is showing high levels of implementation.

Young people who have health problems they are concerned about

According to the Commission's latest *2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings*, 8.5% of young people aged 9 – 18yrs in care who completed the survey stated that they had a health problem they were concerned about. Furthermore, 73.3% of young people stated that they had seen someone about it.[33]

For the previous *Views of Children and Young People in Foster Care Queensland, 2010* survey, 12.3% of young people aged 9 – 18yrs in care who completed the survey stated that they had a health problem that they were concerned about. Of these, 67% stated that they had seen someone about it.[34]

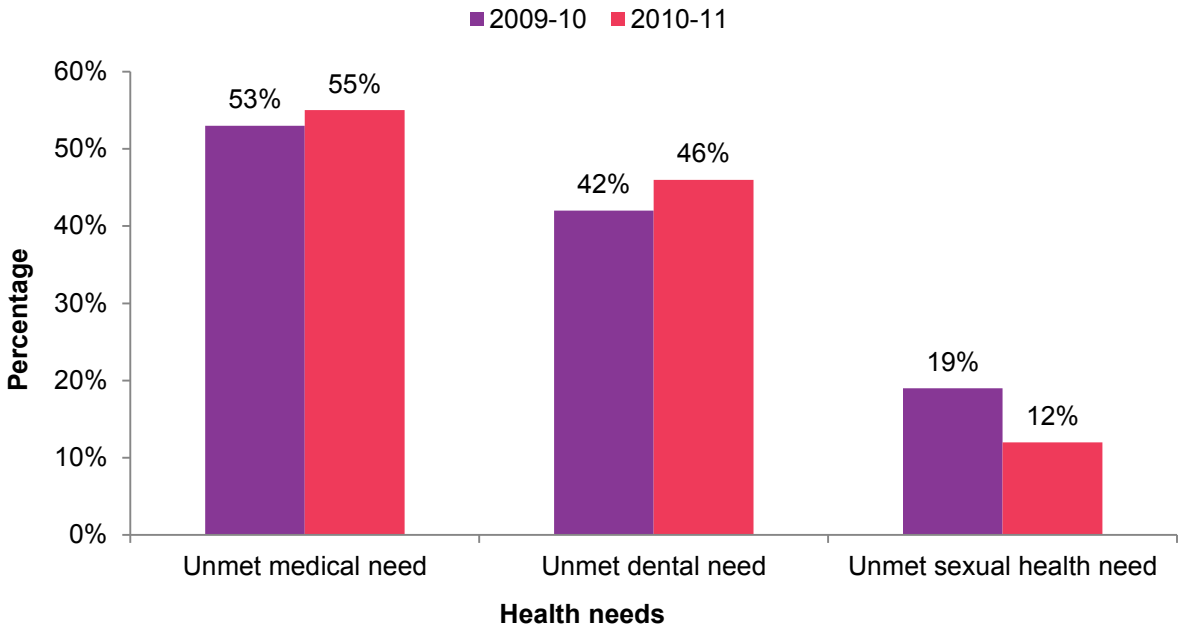
[33] Data source: Commission for Children and Young People and Child Guardian. (2012) [forthcoming]. *The 2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings*. Brisbane.
[34] Data source: Commission for Children and Young People and Child Guardian. (2010). *Views of Children and Young People in Foster Care, Queensland, 2010.* Brisbane.

Children who had an unmet health need

Latest level and trends

Commission Community Visitor (CV) reports identified that approximately 4% of children had an unmet health need in 2010–11.[35] Of these, a little more than half related to medical needs (55%), a similar finding to 2009–10.[36]

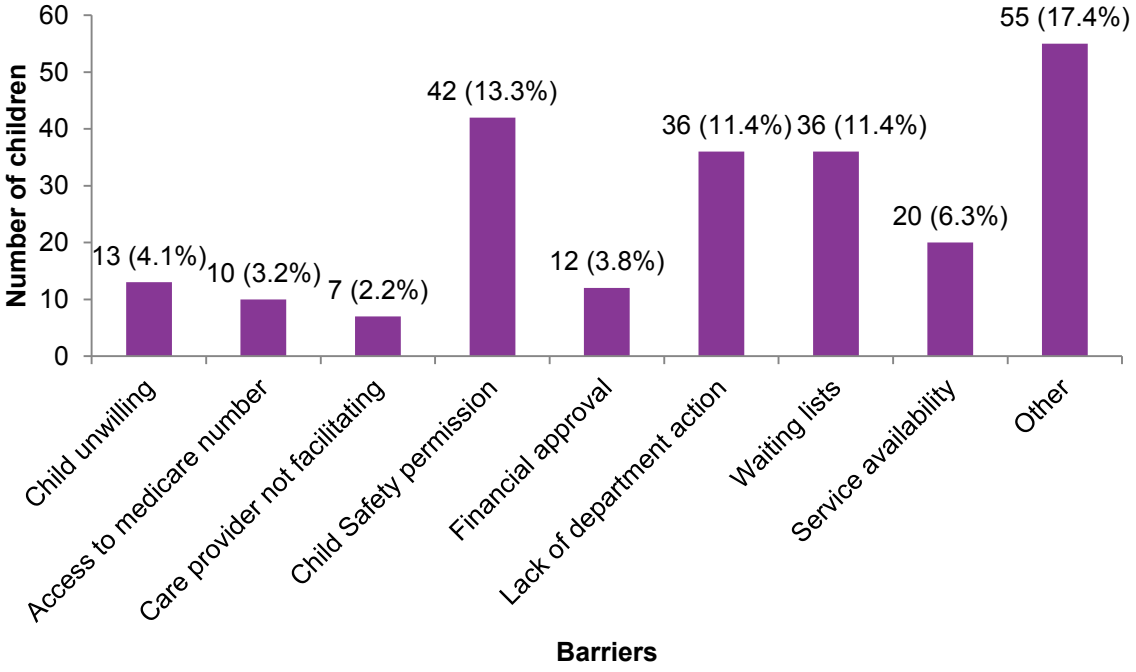
CV reports identifying that a child had unmet health needs, 2009–11



The graph below shows that obtaining the permission of Child Safety was identified as the most common barrier preventing health needs from being addressed in 2010–11 (13.3%).[37] This is a recurring theme, as it was the second most commonly identified barrier in 2009–10 (13%).

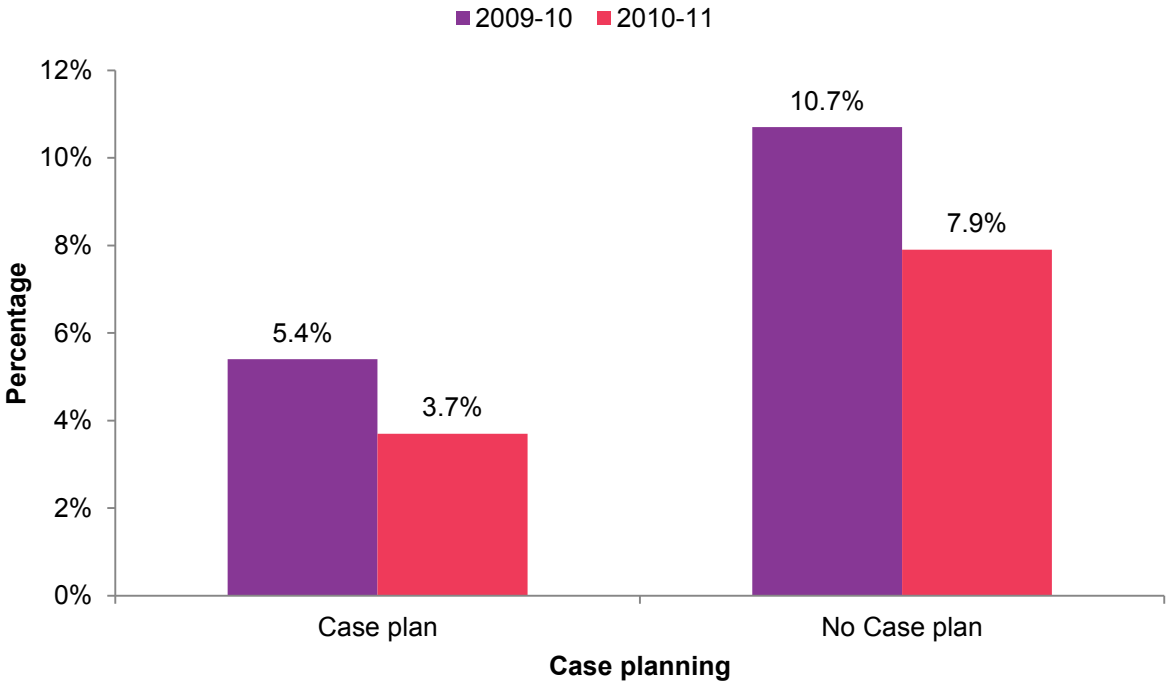
[35] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 7175 valid responses to this question.
[36] More than one issue was identified for some children.
[37] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 231 barriers identified.

CV reports that identified barriers to the child's health needs being met, 2010–11



The graph below shows that children for whom CVs reported as having no case plan in 2010–11 were twice as likely to have a reported unmet health need, a similar finding to 2009–10.[38]

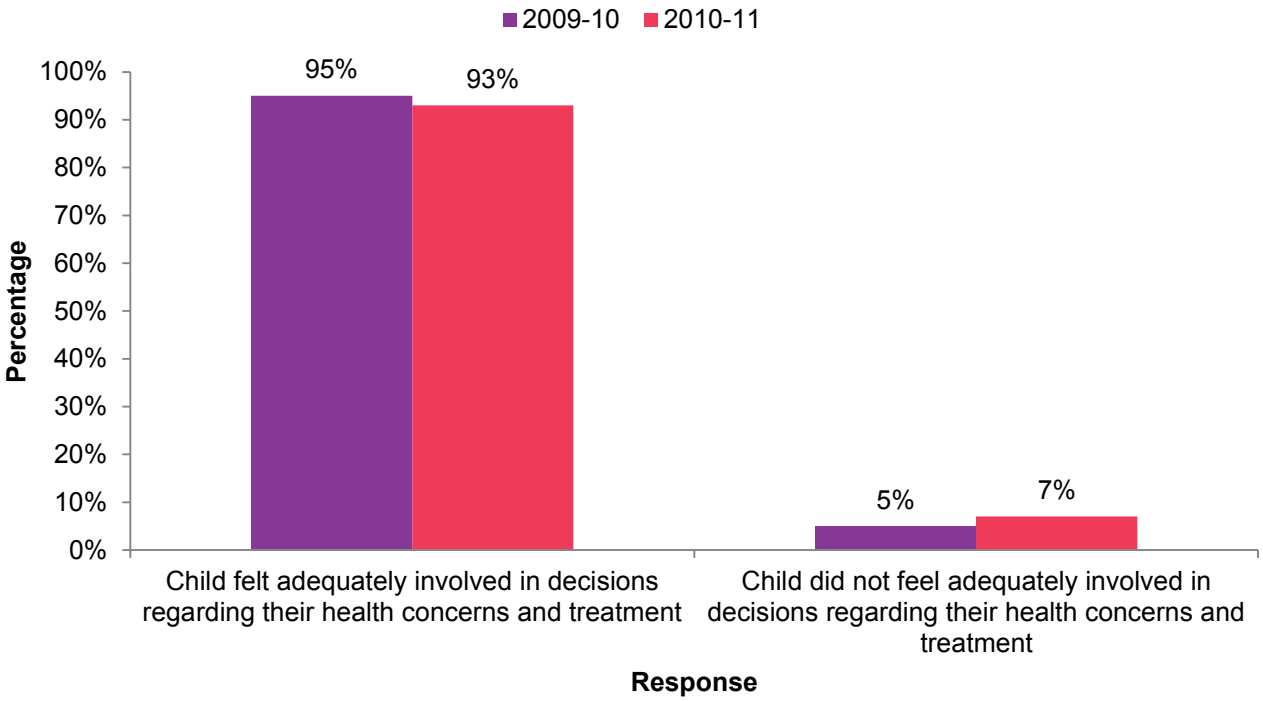
CV reports that identified the child had unmet health needs, by whether they also had a reported case plan, 2009–11



[38] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 4818 valid responses to this question for children who did have a case plan and a total of 329 valid responses to this question for children who did not have a case plan.

The graph below shows that approximately 93% of children told their CV that they felt adequately involved in decisions regarding their health concerns and treatment in 2010–11.[39] This is a slight decrease from 95% in 2009–10.

CV reports that identified that the child felt adequately involved in decisions regarding their health concerns and treatment, 2010–11



The table below shows that over 8% of children had unmet mental health or therapeutic needs in 2010–11 (8.2%), which is consistent with 2009–10.[40]

CV reports that identified that the child had unmet mental health or therapeutic needs, 2009–11

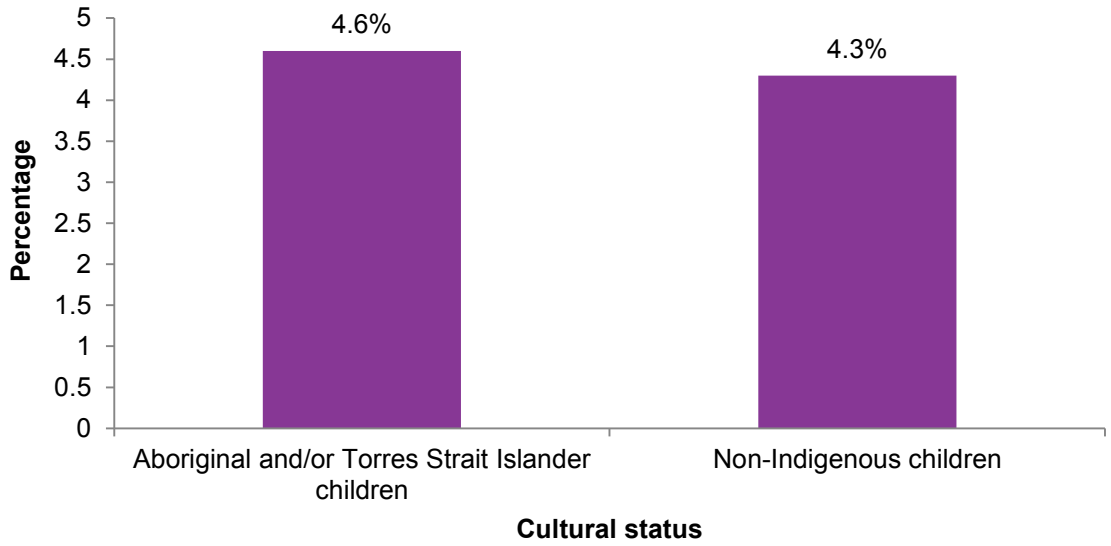
Measure	2009–10		2010–11	
	Number	Percentage	Number	Percentage
Children with unmet mental health or therapeutic needs	472	8.3%	519	8.2%

[39] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 1889 valid responses to this question.
[40] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 6327 valid responses to this question.

Aboriginal and Torres Strait Islander status

CV reports identified similar percentages of Aboriginal and Torres Strait Islander and non-Indigenous children having an unmet health need in 2010–11.[41]

CV reports that identified that the child had unmet health needs, by cultural status, 2010–11

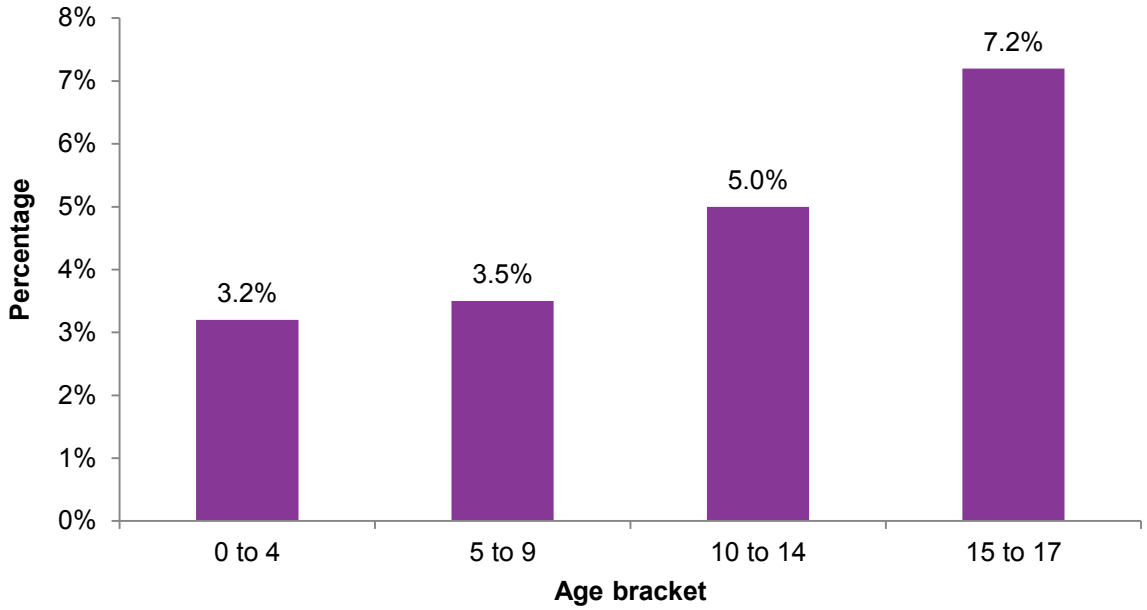


[41] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 2603 valid responses relating to Aboriginal and Torres Strait Islander children and 4572 valid responses relating to non-Indigenous children.

Age differences

CV reports identified that the percentage of children with unmet health needs in 2010–11 increased with each age group, with young people aged 15 to 17 experiencing the greatest percentage of unmet health needs (7.2%).[42]

CV reports that identified that the child had unmet health needs, by age, 2010–11



[42] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. The number of valid responses for each age category is as follows: 0–4 years – 1887, 5–9 years – 2192, 10–14 years – 1955, and 15–17 years – 1119.

Children in out-of-home care who received National Disability Agreement services

Latest level and trends

A total of 376 children subject to finalised child protective orders at any time during the 2009–10 year received a National Disability Agreement (NDA) service in the same period. [43]

	2008–09	2009–10	2010–11
Children subject to finalised protective orders who received a National Disability Agreement (NDA) service	383	376	NA [44]

[43] From 1 January 2009, the National Disability Agreement (NDA) replaced the Commonwealth State/Territory Disability Agreement (CSTDA) for the provision of disability services in Australia to assist and support people, including children and young people with a disability living in the community.
[44] Data not available until September 2012.

Age differences

There has been a significant increase over time in the percentage of children aged 16 years and over subject to finalised child protective orders at any time during the year that received a NDA specialist disability service (13.7% in 2005–06 to 38.0% in 2009–10).[45]

Age group (in years)	2005–06		2006–07[46]		2007–08		2008–09		2009–10		2010–11[47]	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
0 to 5	57	25.2	NA	NA	65	22.4	82	21.4	77	20.5		NA
6 to 12	88	38.9	NA	NA	101	34.8	108	28.2	102	27.1		NA
13 to 15	50	22.1	NA	NA	55	19.0	61	15.9	54	14.4		NA
16 and over	31	13.7	NA	NA	69	23.8	132	34.5	143	38.0		NA
Total	**226**	**100**	**NA**	**NA**	**290**	**100**	**383**	**100**	**376**	**100**		**NA**

[45] Counts may not add to total due to rounding.
[46] Data for 2006–07 were not available for reporting due to the transition to the Integrated Client Management System (ICMS).
[47] Data not available until September 2012.

Children in out-of-home care with a child health passport

Latest level and trends

Data on child health passports has been unavailable for reporting since 2008–09.

The Department of Communities (Child Safety Services) (the Department) has advised that:

"In August 2009, new ICMS fields were introduced to capture data on Child Health Passports. However, it will take some time for data from these new fields to be recorded. Once data becomes available, it will be subject to assessment and validation before the measure can be implemented."[48]

Recent advice provided to the Commission by the Department indicates that this data will become available from December 2012.

[48] Correspondence received on 2 August 2011.

Best education possible

Measures	2008–09	2009–10	2010–11
Percentage of eligible children with an Education Support Plan (Departmental data)	81%	83.4%	82.8%
Number of children in out-of-home care who participated in the National Assessment Program – Literacy and Numeracy tests for years 3,5,7 and 9 (Departmental data)	498[49]	NA[50]	NA
Percentage of children who have adequate resources to allow them to effectively engage in school (Commission Community Visitor data)	NA	96%	95%
Percentage of children who reported having experienced bullying (Commission Community Visitor data)	NA	9.4%	12.6%
Percentage of children who were suspended or excluded (Commission Community Visitor data)	NA	10.3%	13.6%

Performance assessment:
While the percentage of children with an Educational Support Plan is encouraging, their achievement levels according to the most recent NAPLAN data are significantly below their peers who are not in care. Suspensions and exclusions continue to be an issue for children and young people in care. It is also of concern that the percentage of children in care reporting experiences of bullying has risen. The data continues to show a high percentage of children and young people report having adequate resources to allow them to effectively engage in school.

Departmental comment:

The Department advises that it is collaborating with the Department of Education, Training and Employment to facilitate the collection and reporting of additional data on education outcomes for children in out-of-home care, as well as implementing a program to support foster carers in helping improve the literacy and numeracy of children in care. Refer to Appendix E for the full Departmental response.

[49] For 2008-09, this number broke down into 83 (year 3), 123 (year 5), 129 (year 7) and 163 (year 9) respectively.
[50] This is the latest data available from Department of Communities at the time of report publication

Eligible children with an Education Support Plan

Latest level and trends

As at August 2011, 82.8% of children in care had a completed Education Support Plan (ESP), a continuing trend from August 2010. A further 11% had an ESP in development.

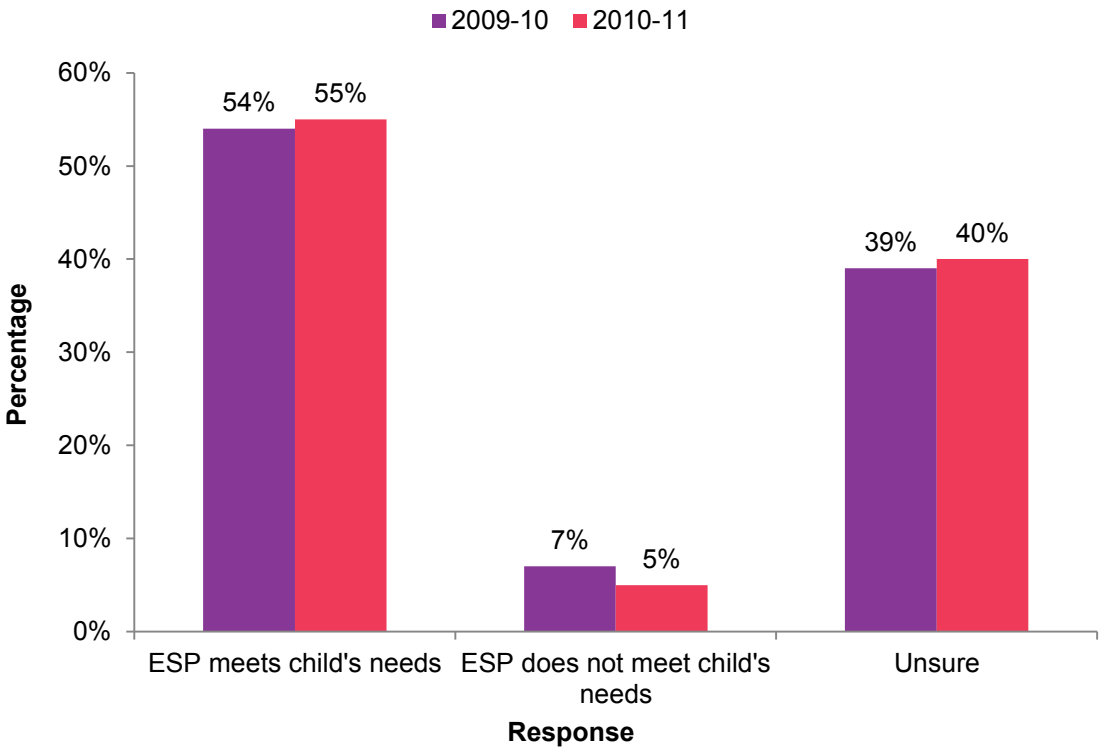
Children in out-of-home care enrolled in Queensland schools with an ESP [51] [52]

Measures	August 2010	August 2011
Total number of children in the care of the state enrolled in Queensland schools	4313	4064
Number of completed ESPs	3599	3372
Percentage of completed ESPs	83.4%	82.8%
Number of ESPs under development	489	441
Percentage of ESPs under development	11.3%	10.8%
Number of ESPs not commenced	225	253
Percentage of ESPs not commenced	5.2%	6.2%

Community Visitors (CVs) who engaged with children with an ESP in 2010–11 identified that 55% felt it met their education needs, a similar finding to 2009–10 (54%).[53]

[51] The Department of Education and Training advised, via correspondence received on 18 August 2011, that schools have one month from the time of enrolment of a child in care, or from when the Department of Communities (Child Safety) informs the principal that a child has been taken into care, in which to complete an ESP for the child. The Department of Education and Training advised that an ESP may not have been commenced because it is within the one month timeframe for completing the ESP, and/or it can be difficult to arrange meetings with a variety of professionals and foster parents to commence the ESP process.
[52] Percentages may not total 100% due to rounding.
[53] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 1827 valid responses to this question. (CVs may not have actually sighted the ESP, depending on whether the child and/or carer had a copy. In these cases, CVs rely on verbal information provided by the child and/or carer. Children and carers may be unfamiliar with the actual term or may not be aware that they are receiving extra assistance (e.g. where the funds are used to extend teach aide hours for specific intervention programs).

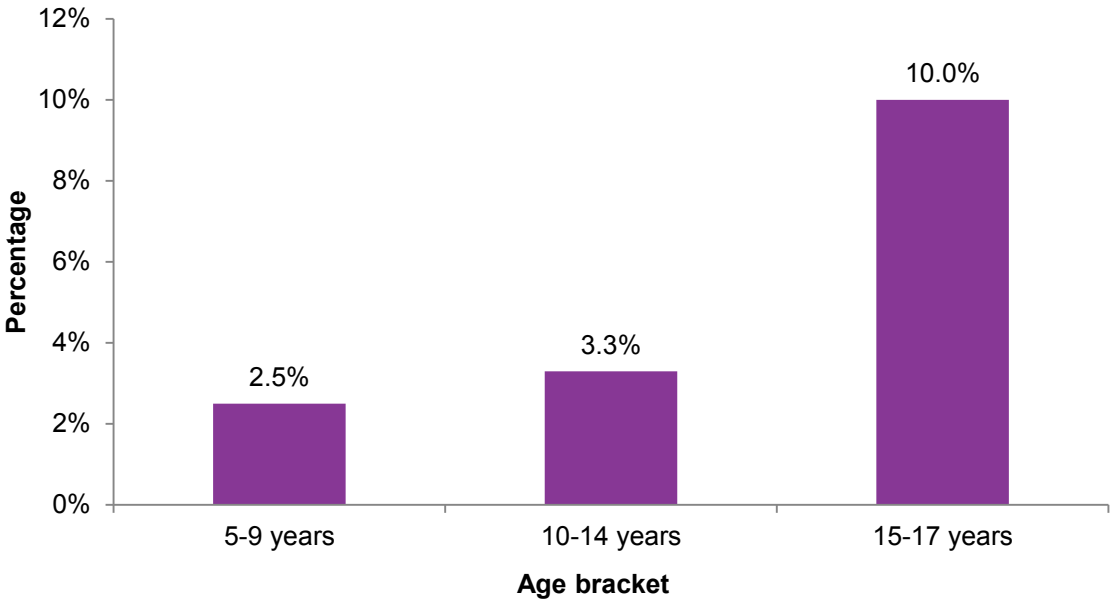
CV reports that identified that a child's ESP met their education needs, 2009-11



Age differences

Young people aged 15–17 years were more likely to report to CVs that their ESP did not meet their educational needs.[54]

Percentage of young people reporting to CVs that their ESP did not meet their education needs



[54] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. The number of valid responses for each age category is as follows: 5–9 years – 589, 10–14 years – 848, and 15–17 years – 390.

Children in out-of-home care who participated in the National Assessment Program – Literacy and Numeracy

Latest level and trends

Children in out-of-home care performed significantly poorer than Queensland students across all age groups and subject matter. In 2009, the overall performance of Queensland children in relation to reading, writing and numeracy was as follows:

- Reading – between 88.9% and 92.9% of year 3, 5, 7 and 9 students met the national benchmark
- Writing – between 85.4% and 93.9% of year 3, 5, 7 and 9 students met the national benchmark, and
- Numeracy – between 92.3% and 94.8% of year 3, 5, 7 and 9 students met the national benchmark.

The following table shows the significant contrast in performance of children in care in comparison to their peers.

Percentage of children in out-of-home care who were at or above the National Minimum Standard in 2008 and 2009, by year level.

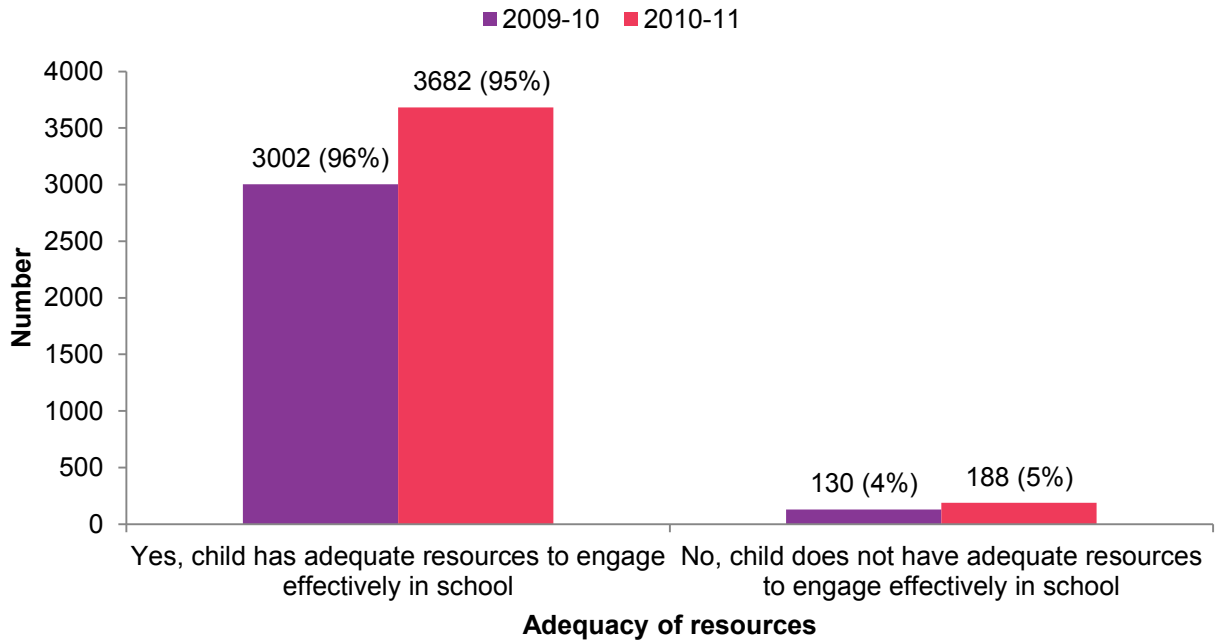
	Reading			Writing			Numeracy		
	2008	2009	Percentage point change	2008	2009	Percentage point change	2008	2009	Percentage point change
Year 3	65%	73%	8%	65%	71%	6%	69%	70%	1%
Year 5	51%	61%	10%	61%	53%	-8%	66%	71%	5%
Year 7	61%	70%	9%	58%	75%	17%	68%	78%	10%
Year 9	66%	52%	-14%	48%	50%	2%	72%	69%	-3%

Children who have adequate resources to allow them to effectively engage in school

Latest level and trends

CV reports showed that 3682 (95%) children reported having adequate resources to allow them to engage effectively in school in 2010–11, a similar finding to 2009–10 (96%).[55]

CV reports that identified that children had adequate resources to allow them to engage effectively in school, 2009-11



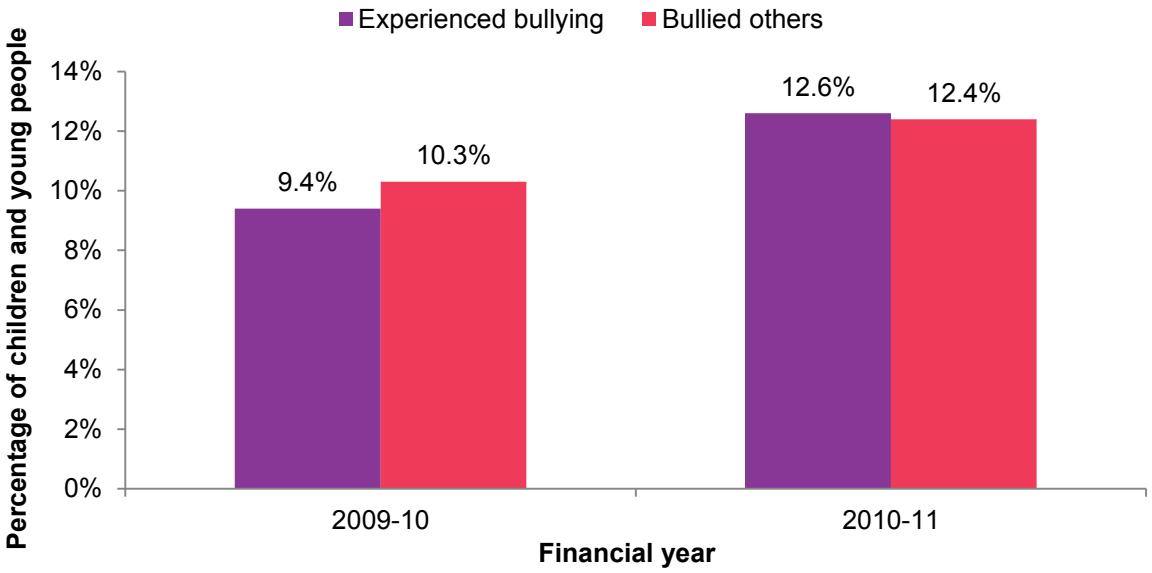
[55] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 3870 valid responses to this question for 2011 and 3132 for 2010. CVs assess the adequacy of resources depending on the individual characteristics and educational needs of the child. Adequate resources may include access to academic assistance, school equipment, a uniform, behaviour support, and transport.

Children who experienced bullying

Latest level and trends

In 2010-11, 12.6% of children reported to their CV that they were experiencing bullying[56] and 12.4% of children were bullying others.[57]

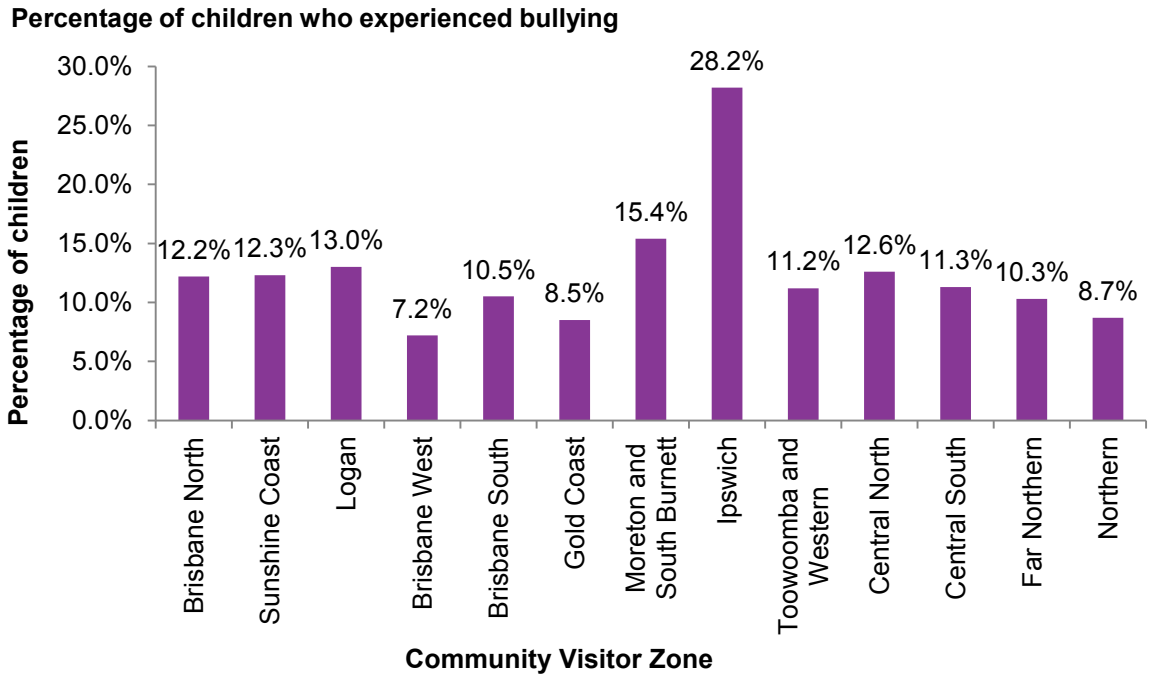
Percentage of children who reported experiencing bullying or who bullied others, 2009-11



[56] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 4212 valid responses to this question.
[57] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 4169 valid responses to this question.

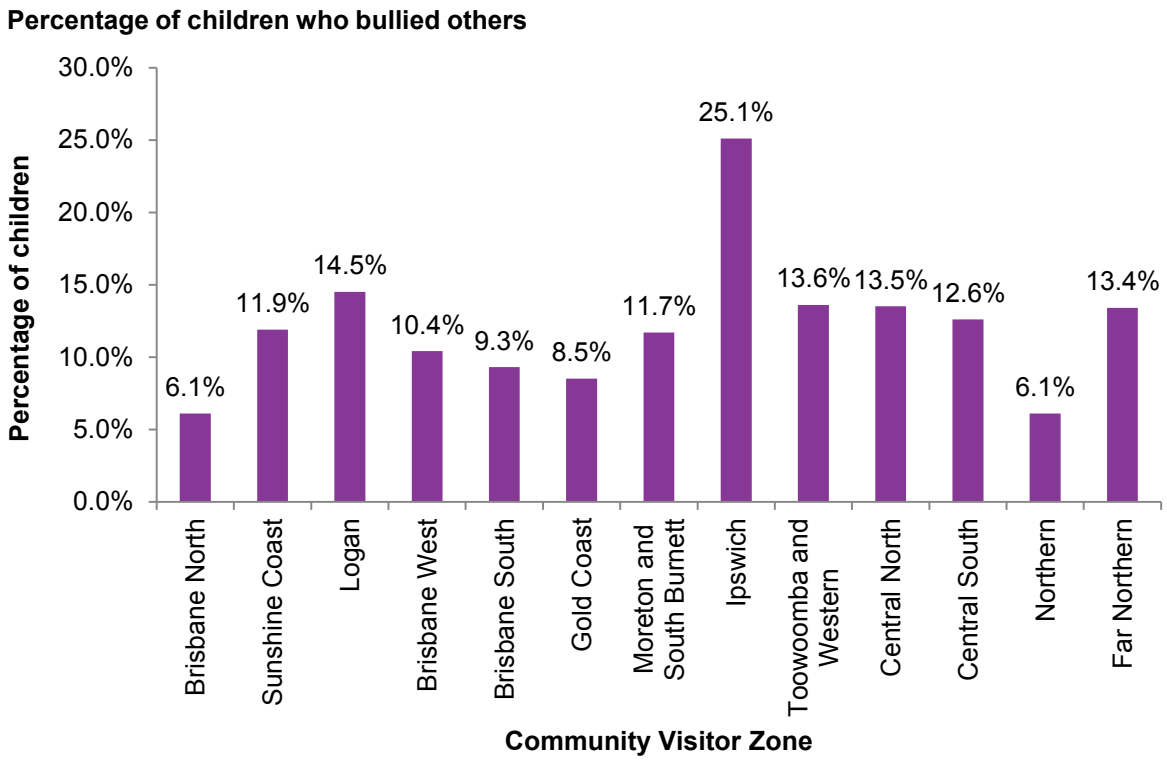
Regional differences

Reported instances of bullying were highest in the Ipswich Community Visitor Zone (28.2%), almost double that of Moreton and South Burnett (15.4%) [58]



[58] Data source: Commission. Community Visitor data. Information extracted from any of the child's report between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 4212 valid responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 245, Sunshine Coast – 236, Logan – 238, Brisbane West – 277, Brisbane South – 248, Gold Coast – 399, Moreton and South Burnett – 214, Ipswich – 425, Toowoomba and Western – 427, Central North – 334, Central South – 353, Northern – 378, and Far Northern – 438.

Reports of bullying others were highest in the Ipswich Community Visitor Zone (25.1%), followed by Logan (14.5%) [59]



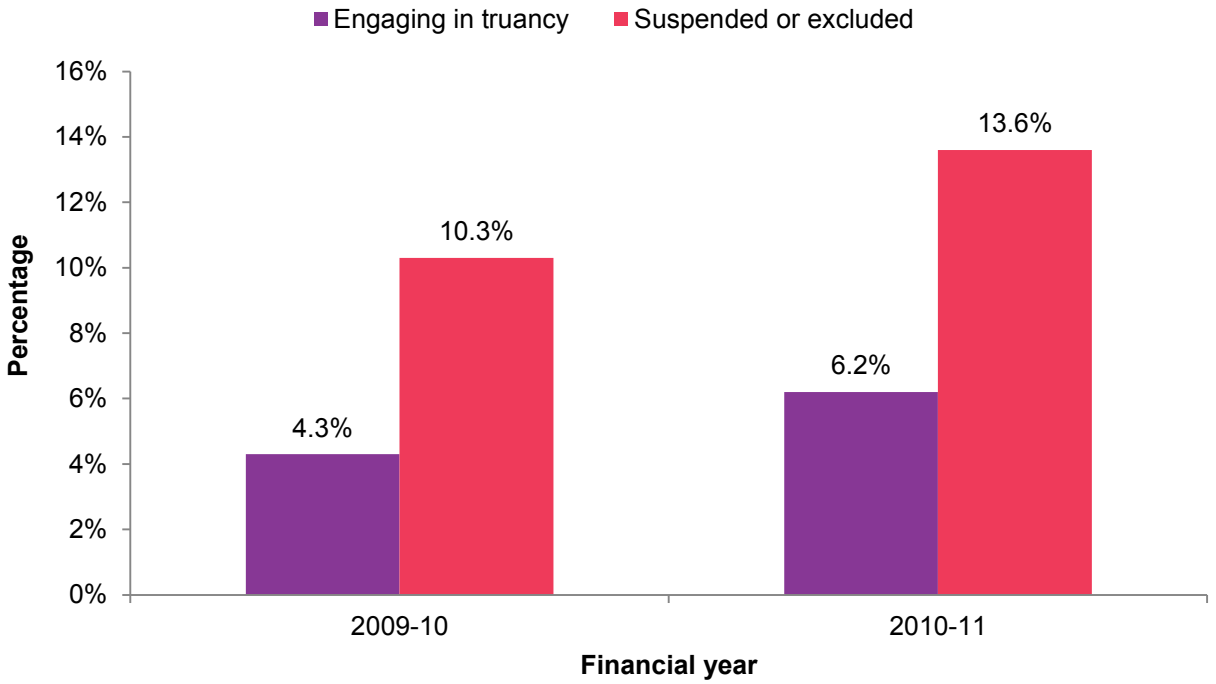
[59] Data source: Commission. Community Visitor data. Information extracted from any of the child's report between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 4169 valid responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 244, Sunshine Coast – 236, Logan – 234, Brisbane West – 279, Brisbane South – 247, Gold Coast – 399, Moreton and South Burnett – 214, Ipswich – 410, Toowoomba and Western – 412, Central North – 334, Central South – 350, Northern – 376, and Far Northern – 434.

Children who were suspended or excluded

Latest level and trends

Almost 14% of children were suspended or excluded from school in 2010–11, compared to 10.3% in 2009-10.[60]

Percentage of reported children engaging in truancy and being suspended or excluded, 2009-11

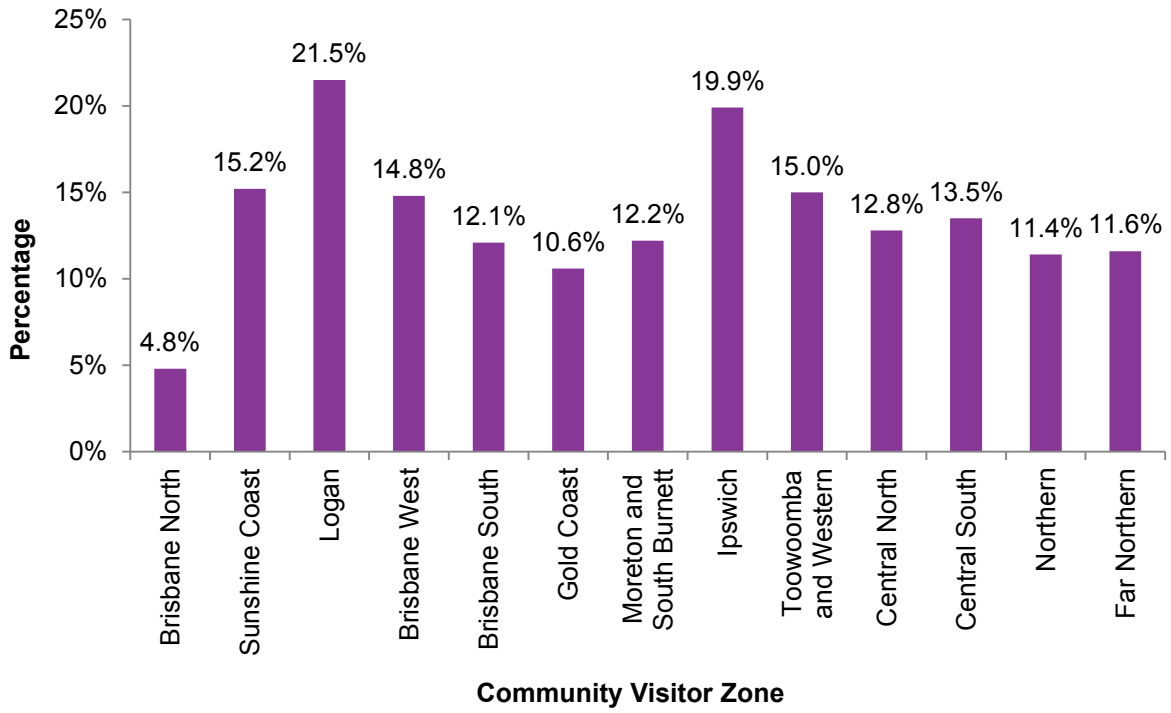


[60] Data source: Commission. Community Visitor data. Data gathered for suspension/exclusion figures were extracted from any of the child's reports between July 2010 and June 2011. Children aged 0–4 years were excluded from the analysis. There was a total of 4311 valid responses to this question.

Regional differences

The Logan Community Visitor Zone had the highest rate of suspensions/exclusions (21.5%), followed by Ipswich (19.9%). [61]

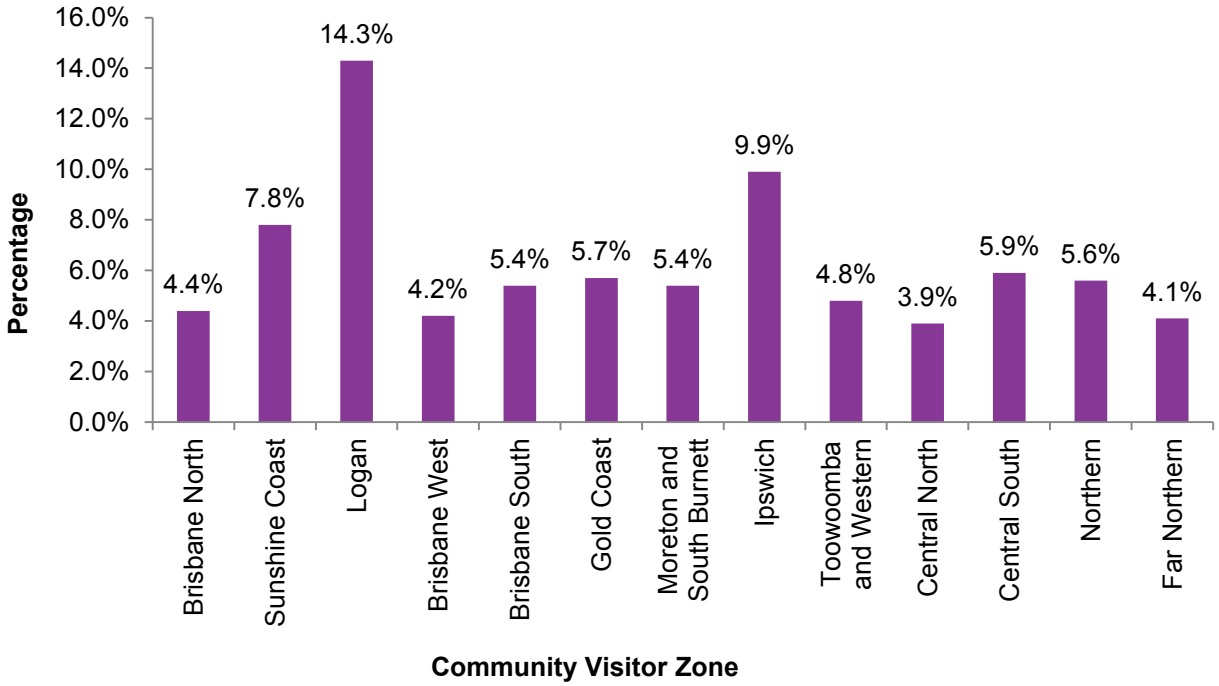
Percentage of reported children being suspended or excluded, 2010-11



[61] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There was a total of 4311 responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 251, Sunshine Coast – 243, Logan – 260, Brisbane West – 283, Brisbane South – 257, Gold Coast – 404, Moreton and South Burnett – 222, Ipswich – 443, Toowoomba and Western – 441, Central North – 335, Central South – 356, Northern – 376, and Far Northern – 440.

The Logan Community Visitor Zone also had the highest rate of truancy (14.3%), followed by Ipswich (9.9%). [62]

Percentage of reported children engaging in truancy, 2010–11



[62] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There was a total of 4307 responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 249, Sunshine Coast – 243, Logan – 259, Brisbane West – 283, Brisbane South – 258, Gold Coast – 404, Moreton and South Burnett – 223, Ipswich – 444, Toowoomba and Western – 440, Central North – 333, Central South – 355, Northern – 378, and Far Northern – 438.

Stable out-of-home care

Measures	2008–09	2009–10	2010–11
Percentage of children exiting care who had three or less placements during their time in care (Departmental data)	81%	78%	76%
Percentage of children exiting care who had seven or more placements during their time in care (Departmental data)	4.5%	4.5%	6.4%
Percentage of children who self-placed or absconded from their placement (Commission Community Visitor data)	NA[63]	4.6%	6.8%
Percentage of children who had contact with their Child Safety Officer in the last month (Commission Community Visitor data)	NA	80%	81%

Performance assessment:
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.

Departmental comment:

The Department advises the slight increase in the number of children who experience seven or more placements while in care may be partly attributable to recent trends for children to enter care at younger ages and spend longer periods of time in care. Further, it has implemented a range of initiatives to improve the stability of placements, including working to increase the size and diversity of the carer pool and promoting the increased use of kinship care where appropriate. Refer to Appendix E for the full Departmental response.

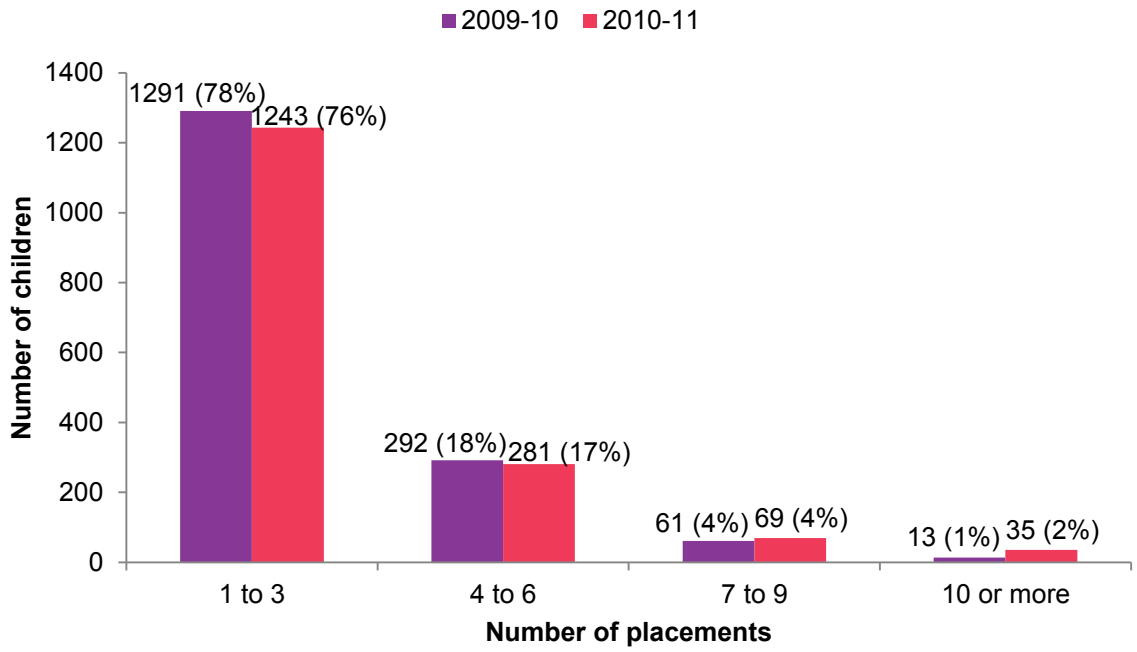
[63] Note that the Commission changed its reporting system in November 2009, hence data for 2008-09 is not directly comparable to subsequent years.

Children exiting care who had three or less placements during their time in care

Latest level and trends

The majority of children who exited care in 2010–11 had experienced one to three placements during their time in care (76%), a similar finding to 2009–10 (78%).

Children who exited care, 2009-11

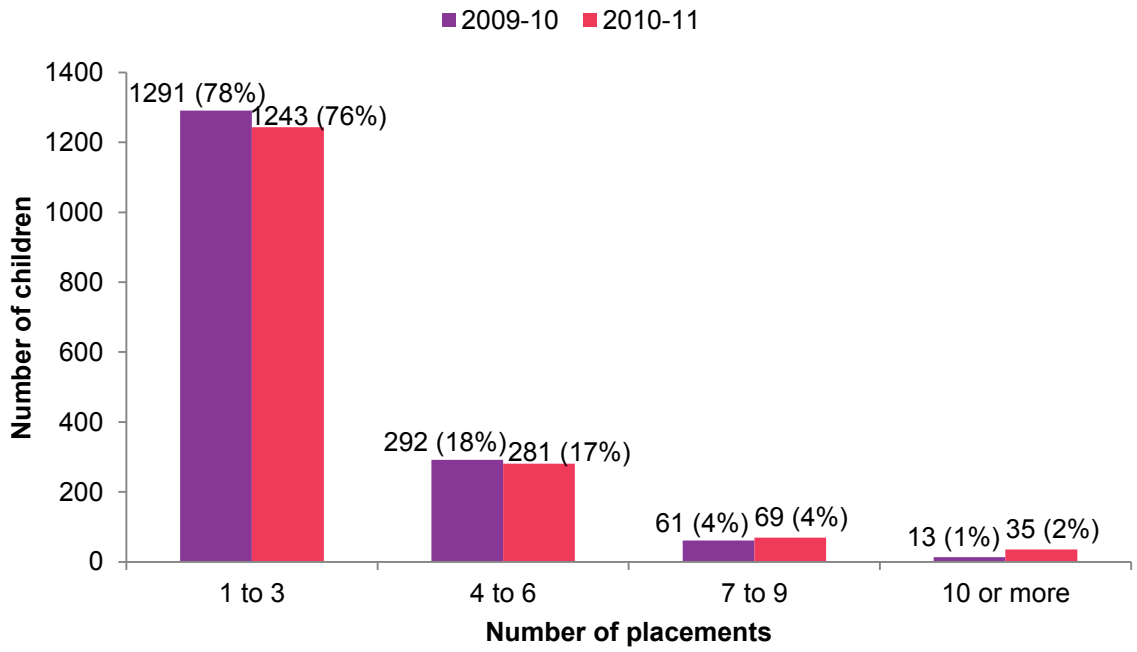


Children exiting care who had seven or more placements during their time in care

Latest level and trends

104 children who exited care in 2010–11 had experienced seven or more placements during their time in care (6%), an increase of 30 children from 2009-10.

Children who exited care, 2009-11

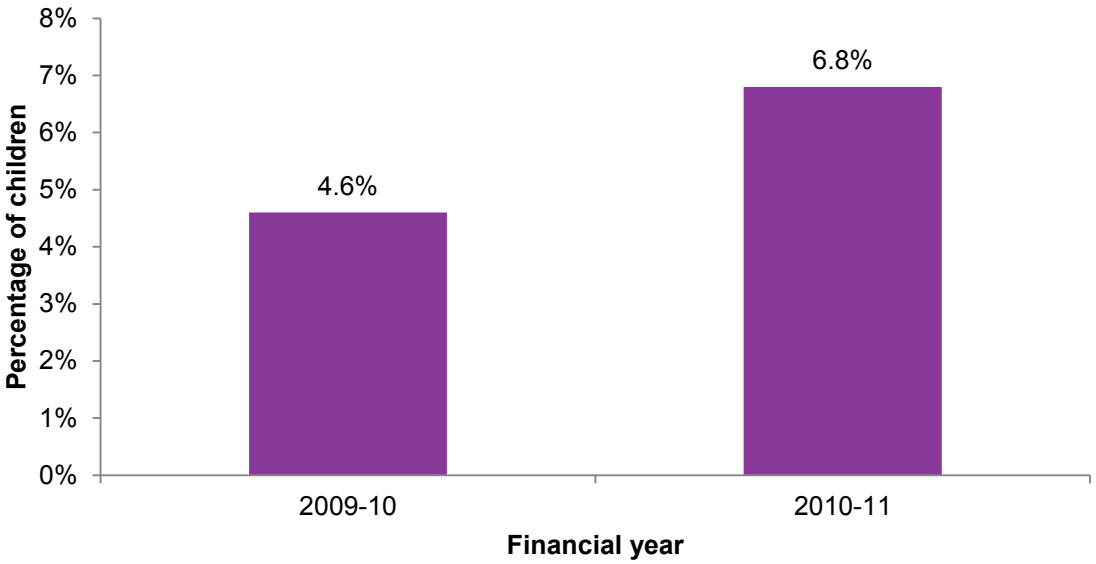


Children who self-placed or absconded from placement

Latest level and trends

508 children (6.8%) visited by the Commission's Community Visitors (CVs) between July 2010 and June 2011 were reported as having self-placed or absconded from their placement.[64]

Percentage of children who self-placed or absconded, 2009-11



The most common reason provided by children for why they self-placed or absconded was that they were seeking connections with family and other people of significance (28.5%).

Reasons why children absconded or self-placed

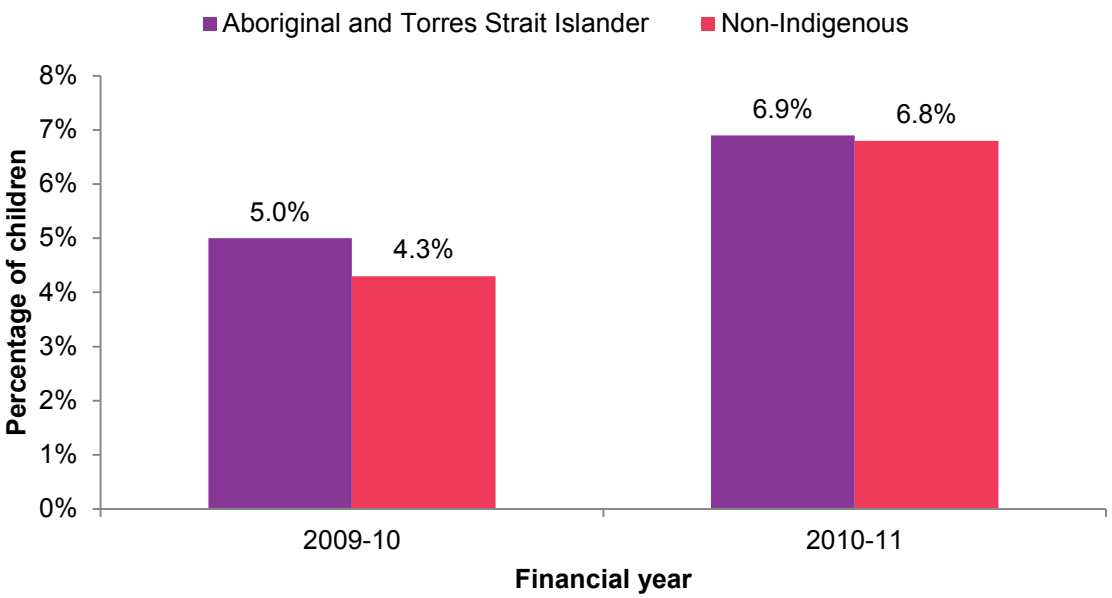
Reason	Number	Percentage
No reason[65]	202	39.8%
Other reason for absconding[66]	178	35.0%
Seeking connections with family and other people of significance	145	28.5%
Seeking independence	74	14.6%
Difficulties in relationship with care providers	62	12.2%
Dislikes where they are living	42	8.3%
Difficulties in relationship with others	34	6.7%
Order due to expire and doesn't want to return home	1	0.2%

[64] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There was a total of 7427 valid responses to this question.
[65] Children and young people may choose not to provide a reason to the Community Visitor as to why they decided to self-place or abscond from placement
[66] More than one reason can be recorded in a Community Visitor Report as to why a child self-placed or absconded from their placement.

Aboriginal and Torres Strait Islander status

CVs reported that the percentage of Aboriginal and Torres Strait Islander children self-placing or absconding (6.9%) was slightly higher than for non-Indigenous children (6.8%).[67]

Percentage of children self-placing or absconding by cultural status in 2009-11

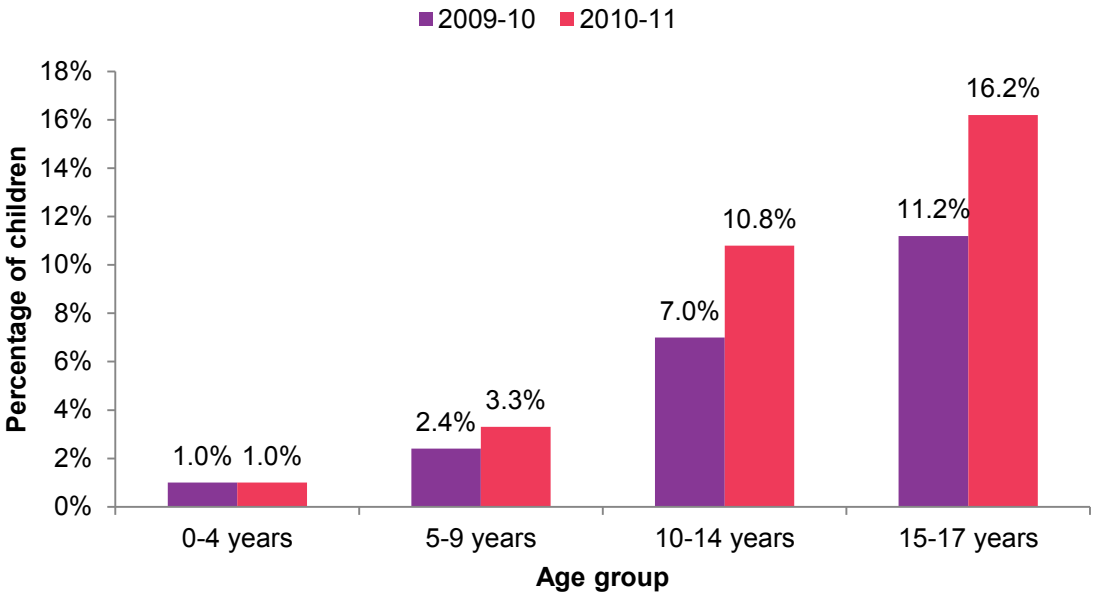


[67] There were 2691 valid responses for Aboriginal and Torres Strait Islander children and young people and 4729 valid responses for non-Indigenous children and young people.

Age differences

Of the children visited by CVs in 2010–11, 10.8% aged between 10–14 years and 16.2% aged between 15–17 years self-placed or absconded.[68]

Percentage of children self-placing or absconding

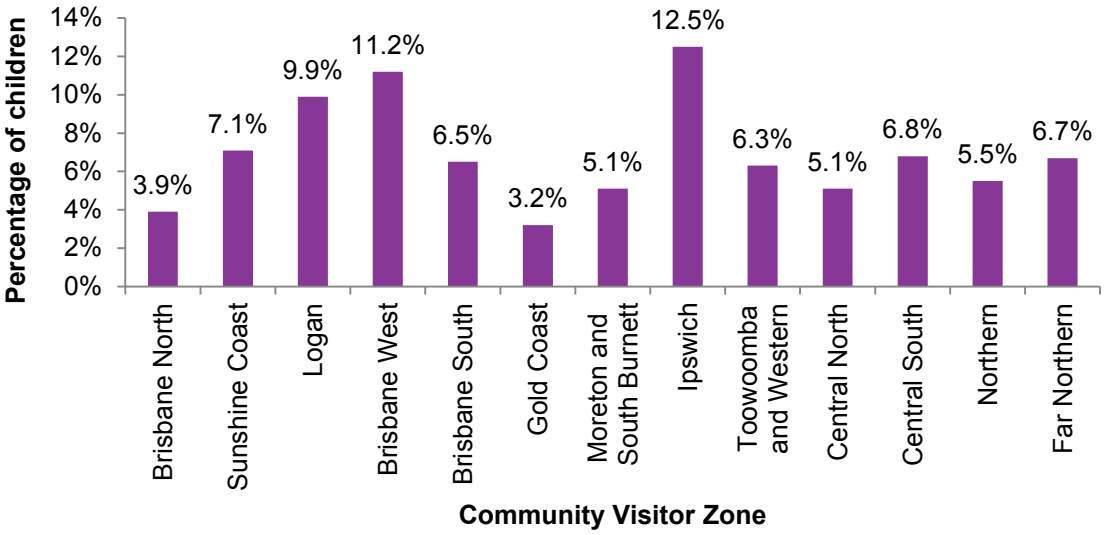


[68] The total valid response for each age group is as follows: 0–4 years – 1889, 5–9 years – 2276, 10–14 years – 2054, and 15–17 years – 1178.

Regional differences

Ipswich and Brisbane West Community Visitor Zones had the highest percentages of children who CVs reported as having self-placed or absconded from their placement (12.5% and 11.2% respectively). [69]

Percentage of children who self-placed or absconded from their placement, 2010-11



[69] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 7420 valid responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 466, Sunshine Coast – 393, Logan – 374, Brisbane West – 516, Brisbane South – 511, Gold Coast – 665, Moreton and South Burnett – 455, Ipswich – 674, Toowoomba and Western – 716, Central North – 569, Central South – 545, Northern – 703, and Far Northern – 833.

Children's relationship with their Child Safety Officers

Latest level and trends

According to CV reports, approximately 81% of children reported having contact with their Child Safety Officer (CSO) in the preceding month.[70] This is consistent with 2009–10.

Contact with CSOs

Measure	2009–10	2010–11
Percentage of children who had contact with their CSO in the last month	80.4%	81.2%
Percentage of children who reported wanting more contact with their CSO[71]	10.3%	11.8%
Percentage of children reporting that CSOs did not respond to their requests or needs[72]	22.6%	17.6%

[70] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 6924 valid responses to this question. The Department does not hold data on the frequency of Child Safety Officer contact with children and young people.
[71] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 3545 valid responses to this question.
[72] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 2418 valid responses to this question.

Aboriginal and Torres Strait Islander status

CVs reported similar numbers of Aboriginal and Torres Strait Islander children had contact with their Child Safety Officer in the preceding month (78.7%), compared to non-Indigenous children (82.7%).[73]

Contact with CSOs by cultural status, 2009-11

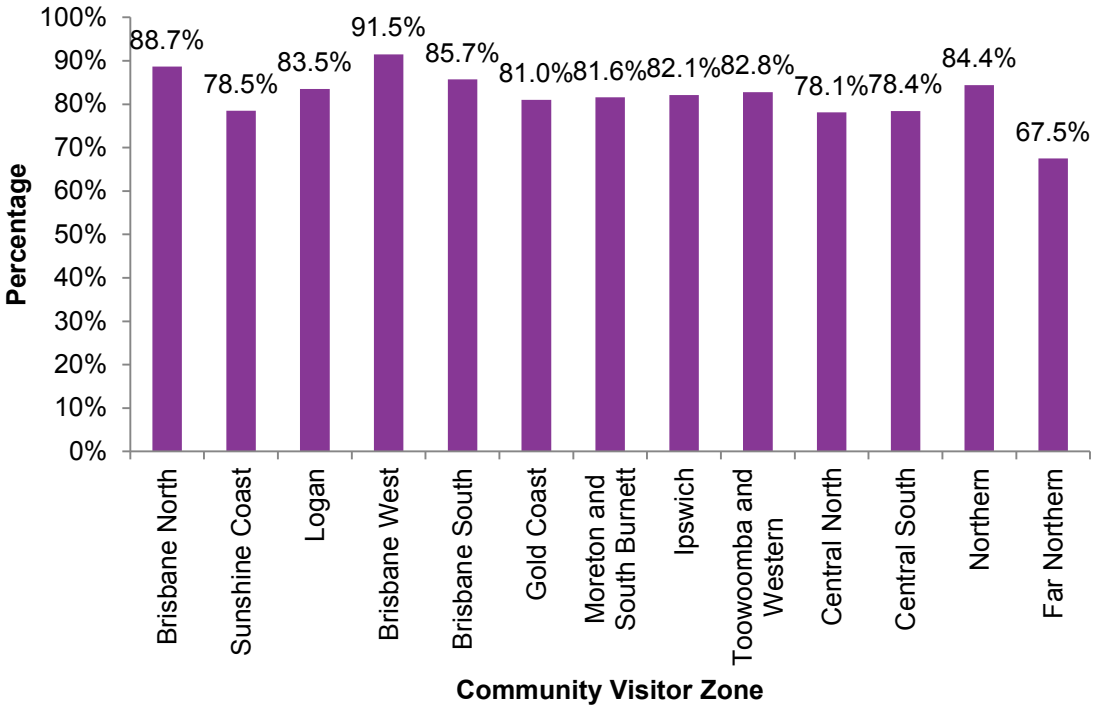
	2009–10		2010–11	
Measure	**Aboriginal and Torres Strait Islander children**	**Non-Indigenous children**	**Aboriginal and Torres Strait Islander children**	**Non-Indigenous children**
Percentage of children who had contact with their CSO in the preceding month	79.2%	81.1%	78.7%	82.7%
Percentage of children who reported wanting more contact with their CSO[74]	12.1%	9.4%	13.6%	11.0%
Percentage of children who reported they were not being listened to by their CSO[75]	20.1%	18.2%	18.4%	12.6%
Percentage of children reporting that CSOs did not respond to their requests or needs[76]	25.2%	21.3%	22.0%	15.7%

[73] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 6924 valid responses to this question. There were 2493 responses relating to Aboriginal and Torres Strait Islander children and young people and 4431 responses relating to non-Indigenous children and young people.
[74] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. A total of 419 children and young people reported wanting more contact with their Child Safety Officer. Of these, 152 were Aboriginal and Torres Strait Islander children and young people and 267 were non-Indigenous children and young people.
[75] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 2953 valid responses to this question. There were 942 responses relating to Aboriginal and Torres Strait Islander children and young people and 2011 responses relating to non-Indigenous children and young people.
[76] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 2418 valid responses to this question. There were 751 responses relating to Aboriginal and Torres Strait Islander children and young people and 1667 responses relating to non-Indigenous children and young people.

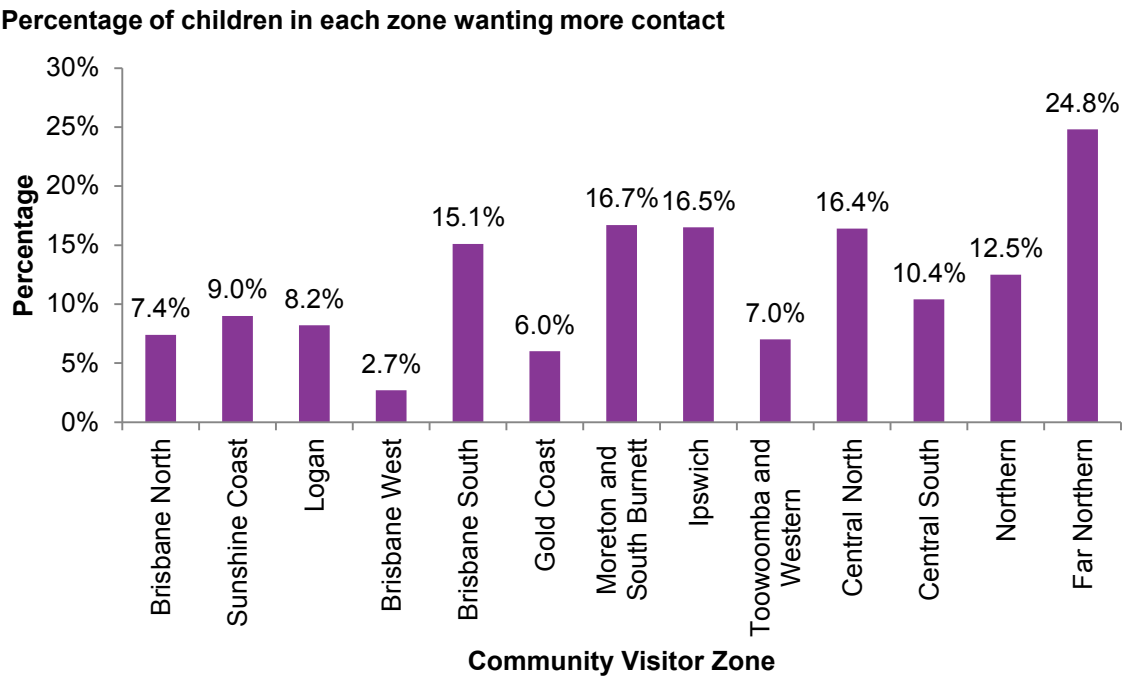
Regional differences

CV reports showed fewer children in the Far Northern Community Visitor Zone reporting contact with their CSO in the preceding month (67.5%) compared to children in other zones.

Percentage of children who CVs reported having contact with the CSO in the preceding month



Almost a quarter of children (24.8%) in the Far Northern Community Visitor Zone reported to their CV that they wanted to see their CSO more often.[77]



[77] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 3545 valid responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 215, Sunshine Coast – 188, Logan – 182, Brisbane West – 293, Brisbane South – 172, Gold Coast – 381, Moreton and South Burnett – 216, Ipswich – 363, Toowoomba and Western – 330, Central North – 287, Central South – 327, Northern – 265, and Far Northern – 326.

Special needs of Aboriginal and Torres Strait Islander children

Measures	2008–09	2009–10	2010–11
Rate of Aboriginal and Torres Strait Islander children subject to a Notification (per 1000) (Departmental data)	68.6	69.2	70.7
Rate of Aboriginal and Torres Strait Islander children living away from home[78] (per 1000) (Departmental data)	39.4	41.5	43.6
Aboriginal and Torres Strait Islander children to Aboriginal and Torres Strait Islander carer ratio (Departmental data)	4.1:1	4.5:1	4.5:1
Number of Aboriginal and Torres Strait Islander children subject to a substantiated Matter of Concern (Departmental data)	102	80	94
Percentage of children reporting wanting more contact with parents (Commission Community Visitor data)	NA	16.9%	16.9%
Percentage of children reporting that they were satisfied with the support provided by the Department to participate in cultural activities and to maintain cultural links (Commission Community Visitor data)	NA	87.3%	85.8%

Performance assessment:
Aboriginal and Torres Strait Islander children and young people remain significantly over-represented at every stage of the child protection system. The available data shows that this vulnerable group of children are increasing their contact with the child protection system at rates disproportionate to non-Indigenous children.

Departmental comment:

The Department advises that it is responding to the over-representation of Aboriginal and Torres Strait Islander children in the child protection system through actioning the state government *Blueprint for Implementation Strategy: Reducing the over-representation of Aboriginal and Torres Strait Islander children in Queensland's Child Protection System*, as well as by responding to recommendations arising out of Commission audits of Departmental compliance with the *Indigenous Child Placement Principle* (conducted in 2008 and 2010). Refer to Appendix E for the full Departmental response.

[78] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.

Aboriginal and Torres Strait Islander children subject to a Notification

Latest level and trends

Representation of children in the Queensland child protection system, by cultural status, in 2010–11

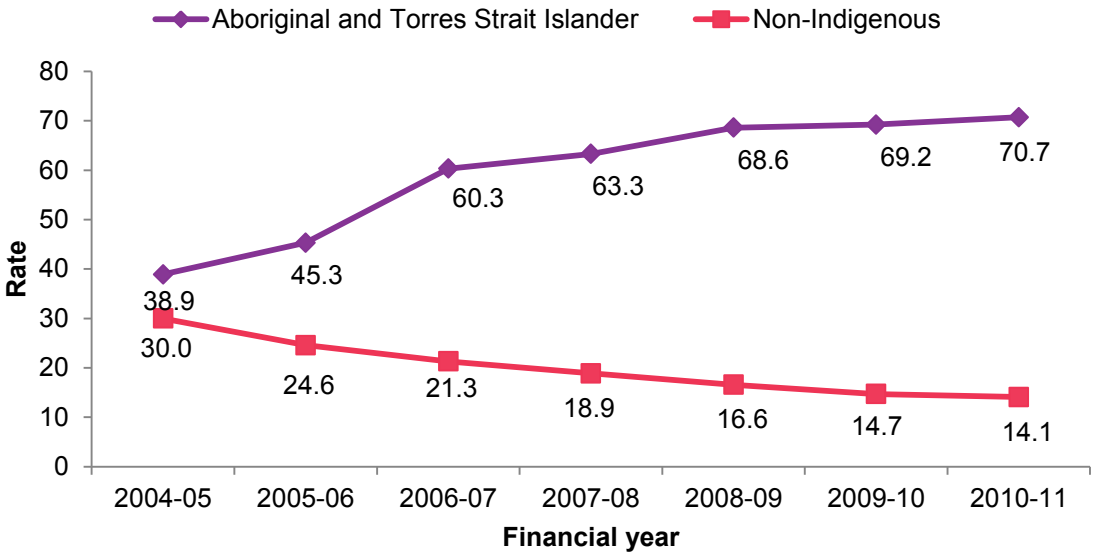
	Aboriginal and Torres Strait Islander children			Non-Indigenous children		
Distinct number of children[79]	**Number**	**Rate per 1000**	**% change (2009-11)**	**Number**	**Rate per 1000**	**% change (2009-11)**
1. Subject to an Intake	13,433	191.7	4.8%	57,731	56.7	6.4%
2. Subject to a Child Concern Report	10,884	155.3	8.2%	49,669	48.8	10.3%
3. Subject to a Notification	4953	70.7	2.5%	14,400	14.1	-2.7%
4. Subject to a Substantiation	1731	24.7	-2.8%	4210	4.1	-5.1%
5. Subject to an Intervention with Parental Agreement[80]*	744	10.6	-17.8%	1212	1.2	-27.6%
6. Subject to protective orders[81]*	3181	45.4	7.1%	5275	5.2	3.0%
7. Living away from home[82]*	3052	43.6	5.5%	5011	4.9	1.9%
8. In out-of-home care[83]*	2850	40.7	6.1%	4752	4.7	1.9%
9. Exiting care in 2010–11	575	8.2	-3.7%	1053	1.0	-0.8%

*As at 30 June 2011

[79] Population figures were sourced from the Department.
[80] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS) took place. This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.
[81] This measure includes all children subject to short and long-term child protection orders and court assessment orders.
[82] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.
[83] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) as per nationally agreed reporting definitions.

The rate of Aboriginal and Torres Strait Islander children subject to a Notification has been increasing each year since 2004–05. The equivalent measure for non-Indigenous children has been decreasing since 2004–05. [84]

Rates per 1000 children subject to Notifications, by cultural status

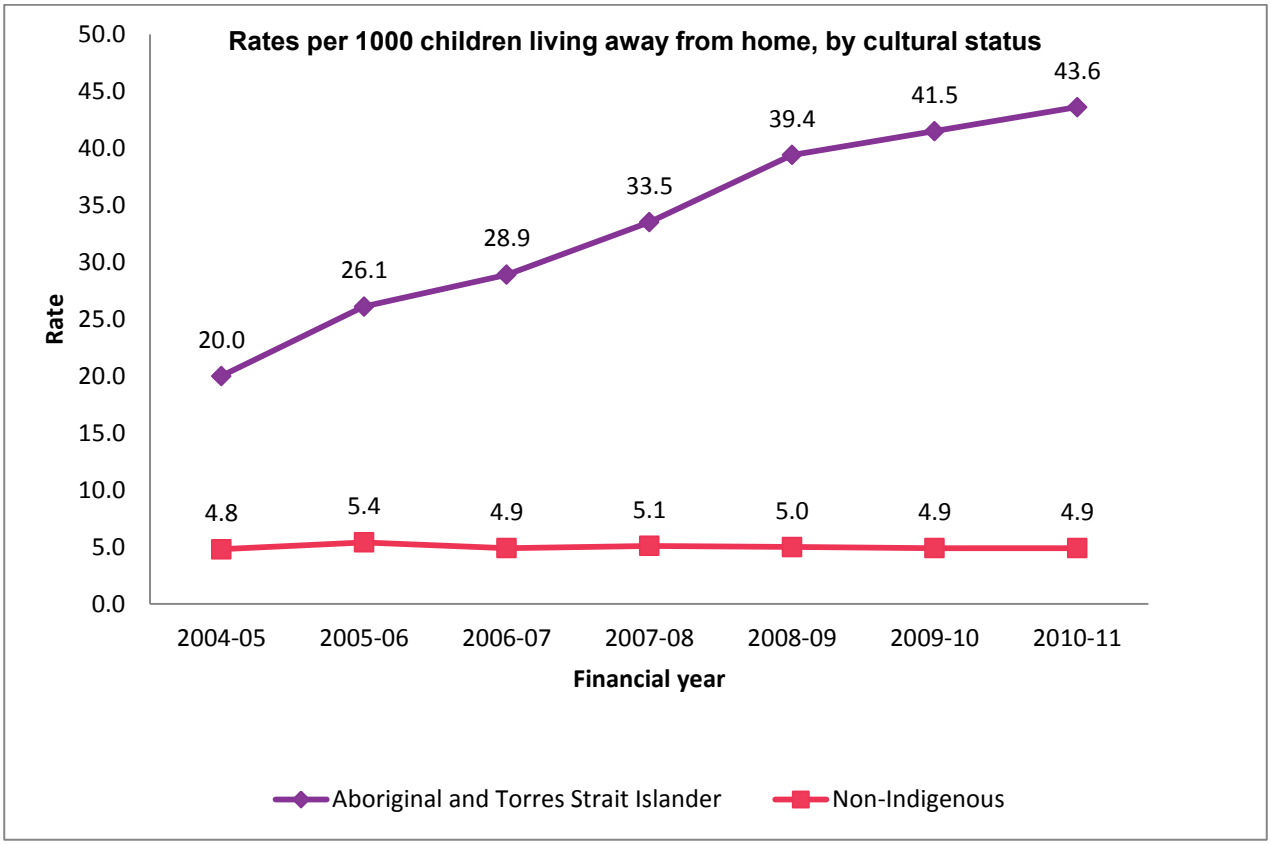


[84] Note that notification time series data has been affected by a combination of legislation, practice and recording changes.

Aboriginal and Torres Strait Islander children living away from home

Latest level and trends

The rate of Aboriginal and Torres Strait Islander children living away from home has been increasing each year since 2004–05. The equivalent measure for non-Indigenous children has remained relatively consistent since 2004–05.[85]



[85] Note that rates for children living away from home are as at the end of the financial year.

Aboriginal and Torres Strait Islander children to Aboriginal and Torres Strait Islander carer ratio

Latest level and trends

The ratio of Aboriginal and Torres Strait Islander children living in home-based care to Aboriginal and Torres Strait Islander carer families has remained consistent with the ratio for 2009–10 at 4.5:1. The ratio for non-Indigenous children to non-Indigenous carers has also remained the same as 2009–10.

Children living in home-based care to carer family ratios

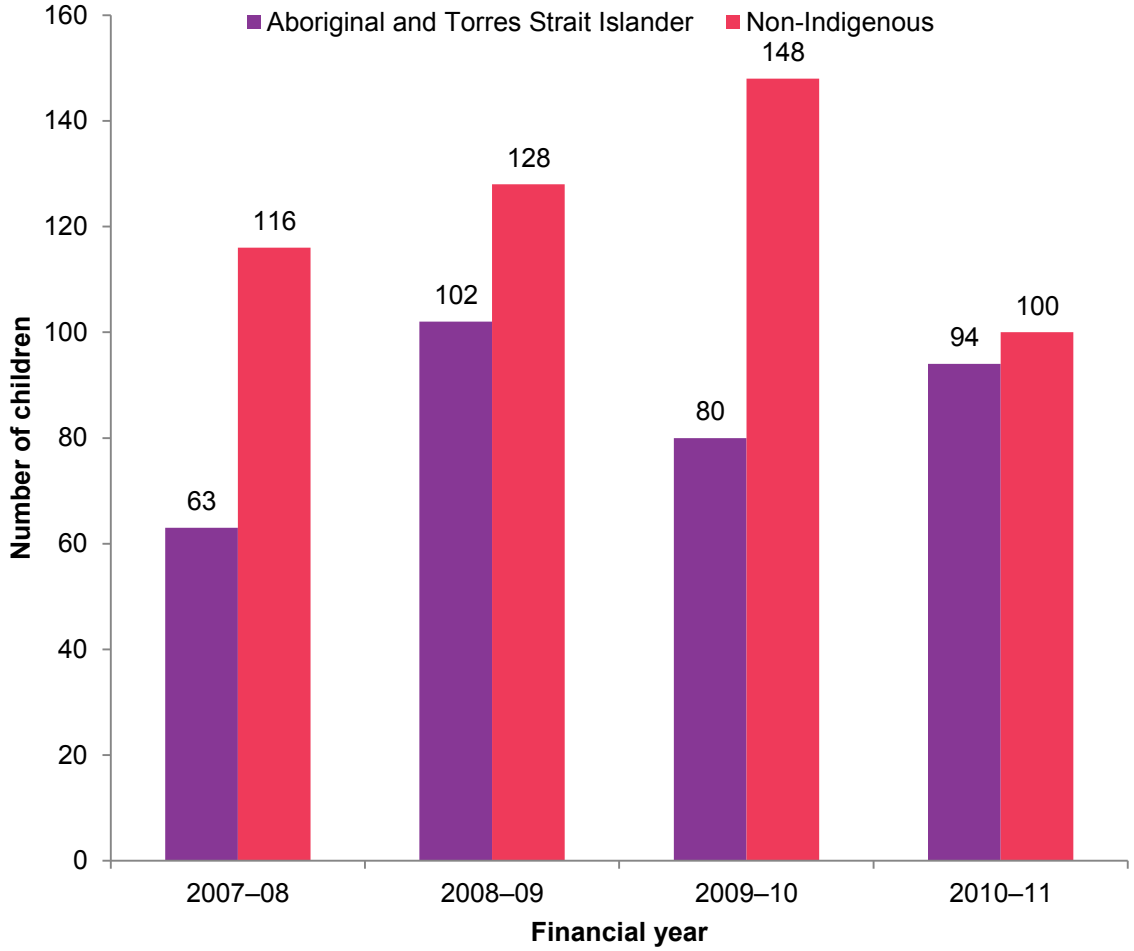
	2009–10	2010–11
Ratio of Aboriginal and Torres Strait Islander children to Aboriginal and Torres Strait Islander carer families	4.5:1	4.5:1
Ratio of non-Indigenous children to non-Indigenous carer families	1.2:1	1.2:1

Aboriginal and Torres Strait Islander children subject to a substantiated Matter of Concern

Latest level and trends

On a state-wide basis, 94 Aboriginal and Torres Strait Islander children were subject to a substantiated Matter of Concern (MOC), while 100 non-Indigenous children were subject to a substantiated MOC. The number of Aboriginal and Torres Strait Islander children subject to a substantiated MOC increased by 17.5% from 2009–10 to 2010–11.

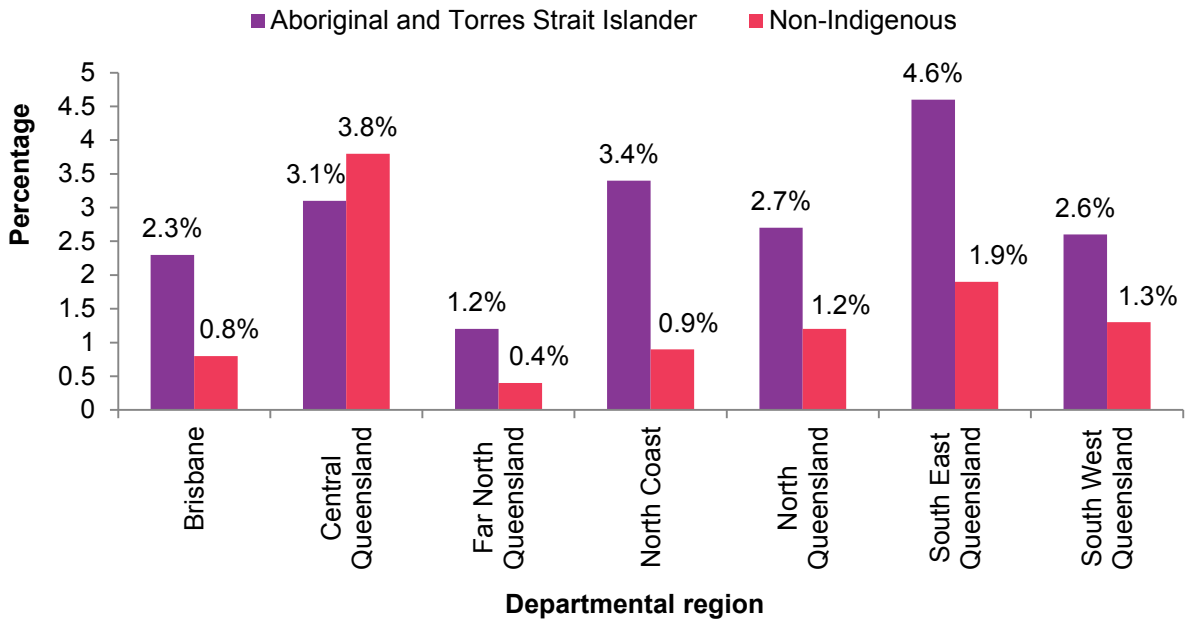
Number of children in out-of-home care at any time during the year who were subject to a substantiated MOC, 2007-11



Regional differences

South East Queensland had the highest percentage of MOC Substantiations for Aboriginal and Torres Strait Islander children in Queensland. For non-Indigenous children, Central Queensland region had the highest percentage.[86]

Percentage of children in out-of-home care subject to substantiated MOC by Departmental Region, 2010-11



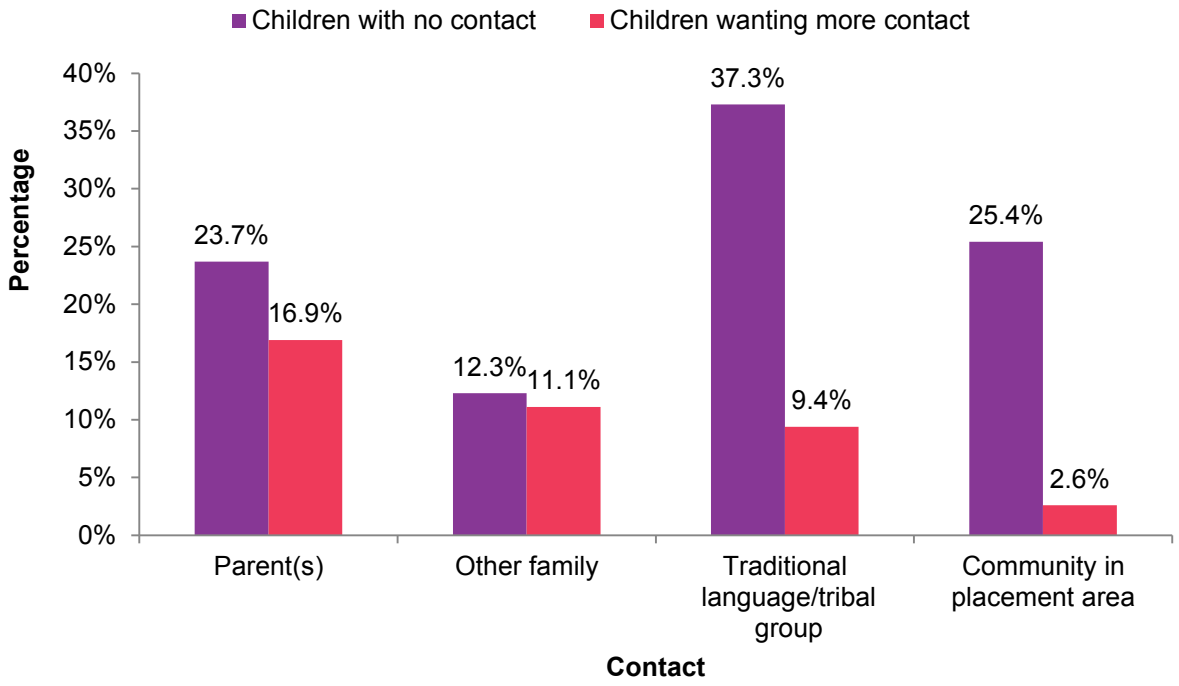
[86] It is important to note that these rates may be an indication of the identification of harm occurring in out-of-home care, rather than the actual incidence of harm.

Children wanting more parental contact

Latest level and trends

Almost one quarter of Aboriginal and Torres Strait Islander children reported to Commission Community Visitors (CVs) that they were not having contact with their parents. Furthermore, nearly 17% of Aboriginal and Torres Strait Islander children reported to CVs that they would like more contact with their parents.[87]

Percentage of Aboriginal and Torres Strait Islander children wanting more contact

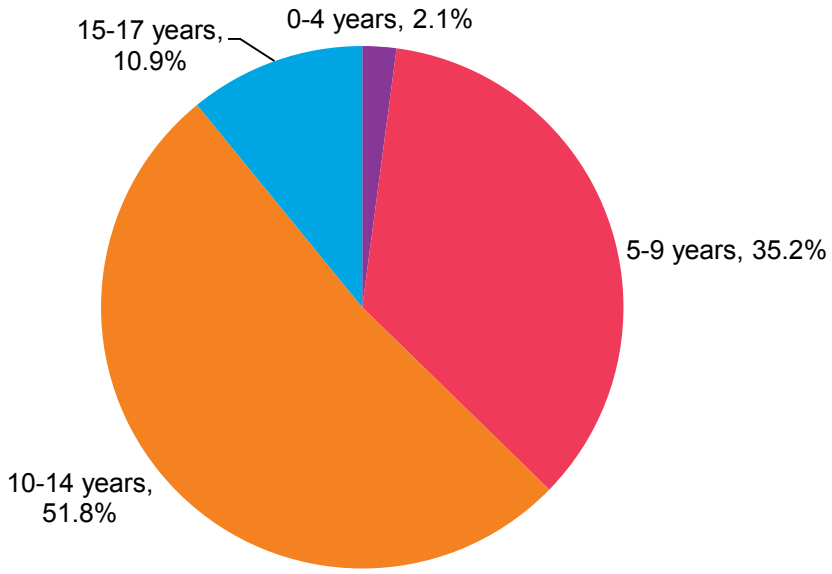


[87] Data source: Commission. Community Visitor data. Information extracted from the child's last report between January and June 2011. The number of valid responses for each category (children with no contact) are as follows: Parents – 2089, Other family – 1941, Traditional language and tribal group – 1108, and Community in placement area – 1198. The number of valid responses for each category (children wanting more contact) are as follows: Parents – 1143, Other family – 1166, Traditional language and tribal group – 523, and Community in placement area – 619.

Age differences

Over half of the Aboriginal and Torres Strait Islander children and young people who reported to CVs that they wanted more parental contact were aged 10–14 years (51.8%).

Percentage of children and young people wanting more parental contact, by age

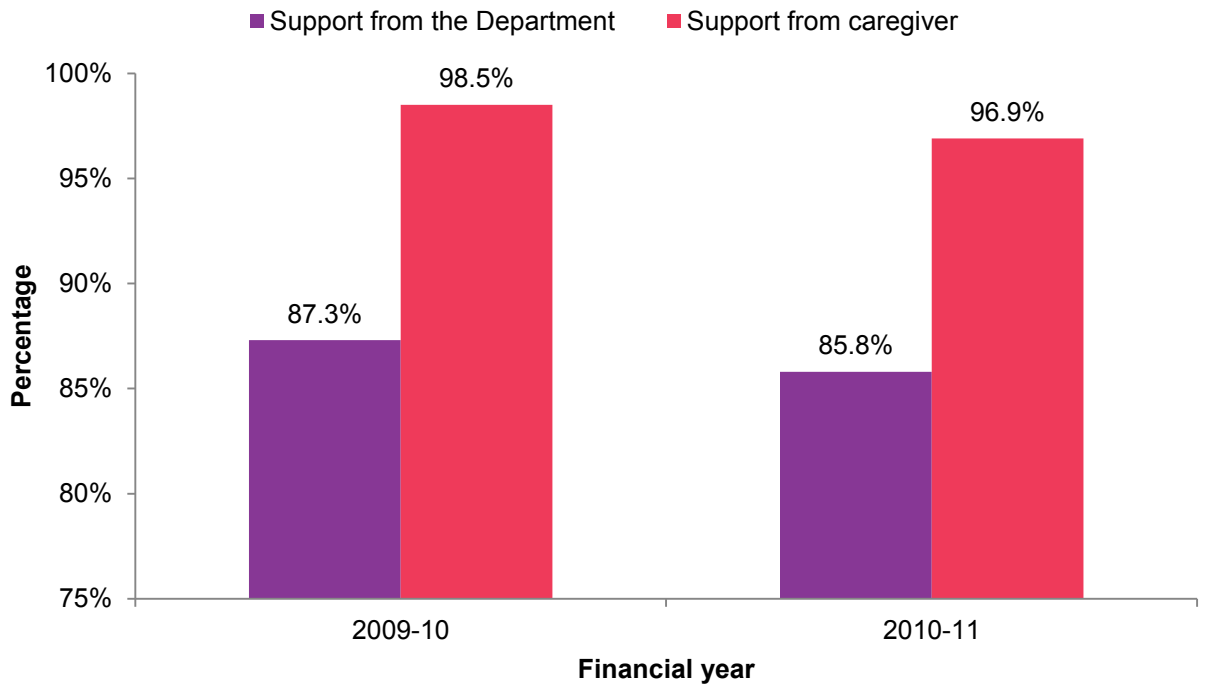


Children satisfied with support from the Department to participate in cultural activities

Latest level and trends

The majority of children reported that they were satisfied with the support provided by the Department to participate in cultural activities and to maintain cultural links (85.8%).[88]

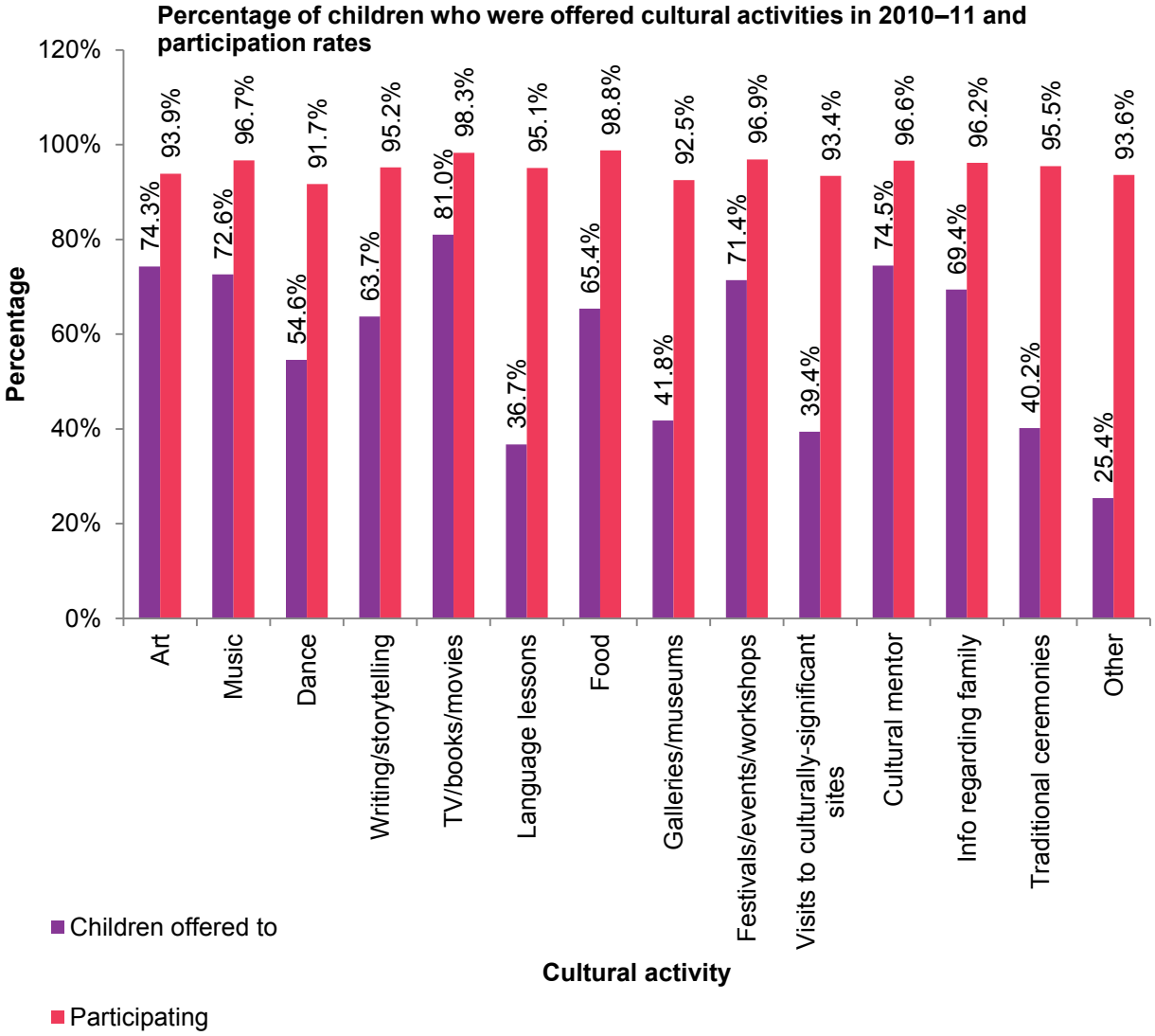
Percentage of children satisfied with support provided to participate in cultural activities



Aboriginal and Torres Strait Islander children were offered a range of cultural activities in 2010–11, according to CVs. There were high levels of participation for all cultural activities if they were offered to the children.[89]

[88] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 431 valid responses to this question.

[89] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. The number of valid responses for each category (children offered) is as follows: Art – 880, Music – 878, Dance – 782, Writing/storytelling – 782, TV/books/movies – 890, Language lessons – 682, Food – 784, Galleries/museums – 629, Festivals/events/workshops – 894, Visits to culturally-significant sites – 639, Cultural mentor – 938, Information regarding family – 785, Traditional ceremonies – 650, and Other – 358. The valid responses for each category (children participating) is as follows: Art – 628, Music – 606, Dance – 412, Writing/storytelling – 484, TV/books/movies – 699, Language lessons – 243, Food – 506, Galleries/museums – 255, Festivals/events/workshops – 618, Visits to culturally-significant sites – 242, Cultural mentor – 671, Information regarding family – 520, Traditional ceremonies – 244, and Other – 78.


Percentage of children who were offered cultural activities in 2010–11 and participation rates
120%
100%
80%
60%
40%
20%
0%
Percentage
74.3%
93.9%
72.6%
96.7%
54.6%
91.7%
63.7%
95.2%
81.0%
98.3%
36.7%
95.1%
65.4%
98.8%
41.8%
92.5%
71.4%
96.9%
39.4%
93.4%
74.5%
96.6%
69.4%
96.2%
40.2%
95.5%
25.4%
93.6%
Art
Music
Dance
Writing/storytelling
TV/books/movies
Language lessons
Food
Galleries/museums
Festivals/events/workshops
Visits to culturally-significant sites
Cultural mentor
Info regarding family
Traditional ceremonies
Other
Children offered to
Participating
Cultural activity

Individual needs met

Measures	2009–10	2010–11
Percentage of young people with a current case plan (Departmental data)	77.4%	81.5%
Percentage of young people who participated in case plan development (Commission Community Visitor data)	54%	57%
Percentage of young people who would like more family contact (Commission Community Visitor data)	17%	18%
Percentage of young people who were identified as demonstrating high risk behaviours (Commission Community Visitor Data)	6%	5.7%

Performance assessment:
Slight gains have been made across this indicator. It is also encouraging to see an increase in both 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.

Departmental comment:

The Department recognises the importance of case planning and case plan reviews in providing well-targeted co-ordinated service delivery to children and young people. Ongoing training is provided to staff across the state to guide practice. The Department further advises that due to a range of circumstances, at any given time a proportion of children and young people subject to ongoing statutory intervention may not have a case plan recorded. Refer to Appendix E for the full Departmental response.

Young people with a current case plan

Latest level and trends

As at 30 June 2011, 9820 (95.1%) of children subject to ongoing intervention with the Department of Communities had a case plan recorded. Of those, 81.5% had a current case plan, an increase from 77.4% in 2009–10.[90]

Children subject to ongoing intervention with a current case plan, by intervention type

Measures	30 June 2010			30 June 2011		
	Intervention with Parental Agreement	Child Protection Order	All children subject to ongoing intervention	Intervention with Parental Agreement[91]	Child Protection Order	All children subject to ongoing intervention
All children subject to ongoing intervention	**2580**	**8026**	**10,606**	**1956**	**8371**	**10,327**
Case Plan Recorded	2061	7860	9921	1615	8205	9820
Created or reviewed within the past 6 months	1412	6266	7678	1298	6708	8006
Not created or reviewed within the past 6 months	649	1594	2243	317	1497	1814
No Case Plan recorded	519	166	685	341	166	507
Percentage of children with a current case plan	**68.5%**	**79.7%**	**77.4%**	**80.4%**	**81.8%**	**81.5%**

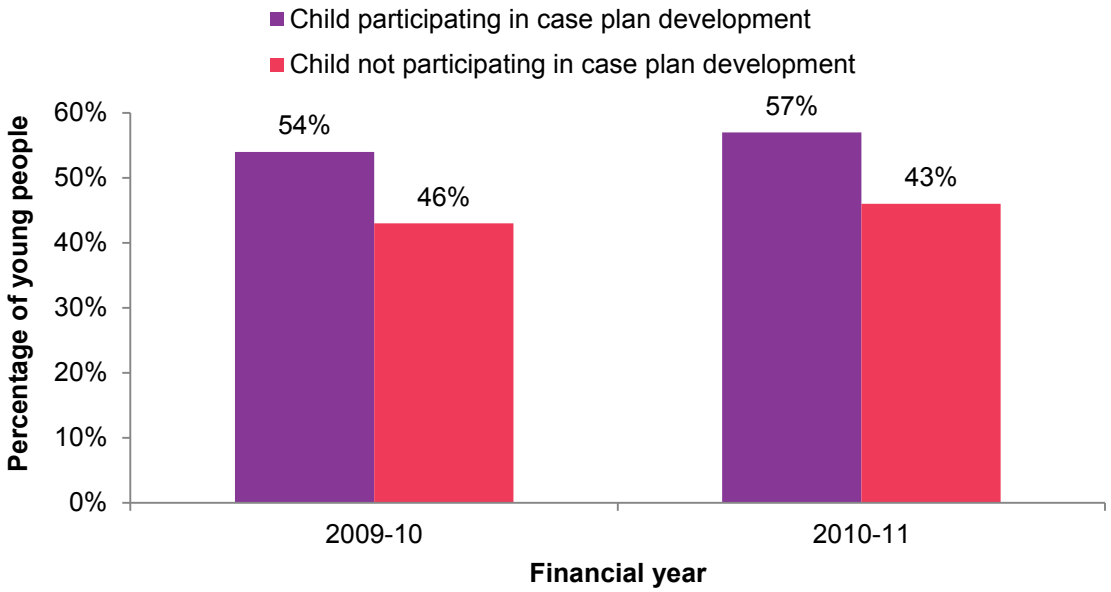
[90] A current case plan is one which has been created or reviewed within the preceding 6 months.
[91] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS) took place. This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.

Young people who participated in case plan development

Latest level and trends

Commission Community Visitor (CV) reports identified that 57% of young people reported participation in case plan development in 2010–11, a slight increase from 54% in 2009–10.[92]

Young people identified as participating in case plan development, 2010-11



[92] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 2787 valid responses to this question.

Young people who would like more family contact

Latest level and trends

Children were more likely to report to their Community Visitor (CV) that they had more frequent contact with their mother than their father. They also reported more weekly contact with their siblings compared to any other family member.[93]

Percentage of children who reported having contact with family

	Mother		Father		Siblings		Extended family	
	Aboriginal & Torres Strait Islander	Non-Indigenous	Aboriginal & Torres Strait Islander	Non-Indigenous	Aboriginal & Torres Strait Islander	Non-Indigenous	Aboriginal & Torres Strait Islander	Non-Indigenous
Weekly	42.1%	46.3%	27.8%	33.0%	70.6%	64.8%	54.8%	47.1%
Fortnightly	13.0%	14.8%	9.4%	11.6%	7.4%	10.4%	10.2%	12.7%
Monthly	12.1%	11.9%	11.1%	7.8%	8.9%	9.7%	11.0%	13.4%
Bi-monthly	2.5%	2.4%	2.2%	2.6%	2.0%	2.7%	3.0%	3.6%
3 months or longer	16.5%	12.0%	17.2%	14.8%	6.0%	6.7%	11.3%	10.2%
Never	13.7%	12.5%	32.3%	30.3%	5.2%	5.7%	9.7%	13.0%

Most children (92.3%) who were asked by CVs about their satisfaction with the frequency of contact with family members reported they were satisfied with the amount of contact they had with at least one family member (mother, father, siblings or extended family).[94] Aboriginal and Torres Strait Islander children were more likely to report wanting additional contact with family (19.7%) compared to non-Indigenous children (17.3%).[95]

CV reports identified that the percentage of young people who would like more contact with their family has remained relatively consistent over the past two years (17% in 2009–10 and 18% in 2010–11).[96]

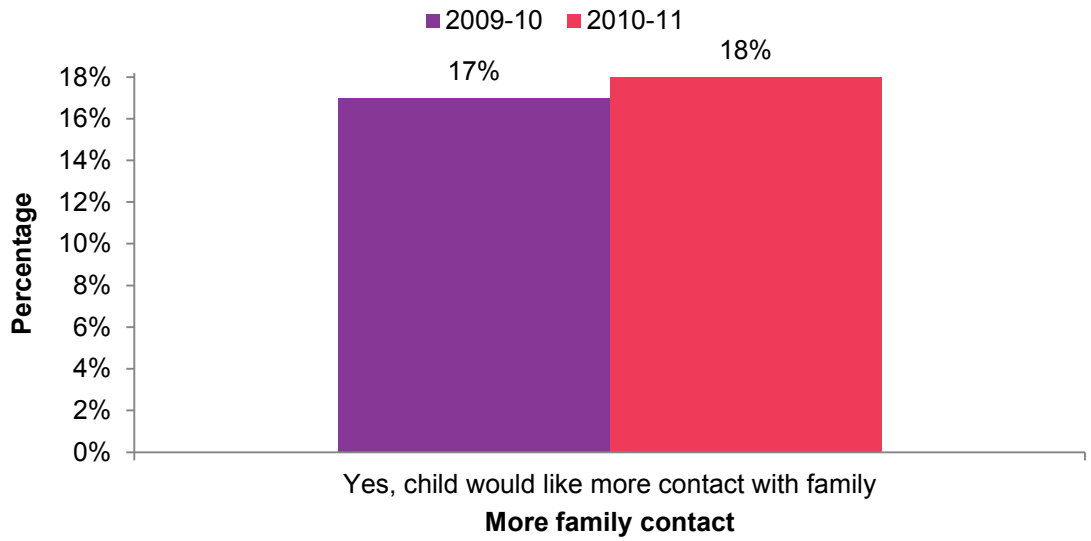
[93] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 5622 responses for the question relating to contact with mother (1944 related to Aboriginal and Torres Strait Islander (A&TSI) children and 3678 to non-Indigenous children), 4416 valid responses for the question relating to contact with father (1559 related to A&TSI children and 2857 to non-Indigenous children), 4913 valid responses for contact with siblings (1825 related to A&TSI children and 3088 to non-Indigenous children), and 3677 valid responses for contact with extended family (1386 related to A&TSI children and 2291 to non-Indigenous children).

[94] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 4676 valid responses for the question. If the child was satisfied with their contact level with **any** of mother, father, sibling or extended family, they were considered to be satisfied for this measure. Otherwise, if they child selected "no wants more", "no wants less" or "wants consistency" with **any** of mother, father, sibling or extended family, they were considered to be not satisfied for this measure.

[95] 1631 responses related to A&TSI children and 3045 related to non-Indigenous children.

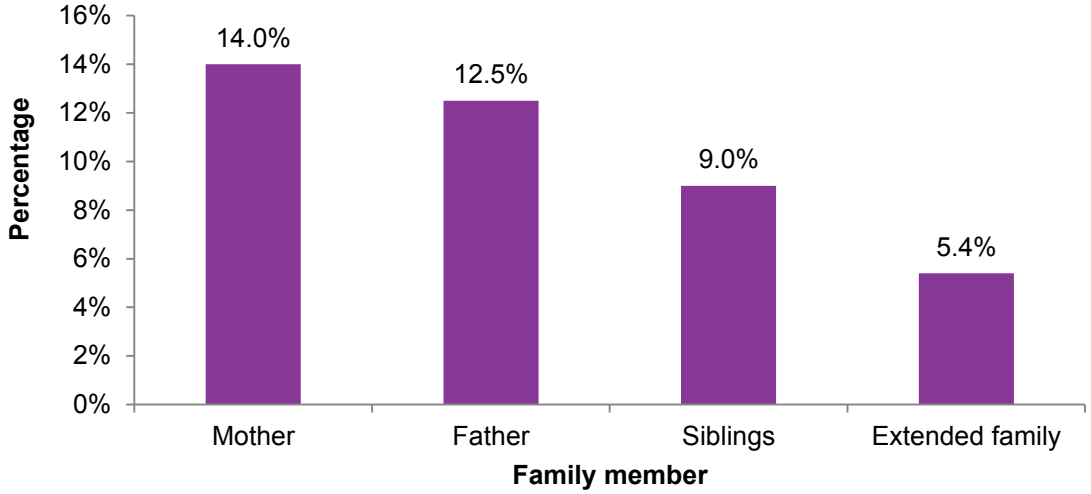
[96] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 4676 valid responses to this question.

CV reports identifying young people who would like more contact with family, 2009-11



Community Visitor reports identified that children most commonly wanted more contact with their mother, followed by their father, siblings and extended family. This is a recurring trend from 2009–10.[97]

CV reports identifying young people who would like more contact with their family, by family members, in 2010-11

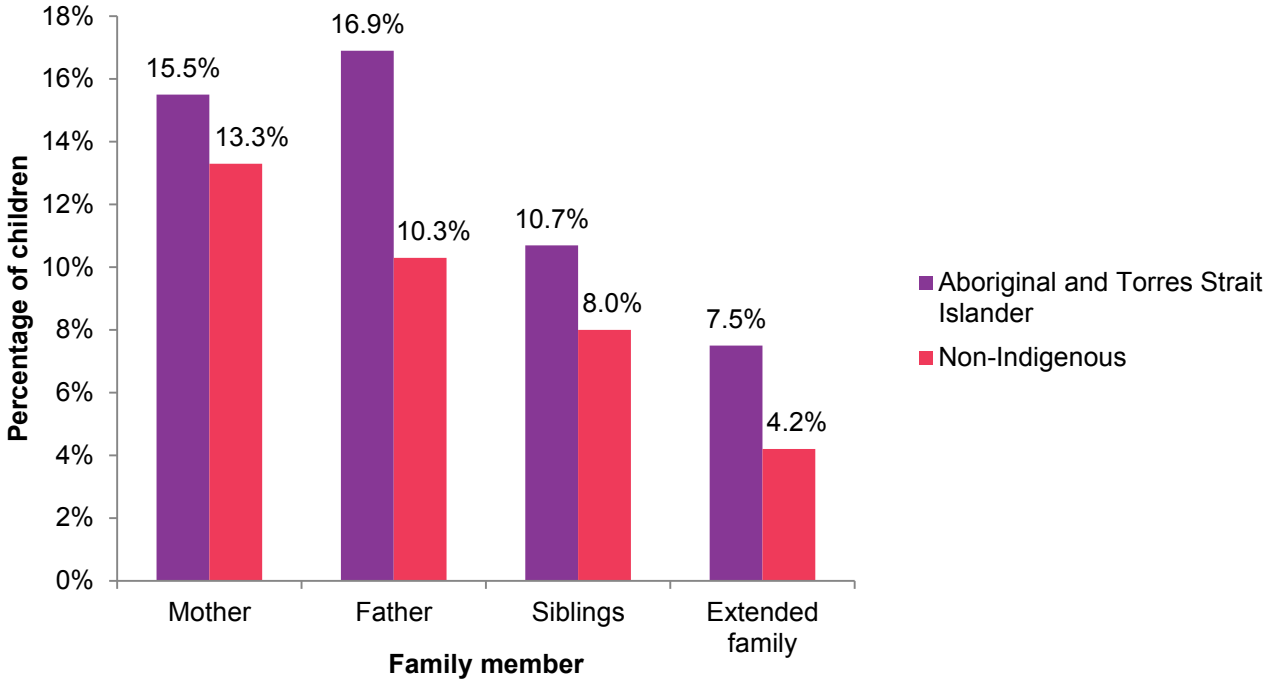


[97] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 502 valid responses relevant to the child wanting more contact with their mother, 296 valid responses relevant to the child wanting more contact with their father, 316 valid responses relevant to the child wanting more contact with their siblings, and 130 valid responses relevant to the child wanting more contact with their extended family.

Aboriginal and Torres Strait Islander status

CV reports identified a greater percentage of Aboriginal and Torres Strait Islander children wanting more contact with their mother, father, siblings and extended family than non-Indigenous children in 2010–11.[98]

CV reports identifying children wanting more contact with family, by cultural status, 2010-11



[98] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 502 valid responses relevant to the child wanting more contact with their mother (184 related to Aboriginal and Torres Strait Islander [A&TSI] children and 318 to non-Indigenous children), 296 valid responses relevant to the child wanting more contact with their father (134 related to A&TSI children and 162 to non-Indigenous children), 316 valid responses relevant to the child wanting more contact with their siblings (140 related to A&TSI children and 176 to non-Indigenous children), and 130 valid responses relevant to the child wanting more contact with extended family (69 related to A&TSI children and 61 to non-Indigenous children).

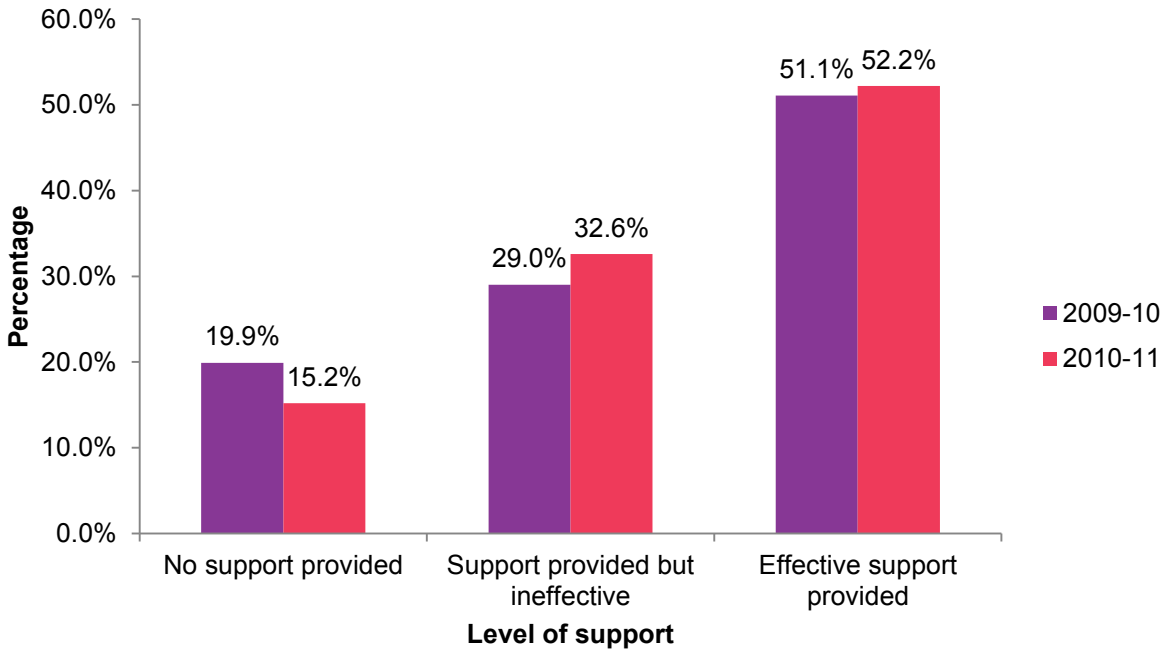
Young people who were identified as having demonstrated high risk behaviours

Latest level and trends

CV reports identified that nearly 6% of young people demonstrated high risk behaviours, such as sexualised behaviours and self-harm.[99]

Children were asked by their CVs whether they were receiving support from the Department and/or their care provider, and whether the support was effective. The figure below shows that more than half of children identified that they were receiving support and that it was effective.[100]

Percentage of young people receiving effective support in relation to their high risk behaviours



[99] Data Source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 7242 valid responses to this question.
[100] Data Source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. There was a total of 368 valid responses to this question.

Successful reunifications

Measure	2008–09	2009–10	2010–11
Number of children known to the Community Visitor Program who were reunified with their families (Commission Community Visitor data)	971	859[101]	828

Performance assessment:
The number of children known to the Community Visitor Program who were reunified with their families has decreased over the past three reporting periods. The percentage of young people reporting being adequately involved in the reunification process has increased over the past two years. Scope also exists for the Department to improve its data to enable better monitoring of reunification outcomes.

Departmental comment:

The Department advises that, subject to testing and quality assurance, new data on family reunifications may be available for reporting from the 2011–12 financial year onward. Refer to Appendix E for the full Departmental response.

[101] Due to data migration to Jigsaw for the 2009–10 year, this figure is an estimate based on a linear extrapolation of 7 months of data. The 2008–09 data finding is based on historical data and has been reported in a previous Child Guardian Report.

Children who were reunified

Latest level and trends

In 2010–11, 828 children known to the Commission Community Visitor (CV) Program were reunified with their families. In total, 1668 children commenced a reunification process.[102]

Of the children who answered the question posed by CVs about whether they felt positive about the reunification process, 81% responded yes.[103] This is similar to 2009–10, where 83% of children reported feeling positive about the reunification process.

Of the children who answered the question posed by CVs about whether they were adequately involved in the reunification process, approximately three-quarters of children (76.5%) responded yes. 16.7% of children reported not being adequately involved in the reunification process.[104]

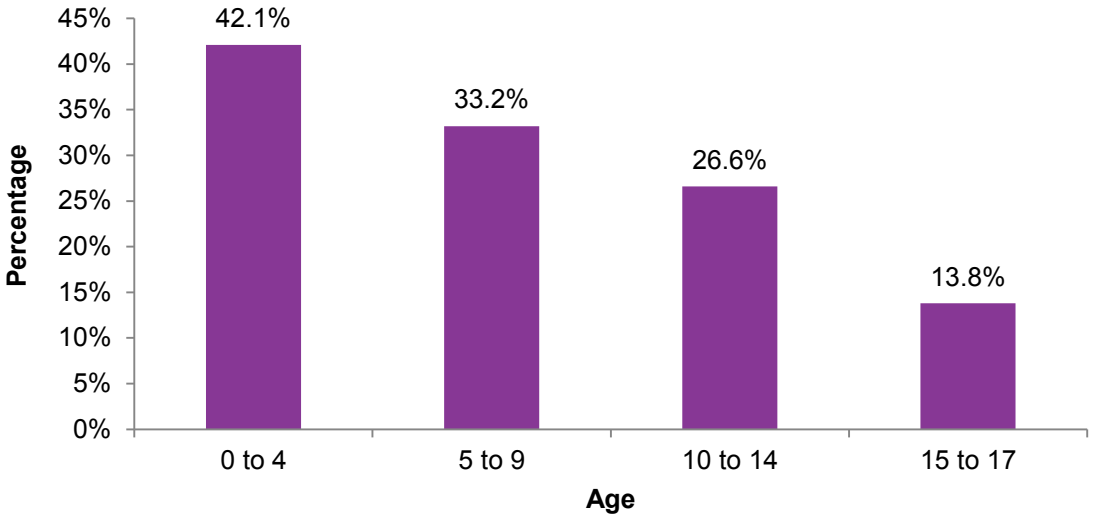
Measures	2009–10	2010–11
Number of children who were reunified with their families	859	828
Number of children who commenced a reunification process	1216	1668
Percentage of children who reported feeling positive about the reunification process	82.7%	80.5%
Percentage of children who reported being adequately involved in the reunification process	69.6%	76.5%
Percentage of children who reported not being adequately involved in the reunification process	19.9%	16.7%

[102] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There were 5221 valid responses to this question. The Department of Communities (Child Safety) is currently unable to provide data on the number of children and young people reunified during the year.
[103] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There were 788 valid responses to this question.
[104] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There were 412 valid responses to this question. This count excludes 0–4 year olds and those children otherwise unable to express a view.

Age differences

Younger children were more likely to be subject to a reunification process, with the percentage decreasing with age.[105]

Percentage of children for whom a reunification process commenced, 2010-11



[105] Data source: Commission. Community Visitor data. Information extracted from any of the child's reports between July 2010 and June 2011. There were 5221 valid responses to this question. The total valid response for each age group is as follows: 0–4 years – 1574, 5–9 years – 1713, 10–14 years – 1298, and 15–17 years – 618.

Successful transitions to independence

Measures	2008–09	2009–10	2010–11
Percentage of young people 15 years and over subject to transition from care planning (Departmental data)	NA	56%	64%
Percentage of young people 15 years and over who had a completed transition from care plan (Commission Community Visitor data)	NA	20%	25%
Percentage of Year 12 completers identified as being in out-of-home care who were either learning or earning[106] (Departmental data)	69.0%	65.8%	NA
Number of children subject to a child protection order for more than 12 months who were admitted to a supervised youth justice order at some time during the year (Departmental data)	150	169	NA

Performance assessment:
While an increase since 2009-10 in transition from care planning is encouraging, more needs to be done to ensure that all children ready to transition out of care have an adequate plan and supports in place.

Departmental comment:

The Department advises that it recognises the importance of transition from care planning and has implemented a wide range of initiatives to ensure effective transitions, including working with other state and territory governments to ensure national consistency in transition from care planning. Refer to Appendix E for the full Departmental response.

[106] Source: 2008 and 2009 Next Step surveys. Due to the small number of young people who had spent time in out-of-home care and taken part in the Next Step survey, percentages represented in the table may vary considerably from year to year. Care must be taken when interpreting these results due to the low numbers involved and the possibility of non-response bias.

Transition from care planning

Latest level and trends

As at 30 June 2011, there were 1231 young people aged 15 years and over subject to a child protection order granting custody or guardianship to the Chief Executive.

Of these, transition from care planning had occurred for 786 young people or 63.9%, which is an increase of over 8 percentage points from 2009–10. The majority of these young people had participated in their planning (89.6%).[107]

Transition from care planning for young people aged 15 years and over subject to a child protection order granting custody or guardianship to the Chief Executive, for 2010 and 2011

Measure	30 June 2010	30 June 2011
Transition from care planning occurred	647	786
Participation in planning	557	704
No participation in planning	90	82
No transition from care planning occurred	518	445
All young people aged 15 years and over subject to a child protection order granting custody/guardianship to the Chief Executive	1165	1231
Percentage of young people aged 15 years and over where planning for their transition from care is required and has occurred as part of their care plan	55.5%	63.9%
Percentage of young people aged 15 years and over who had a transition from care plan and participated in their transition from care planning	86.1%	89.6%

[107] According to the Department's website: "There are a number of valid reasons why a young person may not have a transition from care plan recorded. These include instances where transition from care planning: has not yet occurred (e.g. a young person has only recently turned 15 years or a young person aged 16 years has only recently entered ongoing intervention); has been completed, but not yet recorded on the central system; has been completed and entered on the central system, but is yet to be approved."

Young people with a transition from care plan

Latest level and trends

Over 25% of young people aged 15 years and over reported having a completed Leaving Care Plan (LCP), and a further 50% had one currently in development.[108]

Percentage of young people aged 15 years and over who had a completed LCP, a LCP in development, or no LCP[109]

The majority of young people aged 15–17 years (84%) reported feeling ready to transition from care.[110]

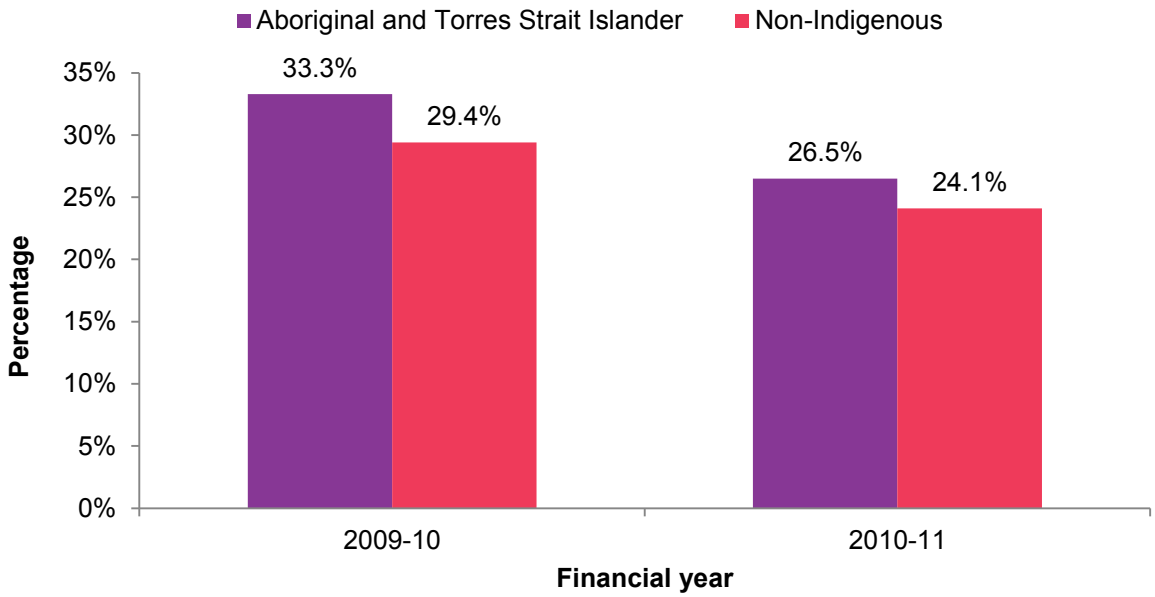
Measure	Percentage
Young people who reported feeling ready to transition from care	83.9%
Young people who reported requiring support with engagement in further education, training or employment	5.0%
Young people who reported requiring support with access to financial assistance and income support	4.2%
Young people who reported requiring support with obtaining their drivers licence or other transport options	4.1%
Young people who reported requiring support with planning and decisions about transitioning	4.0%

Aboriginal and Torres Strait Islander status

Aboriginal and Torres Strait Islander young people were only slightly more likely not to have a LCP compared to non-Indigenous young people (26.5% compared to 24.1%).[111]

[108] CVs may not have actually sighted the Leaving Care Plan, depending on whether the child and/or carer had a copy. In these cases, CVs rely on verbal information provided by the child and/or carer. This could be a reason for the discrepancy with this figure and the figure reported by the Department.
[109] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There were 469 valid responses to this question.
[110] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There were 286 valid responses to this question.

Percentage of Aboriginal and Torres Strait Islander and non-Indigenous young people aged 15–17 years with no LCP, 2009–11



Aboriginal and Torres Strait Islander young people were slightly more likely to report to CVs that they felt ready to transition[112] and knew where they would live once they transitioned.[113] These are in contrast to 2009–10, where non-Indigenous young people were more likely to report to CVs that they felt ready to transition and knew where they would live once they transitioned.

Aboriginal and Torres Strait Islander young people were less likely to report they will be able to achieve what they want to.[114] This is consistent with findings from 2009–10.

[111] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There was a total of 469 valid responses to this question. There were a total of 117 responses relating to Aboriginal and Torres Strait Islander (A&TSI) young people and 352 responses relating to non-Indigenous young people.
[112] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There was a total of 286 valid responses to this question. There were a total of 63 responses relating to A&TSI young people and 223 responses relating to non-Indigenous young people.
[113] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There was a total of 305 valid responses to this question. There were a total of 66 responses relating to A&TSI young people and 239 responses relating to non-Indigenous young people.
[114] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There was a total of 262 valid responses to this question. There were a total of 54 responses relating to A&TSI young people and 208 responses relating to non-Indigenous young people.

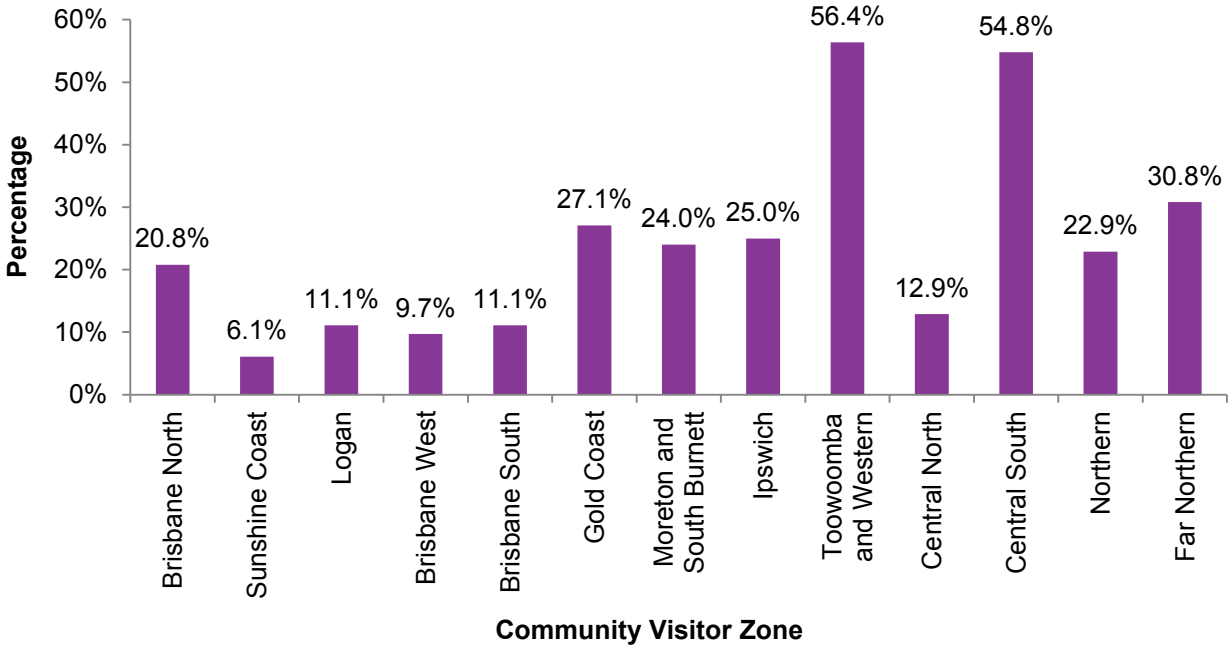
Transition from care statistics by cultural status, 2009–11

Measure	2009–10		2010–11	
	Aboriginal & Torres Strait Islander	Non-Indigenous	Aboriginal & Torres Strait Islander	Non-Indigenous
No Leaving Care Plan	33.3%	29.4%	26.5%	24.1%
Young person feels ready to transition from care	76.7%	82.6%	84.1%	83.9%
Young person reports knowing where they will live once they transition from care	48.6%	67.3%	69.7%	68.2%
Young person reports they will be able to achieve what they want to	83.3%	94.6%	81.5%	89.9%

Regional differences

Commission Community Visitors (CVs) in the Toowoomba and Western zone (56.4%) and Central South zone (54.8%) reported larger percentages of young people with no LCP in development or no LCP at all.[115]

Percentage of young people aged 15–17 years with no current LCP or LCP in development, by zone, 2010-11



[115] Data source: Commission. Community Visitor data. Information extracted from the child's last report between July 2010 and June 2011. Data are for young people aged 15 years and over. There was a total of 469 valid responses to this question. The number of valid responses for each zone is as follows: Brisbane North – 24, Sunshine Coast – 33, Logan – 36, Brisbane West – 31, Brisbane South – 36, Gold Coast – 48, Moreton and South Burnett – 25, Ipswich – 48, Toowoomba and Western – 39, Central North – 31, Central South – 31, Northern – 35, and Far Northern – 52.

Earning or further learning by young people formerly in out-of-home care

Latest level and trends

Data on young people earning or learning is currently unavailable.

The Department of Communities has advised that "due to the small number of young people who had spent time in out-of-home care and taken part in the Next Step survey, it was not possible to make meaningful comparisons about types of further education or employment. Also, due to small numbers, percentages represented in the table may vary considerably from year to year. Care must be taken when interpreting these results due to the low numbers involved and the possibility of non-response bias."

Main destinations of Year 12 completers identified as being in out-of-home care[116]

Destination	Children in out-of-home care				Queensland			
	2007	2008	2009	2010	2007	2008	2009	2010
Learning[117]	37.8%	39.7%	46.1%	NA	63.6%	60.6%	59.6%	60.7%
Earning[118]	28.9%	29.3%	19.7%	NA	29.3%	32.1%	30.3%	27.9%
Neither[119]	33.3%	31.0%	34.2%	NA	7.0%	7.3%	10.0%	11.4%

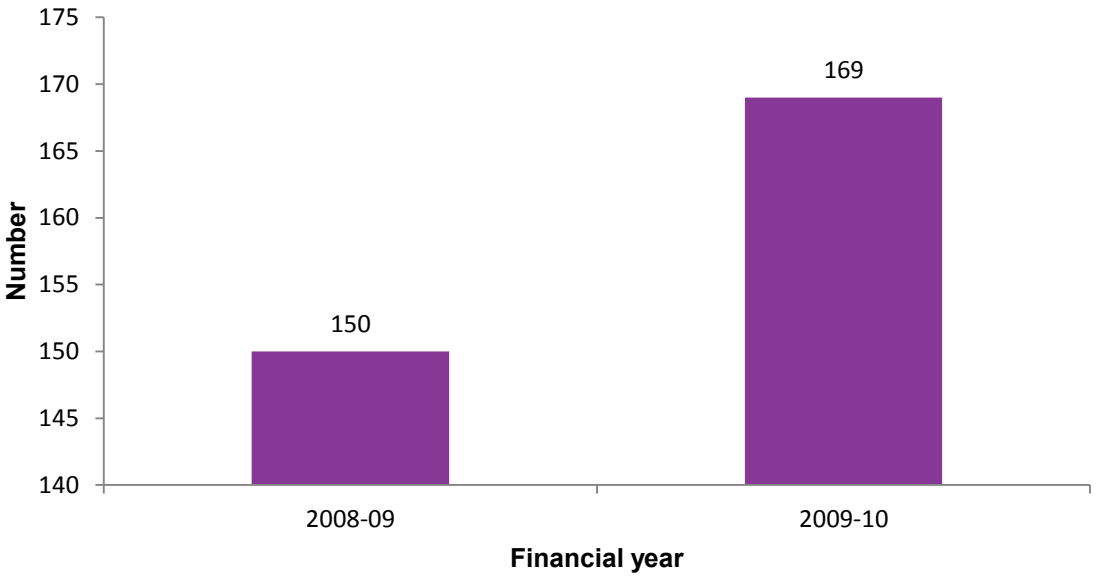
[116] Due to small numbers, percentages represented in the table may vary considerably from year to year. Care must be taken when interpreting these results due to the low numbers involved and the possibility of non-response bias.
[117] The destination of „Learning' includes all students, regardless of their labour force status.
[118] The destination of „Earning' includes those who are working and not in further education or training.
[119] The destination of „Neither learning nor earning' includes categories of „seeking work' and „not in the labour force'.

Number of children subject to a child protection order for more than 12 months who were admitted to a supervised youth justice order at some time during the year

Latest level and trends

In 2009–10, 169 children subject to a finalised child protection order for more than 12 months were admitted to a supervised youth justice order at some time during the year. This represents 4.8% of all children aged 10–17 years under a child protection order during 2009–10 and subject to this order for more than 12 months.[120]

Children in out-of-home care entering the Youth Justice system



[120] Data Source: Department of Communities. (Child Safety). (2010). *2009-10 Child Protection Partnerships Report.* Brisbane.

Appendix A

Overview of Evidence Base

The Key Outcome Indicators (KOIs) draw on a variety of data sources to provide readers with a comprehensive picture of the experiences of children in the child protection system. Each piece of information adds value to understanding how children reliant on this service system are faring. For the purpose of effective interpretation, and so that findings are read in context, it is important to understand how each piece of information is gathered. This section describes the data sources which contribute to the Update and factors to consider when interpreting the data. Where necessary, throughout the Update footnotes have been included to provide further explanation about the data source or findings.

Department of Communities, Child Safety and Disability Services administrative data

The Department of Communities, Child Safety and Disability Services (the Department) provides the Commission with data and information about its service delivery to children under the *Child Protection Act 1999*. Information provided by the Department covers the entire spectrum of the child protection system, from the Investigation and Assessment (I&A) phase to custody and/or guardianship orders to transitions to independence. It includes information about key service delivery areas such as timeliness of actioning IAs, case planning and Education Support Plans (ESPs).

Relevant data is captured in the Department's Integrated Client Management System (ICMS). It is provided to the Commission, along with breakdowns by age, Aboriginal and Torres Strait Islander status and region. The Department also provides data about the Referral for Active Intervention (RAI) program, which delivers early intervention services to children and families at risk of entering the child protection system, and works with the Department of Education, Training and Employment, and the Queensland Studies Authority, to provide the Commission with information about educational outcomes for children in out-of-home care.

Administrative data may provide some, but not all, required insights into the quality of service delivery and the appropriateness of interventions. The quality of record keeping can also influence the availability of data. To aid in developing a complete picture of children in the child protection system, the KOIs draw on other independent data collection sources, such as Commission Community Visitor (CV) report data, collected in Jigsaw, Views survey results, audits, investigations and reviews.

Commission Community Visitor reports about children in care

CVs regularly visit children in out-of-home care, to verify that they are safe and receiving appropriate care, to advocate on their behalf to help resolve any concerns or grievances and to offer support if required. After each visit CVs prepare a written report about the standard of care experienced by the child. These reports are based on an independent assessment made by the CV. Information and evidence used to formulate the CVs assessment is derived from multiple sources. Depending on the nature of the information these may be engagement and one-on-one discussions with the child during the visit, the CV's observations of the standard of care provided during the visit and/or statements made by the child's carer about the child.

In 2009–10, an improved CV report framework was introduced within the new Jigsaw system, to enhance data management and reporting and subsequent individual and systemic advocacy by the Commission. The implementation involved a change in the way CVs record the information from their visits with children. CVs now provide yes/no answers to over 75 questions, categorise their concerns in additional sub-questions and provide some free text responses. This enhanced way of reporting enables detailed data capture about care provided to a child, and becomes an important

tool when that information is analysed across groups of children for trends. Since the new reporting system went live in November 2009, through to 30 June 2011, a total of 63,141 CV visit reports were generated.

A total of 41,156 CV visit reports from 2010–11 (relating to 7,604 distinct children) were analysed for this Update. This provides for a significant sample and representation of issues affecting children in care. Like the Department's administrative data, where relevant, Jigsaw data is disaggregated by age, Aboriginal and Torres Strait Islander status and CV zone. In some cases, data was drawn from the last visit report in the six month period for a child, or from any one of the visit reports recorded for a child in the six month period. The footnotes throughout the report provide this additional detail and further information about children's responses to CV reports can be accessed by emailing **data@ccypcg.qld.gov.au**.

In order to maintain the data quality and integrity of information entered in Jigsaw, the Commission has developed a Data Quality Management Plan. The plan includes strategies to optimise the capacity of CVs to record all required information from their visits and signals the need for careful quality assurance of data.

Views of Children in Care Queensland reports

The Commission regularly conducts surveys of Queensland children in foster care, kinship and residential care, and in youth detention, to capture their subjective views and experiences. The surveys are repeated regularly with cross-sections of children and using a common set of survey questions. The survey comprises a mix of select-response and open-ended questions that gather data on children's and young people's overall feelings of safety and happiness and their perceptions of being cared for and supported. Since the research commenced in 2006, more than 13,000 surveys have been completed.

Views data included in this Update is derived from the *Views of Children in Foster Care Queensland 2010* survey and the forthcoming *2011 Views of Children and Young People in Foster Care Survey: Overview and selected findings*. Where data has been used from these reports, it has been noted in the body of this Update.

A major benefit of the data generated by both the CV reports and the Views survey data is that they augment the scope of existing Departmental administrative data, for example the number of reunifications, successful or otherwise, that children experience.

It is important to note that Views survey findings can not be directly compared to CV findings, due to different methodologies and different time periods for data collection. As noted previously, CV reports are collected as part of the Commission's statutory oversight of service delivery and are the CV's overall assessment of the standard of care experienced by the child or young person. In contrast, the Views survey data are based entirely upon the subjective view and opinions of children.

Appendix B

Profile Page

The following profile illustrates an overview of the numbers of children and young people moving through the child protection system from intake to exiting care. In particular, it provides an overview of the overrepresentation of Aboriginal and Torres Strait Islander children and young people in the child protection system.

Representation of children in the Queensland child protection system in 2010–11

Distinct number of children	Number	Rate per 1000	Percentage change (2009–10 to 2010–11)
Subject to an Intake	71,164	65.4	6.1%
Subject to a Child Concern Report	60,553	55.7	9.9%
Subject to a Notification	19,353	17.8	-1.4%
Subject to a Substantiation	5941	5.5	-4.5%
Subject to an IPA*[121]	1956	1.8	-24.2%
Subject to protective orders[122]*	8456	7.8	4.5%
Living away from home*[123]	8063	7.4	3.3%
In out-of-home care*[124]	7602	7.0	3.4%
Exiting care in 2010-11	1628	1.5	-1.8%

*As at 30 June 2011

[121] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS). This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.
[122] This measure includes all children subject to short and long-term child protection orders and court assessment orders.
[123] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.
[124] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) as per nationally agreed reporting definitions.

Representation of children in the Queensland child protection system, by cultural status, in 2010–11

	Aboriginal and Torres Strait Islander children			Non-Indigenous children		
Distinct number of children[125]	**Number**	**Rate per 1000**	**% change (2009-11)**	**Number**	**Rate per 1000**	**% change (2009-11)**
Subject to an Intake	13,433	191.7	4.8%	57,731	56.7	6.4%
Subject to a Child Concern Report	10,884	155.3	8.2%	49,669	48.8	10.3%
Subject to a Notification	4953	70.7	2.5%	14,400	14.1	-2.7%
Subject to a Substantiation	1731	24.7	-2.8%	4210	4.1	-5.1%
Subject to an Intervention with Parental Agreement*[126]	744	10.6	-17.8%	1212	1.2	-27.6%
Subject to protective orders[127]*	3181	45.4	7.1%	5275	5.2	3.0%
Living away from home[128]*	3052	43.6	5.5%	5011	4.9	1.9%
In out-of-home care[129]*	2850	40.7	6.1%	4752	4.7	1.9%
Exiting care in 2010–11	575	8.2	-3.7%	1053	1.0	-0.8%

*As at 30 June 2011

[125] Population figures were sourced from the Department.
[126] In June 2011, the Department undertook an audit and cleansing of intervention with parental agreement records in the Integrated Client Management System (ICMS) took place. This included closing down historical records where a child was no longer subject to intervention with parental agreement. As a result, data reported for 30 June 2011 and onwards is not comparable to previous years.
[127] This measure includes all children subject to short and long-term child protection orders and court assessment orders.
[128] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) or other locations such as hospitals, Queensland youth detention centres and independent living.
[129] This measure includes all children in out-of-home care (including foster care, kinship care, provisionally approved care and residential care services) as per nationally agreed reporting definitions.

Appendix C

Dictionary and abbreviations

Case plan

A written document identifying the goals of the ongoing child protection intervention with a child and the outcomes and actions required to achieve the goals. The *Child Protection Act 1999* states that every child who is in need of protection and requires ongoing help (such as those in out-of-home care) must have a case plan that is reviewed regularly. At a minimum, case plans must be reviewed every six months. The plan should be focused on meeting the child's protection and care needs, and is developed in a participative process between the Department of Communities, Child Safety and Disability Services, the child, the child's family and other significant people.

Children (when used within the context of the *Child Guardian Views of Young People in Residential Care 2009* report)

Persons aged 5 to 8 years.

Children and young people or children

Persons aged 0 to 17 years.

Child Concern Report

A Child Concern Report is a record of child protection information received by the Department of Communities, Child Safety and Disability Services that has been "screened out" and does not meet the threshold for a notification.

Child Guardian

External accountability mechanism in relation to the provision of services to, and decisions made in respect of, children and young people in the child safety system. The Commissioner's Child Guardian functions are specified in section 17(2) of the *Commission for Children and Young People and Child Guardian Act 2000*.

Child Guardian Key Outcome Indicators

An agreed framework established by the Child Guardian to monitor the effectiveness of priority areas of service delivery within the child safety system. There are 10 Key Outcome Indicators:

- Effective assessment
- Appropriate interventions
- Safe out-of-home care
- Stable out-of-home care
- Individual needs met
- Best education possible
- Best health possible
- Special needs of Aboriginal and Torres Strait Islander children and young people met
- Successful reunifications, and
- Successful transitions to independence.

Child Health Passport

The Child Health Passport is a joint initiative of the Department of Communities, Child Safety and Disability Services and Queensland Health. The Child Health Passport records a child's or young person's health information and provides carers with the information they need to meet the child's day-to-day health needs. The passport is to be updated throughout a child's time in care and will include a "Child Information Form" with immunisation details, a photocopy of the child's Medicare card, details of the child's baseline health assessment or annual health check details and pertinent health alerts. The passport moves with the child or young person if they change placements.

Child Placement Concern Report

This is recorded, in response to a matter of concern, where the information gathered indicates that:

- an approved carer or staff member has provided inadequate or poor quality care (for a child in out-of-home care) that fails to meet the standards of care detailed in the *Child Protection Act 1999*, section 122, and
- a child did not suffer harm, is not suffering harm and is not at unacceptable risk of suffering harm, as defined in the *Child Protection Act 1999*, section 9 due to the actions or inactions of an approved carer or staff member of a licensed care service or another entity.

Child protection order

Under section 54 of the *Child Protection Act 1999* an authorised officer may apply to the Children's Court for a child protection order for a child. Section 59 of the *Child Protection Act 1999* specifies that a court may make a child protection order only if it is satisfied the child is in need of protection and the order is appropriate and desirable for the child's protection.

Child protection system

The child protection system includes the services collectively delivered by the Department of Communities, Child Safety and Disability Services (as lead agency) and relevant government service providers, including Queensland Health and the Department of Education and Training as well as non-government service providers. The system also includes children and young people of whom the Department of Communities (Child Safety Services) becomes aware because of allegations of harm or risk of harm, regardless of whether these children enter out-of-home care.

Child Safety Officer (CSO)

CSOs provide statutory child protection services to children and families through:

- undertaking the roles of an authorised officer under the *Child Protection Act 1999*
- the application of relevant legislation, delegations, policies, procedures and quality standards
- working collaboratively with approved carers, the community, government and non-government service providers.

Child Safety Service Centre or CSSC and Child Safety Zone

Regional offices of the Department of Communities, Child Safety and Disability Services.

Commission Community Visitors (CVs)

An authorised person under the Commission's Act who visits and checks on the safety and wellbeing of children and young people who are in care.

The Department

Department of Communities, Child Safety and Disability Services (formerly Department of Communities, Child Safety Services)

Education Support Plan (ESP)

The Education Support Plan is a joint initiative of the Department of Communities, Child Safety and Disability Services and the Department of Education and Training, which plans and documents the child's educational goals and outcomes and strategies to achieve identified outcomes. An Education Support Plan is required when a child meets all of the following requirements:

- is subject to a child protection order granting custody or guardianship to the chief executive
- resides in an out-of-home care placement, and
- is of compulsory school age, or enrolled at school in Years 1–12.

The plan is reviewed on an annual basis or in situations when the child or young person's circumstances change significantly.

Exclusion

Exclusion of a child or person from a Queensland state school is governed by the provisions of the *Education (General Provisions) Act 2006*. Exclusion occurs when the state school principal believes there are grounds for the student to be excluded from that school. The principal's supervisor can also exclude a student from a school or schools they supervise. The chief executive may determine that the child is to be excluded from a state school at which the student is enrolled, certain state schools or all state schools. The decision to exclude a child or young person from a state school is to be based on the student's behaviour and conduct.

Family group meeting (FGM)

According to section 51G of the *Child Protection Act 1999*, the purpose of family group meetings are to provide family-based responses to children's protection and care needs and to ensure an inclusive process for planning and making decisions relating to children's wellbeing and protection and care needs. Under the *Child Protection Act 1999* section 51H, the chief executive must convene a family group meeting or have a private convenor convene a family group meeting to develop a case plan for a child. In relation to case planning occurring at a family group meeting, section 51L of the *Child Protection Act 1999* specifies the people who must be given the opportunity to participate in the meeting. This includes the child, unless it would be inappropriate because of the child's age or ability to understand, the child's parents, a legal representative of the child and a Recognised Entity if applicable.

Harm

Under section 9 of the *Child Protection Act 1999*, harm to a child is defined as any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.

Integrated Client Management System (ICMS)

A computerised system intended to centralise all records relating to foster carers, children in care or "at risk" of harm, and young people in the youth justice system. ICMS replaced the existing Child Protection System (CPS) and Families Information System (FAMJY) in 2007.

Indigenous Child Placement Principle

A decision-making hierarchy of placement options that must be observed when placing Aboriginal and Torres Strait Islander children and young people in out-of-home care, as described in section 83 of the *Child Protection Act 1999*.

Intake

Intake is the first phase of the child protection continuum, and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child, or when a request for departmental assistance is made.

Intervention with Parental Agreement (IPA)

Ongoing intervention with a child who is considered in need of protection, based on the agreement of a child's parent/s to work with the Department of Communities (Child Safety Services) to meet a child's safety and protection needs.

Investigation and Assessment or I&A

The response of the Department of Communities, Child Safety and Disability Services to all Notifications, to determine the safety and protective needs of a child under section 14 of the *Child Protection Act 1999*. The I&A process involves determining if the child is safe, investigating allegations of harm and risk of harm, undertaking a holistic assessment of the child and family within their usual home environment, determining if the child is in need of protection, and deciding whether there are supports that the department or other agencies can provide to the child and family.

Jigsaw

The Commission's information management system which provides case management support for, and reporting on individual and systemic advocacy activities under, the Commission's Child Guardian functions.

Locally Resolvable Issue

Locally Resolvable Issues are those which can be addressed by CVs using their functions as outlined in Chapter 5 of the *Commission for Children and Young People and Child Guardian Act 2000*, and are typically service delivery issues significantly impacting on a child or young person's wellbeing and development. A Locally Resolvable Issue could include instances where a child is significantly impacted by not having access to appropriate dental care, education support or contact with family. Action taken in response to these issues is known as local resolution, which describes a range of activities undertaken by CVs to raise and seek resolution for issues, concerns or grievances impacting on a child or young person's wellbeing or development, with appropriate stakeholders who have the responsibility and capacity to take action to address it.

Matter of Concern (MOC)

A Matter of Concern is any concern raised in relation to the quality of care provided to a child or young person placed in out-of-home care under the *Child Protection Act 1999*, Section 82(1), where a breach of the standards of care is indicated. Matters of Concern apply to children subject to the custody or guardianship of the chief executive or subject to a care agreement who are in an out-of-home care placement with a foster carer, kinship carer or provisionally approved carer, a licensed care service or another entity.

National Assessment Program – Literacy and Numeracy (NAPLAN)

A national program, commenced in 2008, by which all students in years 3, 5, 7 and 9 are assessed on the same days using national tests in reading, writing, language conventions and numeracy.

National Disability Agreement (NDA)

An agreement between the Commonwealth of Australia and the states and territories providing the national framework and key areas of reform for the provision of government support to services for people with disabilities.

Notification or Child Protection Notification (CPN)

Information received about a child who may be at harm or at risk of harm which requires an Investigation and Assessment response. A notification is also recorded on an unborn child when there is reasonable suspicion that the child will be at risk of harm after he or she is born.

Out-of-home care (and the reporting on services provided to children and young people in out-of-home care)

The provision of care outside the home to children and young people who are in need of protection or who require a safe placement while their protection and safety needs are assessed.

The Department of Communities, Child Safety and Disability Services reports on this group of children and young people as follows:

- Subject to protective orders: this measure includes all children and young people subject to short and long-term child protection orders and court assessment orders.
- In out-of-home care: this measure is reported in accordance with the nationally agreed reporting definitions. It includes care provided to all children and young people in out-of-home care (including foster care, kinship care, provisionally approved care and residential services).
- Living away from home: data reported under this category includes all children and young people who have been removed from their home, regardless of whether the placement is departmentally funded or unfunded. It is important to note that not all of these children and young people are subject to a protective order, but are subject to some form of intervention by the Department of Communities, Child Safety and Disability Services.

The reporting on the services provided to children and young people in out-of-home care is also impacted by their custody and guardianship arrangements. The child protection system is required to provide more services to children and young people in the custody or guardianship of the chief executive, for example Education Support Plans and Child Health Passports.

For children and young people in out-of-home care, the Commission's Community Visitor Program is legislatively obligated to visit children and young people who are in the custody or guardianship of the chief executive.

This means that the reporting on services provided to children and young people in out-of-home care is a complex matter. Care has been taken throughout the report to clearly identify the population being referred to.

QH

Queensland Health

QPS

Queensland Police Service

Recognised Entity (RE)

An entity (an individual or organisation) with whom the Department of Communities, Child Safety and Disability Services must either provide the opportunity to participate in the decision-making process for significant decisions or consult with for all other decisions relating to the protection and care of an Aboriginal and Torres Strait Islander child.

Referral for Active Intervention (RAI)

Referral service to non-government organisations for low level child protection notifications involving children up to 10 years of age. A referral to a RAI service may be made by Child Safety Services, a guidance officer from the Department of Education and Training or a child health nurse from Queensland Heath. A referral cannot be made where the child is in need of protection or the family is not in agreement to the referral.

Regions

The Child Safety Service Centre Regions for the state of Queensland are as follows:

- Brisbane
- Central Queensland
- Far North Queensland
- North Coast
- North Queensland
- South East Queensland
- South West Queensland

Residential care

Non-family based accommodation for children and young people in out-of-home care.

Reunification

The process of returning a child or young person to live with his or her family. The process should be planned and involve the provision of any required services and supports to the child or young person and family.

Self-placing

The decision of a child or young person to leave their Department of Communities (Child Safety Services) placement to live somewhere else, without the approval of the department.

Serious Issue

Serious Issues are those which require immediate referral to a relevant agency (relevant agencies include the Department of Communities, Child Safety and Disability Services, Queensland Police Service and the Crime and Misconduct Commission) under section 25 or Chapter 4 of the *Commission for Children and Young People and Child Guardian Act 2000*. These relate to:

- a child or young person who is or may be in need of protection

- a child or young person who is or may be the victim of a criminal offence, and
- a service delivery issue significantly impacting on a child or young person's wellbeing and development which remains unresolved after two months of advocacy.

Suspected Child Abuse and Neglect Teams (SCAN) Teams

SCAN Teams combine the child protection expertise of four core agencies – the Department of Communities, Child Safety and Disability Services, Queensland Police Service, Queensland Health, and the Department of Education and Training. It is intended to provide a coordinated, multi-disciplinary response to reports of serious harm or risk of harm to children.

Standards of care

The framework Community Visitors use when reporting about their visits to children and young people in out-of-home care. These standards are based on the Charter of rights for a child in care as specified in Schedule 1 of the *Child Protection Act 1999*.

Substantiation

The outcome of an Investigation and Assessment of a Notification by the Department of Communities, Child Safety and Disability Services where it is determined that the child or young person has experienced harm or there are risk factors indicating future harm.

Suspension

The suspension of children and young people is governed by the *Education (General Provisions) Act 2006*. Suspension occurs when a student is not allowed to attend the school at which he or she is enrolled, or any other state school, for a particular period of time. The decision to suspend a child or young person is to be based on the behaviour and conduct of the student.

Systemic issues

Includes issues relating to children and young people in the child safety system which have affected, or will potentially affect, more than one child in a way detrimental to their rights, interests and wellbeing.

Therapeutic services

Allied health services provided or required by children and young people in out-of-home care, for example, counselling.

Transition from care

Process of preparing a young person in out-of-home care to transition to adulthood as required by Schedule 1(k) of the *Child Protection Act 1999*.

Unsubstantiated

The outcome of an Investigation and Assessment of a Notification by the Department of Communities, Child Safety and Disability Services where it is determined that a child or young person has not suffered harm and no risk factors for future harm have been identified.

Views of Young People in Residential Care

The latest survey of children and young people in residential care in Queensland, including 169 young people (or 34% of those) in statutory care. Survey findings are published in *Views of Young People in Residential Care, Queensland, 2009*. This report focuses on the findings of the survey in relation to the subset of young people in statutory care. Accordingly, response frequencies for variables such as „feeling safe' vary from those published in the main survey report.

The survey is part of the Commission's Views of Children and Young People in Care survey series – an ongoing body of research capturing the views and experiences of young people in foster and kinship care, residential care and youth detention.

Young people (when used within the context of the Child Guardian survey)

Persons aged 9 to 18 years.

Appendix D

Child Guardian Performance Assessment

Key Outcome Indicator	Performance Assessment	Rationale
Effective assessment		Despite significant efforts across the past eight years, which have succeeded in reducing the Investigation and Assessment backlog, the percentage of matters responded to and completed within Departmental benchmarks remains low and there have been relatively minor improvements evident in Investigation and Assessment response and finalisation rates over the past three years
Appropriate interventions		The rate of Queensland children in out-of-home care (7.0 per 1000) remains below the national average of 7.3 per 1000 children (as at June 2011). Aboriginal and Torres Strait Islander children and young people continue to be over-represented in the child protection system. Further, the percentage of families demonstrating an improvement in primary presenting factors, secondary presenting factors, or both decreased by 10% (from 2009–10 to 2010–11)
Safe out-of-home care		Children and young people continue to report feeling safe in out-of-home care and both Matters of Concern and Issues of Concern have decreased
Best health possible		Commission Community Visitors have identified children with unmet health needs. The lack of Departmental child health passport data, indicating health needs assessments and planning are occurring, creates concerns in relation to this indicator
Best education possible		While the percentage of children with an Educational Support Plan is encouraging, their achievement levels according to the most recent NAPLAN data are significantly below their peers who are not in care. Suspensions and exclusions continue to be an issue for children and young people in care. It is also of concern that the percentage of children in care reporting experiences of bullying has risen. The data continues to show a high percentage of children and young people report having adequate resources to allow them to effectively engage in school
Stable out-of-home care		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
Special needs of Aboriginal and Torres Strait Islander Children		Aboriginal and Torres Strait Islander children and young people remain significantly over-represented at every stage of the child protection system. The available data shows that this vulnerable group of children are increasing their contact with the child protection system at rates disproportionate to non-Indigenous children
Individual needs met		Slight gains have been made across this indicator. It is also encouraging to see an increase in both 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
Successful reunifications		The number of children known to the Community Visitor Program who were reunified with their families has decreased over the past three reporting periods. The percentage of young people reporting being adequately involved in the reunification process has increased over the past two years. Scope also exists for the Department to improve its data to enable better monitoring of reunification outcomes
Successful transitions to independence		While an increase of 8.1% since 2009-10 in transition from care planning is encouraging, more needs to be done to ensure that all children ready to transition out of care have an adequate plan and supports in place

Appendix E

Full Department of Communities, Child Safety and Disability Services response to Commission's Performance Assessments

Effective assessment

Under section 14 of the *Child Protection Act 1999*, if the chief executive becomes aware of alleged harm or risk of harm to a child and reasonably suspects the child is in need of protection, the chief executive is mandated to take certain actions immediately, including having an authorised officer investigate the allegation and assess the child's need for protection or, under section 14(1)(b) take other action the chief executive considers appropriate. Under existing Queensland policy, departmental officers currently investigate all matters.

The investigation and assessment of a notification is a complex and sensitive process that may take weeks, and in some cases months to finalise, especially if a criminal investigation is also involved. In Queensland all notifications are investigated as part of a broad-based approach to assessing children at risk of harm.

21,655 notifications were recorded by Child Safety Services in 2010-11. Over the last six years the department has observed a significant increase in referrals to child safety, with an increase of 80%. These figures are currently projected to increase over coming years.

The Department of Communities has undertaken a number of initiatives to reduce the number of outstanding Investigation and Assessments. In January 2012, the Budget Review and Capital Infrastructure Committee approved the allocation of non-recurrent resources over a six month period to finalise all investigation and assessments older than two months. The objectives of the Investigation and Assessment Project are to:

- finalise the regional investigation and assessment backlogs within six months of the commencement of the project
- review and implement improvements to embed and sustain quality practice to improve client service delivery
- develop agreed performance targets and monitoring and reporting arrangements that support quality investigation and assessment practice.

In addition to this project, the department has also undertaken a number of strategies to improve investigation commencement and completion times. These include:

- the use of structured decision making tools at key decision making points
- supporting child safety officers to focus on direct service delivery through the use of specialist positions, such as court coordinators, Suspected Child Abuse Network coordinators, family group meeting convenors, placement officers and business support officers
- amendments to the procedures in relation to the commencement and completion of an investigation and assessment in exceptional circumstances in November 2010.

The criteria for commencement of an investigation and assessment has been broadened so that, where an authorised officer is not able to access and sight a child within the required timeframe, significant information can be gathered that relates to the child's immediate safety by interviewing a parent or contacting a government or non-government agency. This more accurately reflects that an investigation and assessment is commenced once significant information has been gathered in relation to the child's immediate safety.

The introduction of two differential pathways for the completion of an investigation and assessments provide greater flexibility in the assessment of child protection concerns that are tailored to a family's individual circumstances. The first „core assessment' allows for the finalisation

of an investigation and assessment without the completion of certain actions that may ordinarily be undertaken, where it is determined that the actions would not provide additional relevant information. The „contact with other professional' allows for another professional to assist in speaking to a child, where they have not been sighted by the department, but there is a comprehensive assessment of harm and risk of harm already made.

There are a number of valid reasons which may contribute to delays in commencing or completing an investigation, including some outside the control of Child Safety Services, for example: geographical distance or a lack of access due to seasonal conditions may prevent an authorised officer from sighting the child; the family are not at home or are otherwise unable to be located at the time.

The new government's commitment to „Fostering Families' aims to support families before entering the tertiary child protection system. „Fostering Families' aims to build strong resilient families and act to reduce the number of children entering out of home care by working with families to address the child protection issues. It is anticipated that the government's commitment to implementing appropriate intervention services combined with better identification and follow up for families at risk will have a significant impact on the number of notifications and subsequent investigation and assessments received by the statutory child protection authority.

Appropriate interventions

The Commission's findings confirm what we already know – indigenous children are over-represented in the child protection system, not just in Queensland, but across all Australian jurisdictions.

In December 2010, the *Blueprint for Implementation Strategy* was released as the Government's response and commitment to reducing over-representation. The Blueprint was informed by the Queensland Aboriginal and Torres Strait Islander Child Safety Taskforce's August 2010 *Together keeping our children safe and well - Our Comprehensive Plan.*

In response, the 2011 *Blueprint for implementation strategy: Reducing the over-representation of Aboriginal and Torres Strait Islander children in Queensland's child protection system* (the *Blueprint*) was developed.

The *Blueprint* recognises that responding to this vulnerable group is a shared responsibility and identified actions are grouped under the key priority areas:

- sharing a common vision and commitment
- providing the right services at the right time
- ensuring the existence and application of sound legislation, policy, practice and procedures
- building a robust network of Indigenous service providers.

Implementation of the *Blueprint* Strategy has commenced and will continue, and is oversighted by a sub-working group whose membership includes representatives from the Department and our non-government partners; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, Create, Queensland Council of Social Services and Peakcare. The sub-working group meets on a quarterly basis to consider the progress of Blueprint actions, including key performance measures relevant to over-representation.

The department has also been responding to recommendations from the Commission's audits of the Department's compliance with the Indigenous Child Placement Principle. This has driven significant policy, procedural and resource development in line with the Commission's recommendations. A review of staff and carer training has also been undertaken to ensure it incorporates any changes.

Strategies to enhance placement decision making and record keeping, promote the importance of kinship care, and improve awareness of the respective roles of departmental staff and staff from Aboriginal and Torres Strait Islander community controlled child protection services are currently in progress.

This is in addition to the department's ongoing support of Aboriginal and Torres Strait Islander community controlled child protection services, specifically Recognised Entities, Family Support Services and Foster and Kinship Care Services. The Safe House initiative continues to expand, enabling Aboriginal and Torres Strait Islander children from remote communities to remain within their community when they require an out-of-home care placement.

Safe out–of–home care

It is a pleasing to note that children and young people themselves continue to articulate they feel safe in care and the Department of Communities, Child Safety and Disability Services (the Department) will persist to ensure children are and feel safe when placed in out-of-home care.

Numbers of Matters of Concern
It is expected that with the continuation of the majority of children feeling safe in care that the numbers of Matters of Concern would remain stable or decrease, as is borne out in the data. The safety and wellbeing of children in care is paramount and monitored regularly via a range of means. Where concerns are identified about the care of a child in out-of-home care, the Department acts to address the concerns and develop an action plan where required to reduce the possibility of an escalation of concerns or further Matters of Concern.

The Department of Communities, Child Safety and Disability Services has one of the most thorough assessments of persons applying to become carers. All carers must undergo a rigorous assessment and screening process prior to being approved to care for children and young people. The Department has maintained the requirement that all carers and their adult household members undergo criminal and child protection history checks as well as hold a current blue card prior to becoming carers or residing in the household.

All carers approved by the Department of Communities, Child Safety and Disability Services are required to meet the legislated statement of standards (section 122 of the Child Protection Act 1999) and undergo a review of their approval after the first year then every two years thereafter. Matters of concern, carer learning and development needs, criminal history and household environment are part of the renewal of approval process. Where it is identified that there are serious breaches of the standards of care or substantiated Matters of Concern the Department continues to consider cancelling the carer's certificate of approval and removing children when necessary. The Department will continue to explore strategies and initiatives that support the safety and wellbeing of children in care.

Best health possible

- Child Safety Services will continue to ensure that children and young people's health needs, including their dental needs, are met through quality health assessments and planning.
- The child health passport contains the information required by a carer to meet the day-to-day health needs of the child and, at a minimum, a review of the information in this child health passport will occur during each review of the child's case plan.
- To further support the development of child health passports, the resource *A guide for general practitioners completing health assessments and appraisals for children* in *out-of-home care* was distributed to General Practice Queensland Divisions for dissemination across their networks in early 2011.
- To accommodate the new reporting arrangements that will be required by the National Standards for Out-of-Home Care, new fields have been added to the Integrated Client Management System (ICMS) to accurately capture data on health assessments.

- Changes to ICMS occurred in November 2011, to capture a record of all health information, including details regarding the development of a child health passport, under a health tab rather than in a child's case plan.
- The data in these fields is subject to extensive quality assurance before any data can be released for corporate reporting purposes

Best education possible

- It is positive that a high percentage of children and young people in out-of-home care have a completed Education Support Plan (ESP) and have identified that they have adequate resources to effectively engage in school.
- The Department of Communities, Child Safety and Disability Services and the Department of Education, Training and Employment (DETE) are working together to facilitate the collection and reporting of additional data on Education outcomes under the 2010 MOU. Our departments are also currently revising this MOU to further enhance the strong partnership to maximise a child's educational potential.
- Child Safety is committed to improving the educational outcomes for children and young people in care and to building the capacity of carers so they are able to better support the learning needs of children in care.
- Together Child Safety and DETE have been implementing the *Beam: Learning for everyday life* program. This program teaches foster carers how to support their child's learning at home and provides materials to help with literacy and numeracy development. This program aims to improve a child's academic achievement including the literacy and numeracy results captured in NAPLAN data.
- Child Safety and DETE also jointly support non-government partners to assist children in care to reach their full potential. One of these is the Pyjama Foundation, which recruits and trains volunteer readers, known as „Pyjama Angels', to visit children in care to teach them literacy and numeracy skills through educational games. Pyjama Angels may participate in departmental case planning meetings so they can tailor their approach to a child's educational needs.
- Case planning is directly linked to the development of the ESP which is designed to specifically target the child's individual goals and put in place strategies to reduce barriers to achieving educational outcomes and improving wellbeing.

It is acknowledged that many children and young people in out-of-home care have significant learning difficulties and are behind in their educational achievement due to their history of abuse and neglect. For some children, the level of trauma experienced from their history of abuse and neglect can result in the child displaying severe and complex challenging behaviours leading to suspensions or expulsions from school. This can have a flow on effect resulting in placement breakdown and the absence of school activities.

- The ESP process provides an opportunity for collaborative problem solving with the child, carer, family, school and other key stakeholders to address any schooling issues including suspensions, expulsions, non-attendance, bullying and support for learning difficulties.
- Child Safety provided funding of $6.647 million to DETE in 2011/12 to support strategies identified in the ESP that would maximise educational outcomes for children and young people in care.

Stable out–of–home care

The slight increase in the number of children who experience seven or more placements while in care may be partly attributable to recent trends for children to enter care at younger ages and spend longer periods of time in care.

The Department has implemented a range of initiatives to improve the stability of placements. The department is:

- continuing to conduct the statewide foster carer recruitment campaign, Foster a Future, to increase the size and diversity of the carer pool, which will provide greater options for matching children with carers
- promoting the increased use of kinship care, to provide appropriate placements for children and ease pressure on the foster carer pool
- implementing the Contemporary Model of Residential Care, to enhance residential care service delivery, through improved training and learning and professional development opportunities for residential care service staff and managers
- rolling out the recently developed intensive foster care program description, to ensure that children placed in intensive foster care (formerly specialist foster care) receive care and support that best meets their needs.

While a low number of placements is desirable, it needs to be balanced against other considerations such as compliance with the Indigenous Child Placement Principle or a general preference for placement in a child's local community and with siblings. Placement changes may occur for positive reasons, such as transition from an emergent placement to a long-term arrangement, or a change to a placement that better promotes family and/or cultural connection.

Special needs of Aboriginal and Torres Strait Islander children

The Commission's findings confirm what we already know – indigenous children are over-represented in the child protection system, not just in Queensland, but across all Australian jurisdictions.

In December 2010, the *Blueprint for Implementation Strategy* was released as the Government's response and commitment to reducing over-representation. The Blueprint was informed by the Queensland Aboriginal and Torres Strait Islander Child Safety Taskforce's August 2010 *Together keeping our children safe and well - Our Comprehensive Plan.*

In response, the 2011 *Blueprint for implementation strategy: Reducing the over-representation of Aboriginal and Torres Strait Islander children in Queensland's child protection system* (the *Blueprint*) was developed.

The *Blueprint* recognises that responding to this vulnerable group is a shared responsibility and identified actions are grouped under the key priority areas:

- sharing a common vision and commitment
- providing the right services at the right time
- ensuring the existence and application of sound legislation, policy, practice and procedures
- building a robust network of Indigenous service providers.

Implementation of the *Blueprint* Strategy has commenced and will continue, and is oversighted by a sub-working group whose membership includes representatives from the Department and our non-government partners; Queensland Aboriginal and Torres Strait Islander Child Protection Peak, Create, Queensland Council of Social Services and Peakcare. The sub-working group meets on a quarterly basis to consider the progress of Blueprint actions, including key performance measures relevant to over-representation.

The department has also been responding to recommendations from the Commission's audits of the Department's compliance with the Indigenous Child Placement Principle. This has driven significant policy, procedural and resource development in line with the Commission's recommendations. A review of staff and carer training has also been undertaken to ensure it incorporates any changes.

Strategies to enhance placement decision making and record keeping, promote the importance of kinship care, and improve awareness of the respective roles of departmental staff and staff from Aboriginal and Torres Strait Islander community controlled child protection services are currently in progress.

This is in addition to the department's ongoing support of Aboriginal and Torres Strait Islander community controlled child protection services, specifically Recognised Entities, Family Support Services and Foster and Kinship Care Services. The Safe House initiative continues to expand, enabling Aboriginal and Torres Strait Islander children from remote communities to remain within their community when they require an out-of-home care placement.

Individual needs met

- The department recognises the importance of case planning and case plan reviews in providing well targeted co-ordinated service delivery to children and young people in the statutory child protection system.
- Case planning is a participative process. The case plan is developed with the child, the child's family and other significant people in the child's life and involves a cycle of assessment, planning, implementation and review.
- Ongoing case plan training is provided to staff across the State to ensure that departmental officers are aware of the legislation, policy and procedures that guides this intervention.
- There are a number of valid reasons why, on a given day, a proportion of all children and young people subject to ongoing statutory intervention may not have a case plan recorded on Child Safety Services Integrated Client Management System (ICMS). These include:
    - the need to convene a family group meeting to develop a case plan. This family group meeting is convened within 30 days of the decision that a child or young person will require ongoing statutory intervention or within the timeframe set by the court on an adjournment. As the case plan is not recorded or approved until after this meeting, there will be a period of time when each child or young person does not have an approved case plan on ICMS. For example, it would be legitimate for a child who enters ongoing intervention on 5 June to not yet have a case plan approved and recorded on ICMS before 30 June.
    - the impact of exceptional circumstances on the development of the case plan. For example, there may be delays in the development of a case plan when parents are unwilling to engage in the case planning process; the current case plan is considered to no longer be in the child's best interests and an amended case plan is required; or where a child protection order must be sought prior to developing a case plan to ensure the child's safety.
- There are also a number of reasons why a case plan review may not be conducted within six months. These include instances where:
    - parents are unwilling to engage in the review process
    - the review is still in progress
    - the review has been completed but not yet recorded on the central system
    - the review is completed and entered into the central system but is yet to be approved.
- The department is committed to enacting the principles outlined in the Children and Young People's Participation Strategy. The strategy enhances opportunities for a child or young person to overcome barriers and have involvement in decisions that affect their lives. The strategy was developed with input from external stakeholders, including consultation with young people selected by the CREATE Foundation and young people involved with the Out Loud group in Townsville.
- In some circumstances, a child or young person's capacity to actively participate in decision-making may be diminished or not be appropriate. Such circumstances may include:

- when the risk of significant harm indicates the need for statutory intervention, irrespective of the child's, young person's or parent's wishes
- when the child or young person is unable to participate fully in decision-making because of factors such as drug or alcohol abuse or severe disability
- when the child's or young person's age or ability prevents them from understanding and actively contributing to the decision-making process.

- In these situations, children and young people are entitled to information and involvement as is appropriate for their age, ability to understand and psychological state, including information about the decision and rationale for the decision.
- Case planning is an integral component of the department's intervention with a child or young person and each child's need for safety and stability is prioritised throughout the complex cycle of case planning and review.

Successful reunifications

New fields were added to the Integrated Client Management System (ICMS) in April 2011 to enable the recording of information about reasons for case closure, such as family reunification. Subject to testing and quality assurance, it is currently anticipated this data may be available for reporting from the 2011-12 financial year onward. Following this, a future priority for the Department is the development of measures that focus on reunification outcomes for children and young people.

Successful transitions to independence

Child Safety Services recognises the importance of transition from care planning and has implemented a range of initiatives to ensure effective transition from care planning, including:

- Ensuring that transition from care planning, as part of the ongoing case planning process, commences when a young person turns 15 years of age and clearly identifies the young person's individual needs and activities required to address these.
- In November 2010 and November 2011, the CREATE Foundation Queensland (CREATE), with funding from the then Department of Communities, launched and distributed the „Go Your Own Way' kits. The kits, which were developed in consultation with young people with experience of the care system, provide practical information about services and other tools to assist young people transitioning into independent living and adulthood. In 2012, the kit will become a national resource with state and territory specific information.
- Under the National Partnership Agreement on Homelessness (the Agreement), the Department of Communities, Child Safety and Disability Services provides a range of services and programs that assist young people leaving state care who may be at risk of homelessness:
  - The Youth, Housing and Reintegration Service (YAHRS), including the After Care Service, is an initiative funded under the Agreement, to provide individualised support to assist young people, aged 12 to 20 years, who are leaving state care and may be at risk of homelessness. The After Care Service within YAHRS focuses on young people who have exited out-of-home care. It supports these young people to transition to greater independence and stability through engagement in education, training and employment activities and establishing and maintaining successful tenancies.
  - The Transition Officer program, which is also funded under the Agreement, supports young people with a disability who are turning 18 years of age and transitioning from care to community-based living and independent adult life.
- Celebrating Transition from Care (TFC) Month in November each year. This provides an opportunity to focus on the journey to independence undertaken by young people leaving our child protection system. November 2011 was the third anniversary of TFC Month.
- The Life Without Barriers (LWB) Transition from Care program is jointly funded by the Department of Communities, Child Safety and Disability Services and the Department of Education Training and Employment. This program, which is provided in the Logan, Inala,

Goodna, Beenleigh and Browns Plains areas, offers support and practical assistance to meet the identified needs of young people aged 15 to 17 years who are preparing to leave care.

Transition to independence is a national priority, under the National Framework for Protecting Australia's Children 2009-2020 (the Framework), which is being delivered through a series of three-year action plans. Queensland will continue to work with other state and territory governments to develop working arrangements that enable consistency in transition planning.

The Department of Communities, Child Safety and Disability Services is also a member of G-Force which is a cross sector working party made up of government and non-government organisations including the Commission and key agencies such as CREATE and Foster Care Queensland. The group focuses on building the capacity of the sector to facilitate engagement and participation of children and young people in decision-making about their own lives and respond to the needs of young people transitioning from out-of-home care.

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This version of the *Child Guardian Key Outcome Indicators Update – Child Protection System 2008-11* was developed and updated by the Commission for Children and Young People and Child Guardian.

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commission for children and young people and child guardian

A better life for Queensland children

Indigenous Child Placement Principle

Audit Report 2010/11

Child Placement Principle Compliance Assessment Tool

Every applicable step must be complied with and recorded to fully comply with s83 of the *Child Protection Act 1999*

WHEN CONSIDERING ALL PLACEMENT OPTIONS THE WELFARE AND BEST INTERESTS OF THE CHILD ARE PARAMOUNT.

STEP 1
Identify the child is Indigenous under s83(1)

Is the child Indigenous?

✓ Yes: compliance

go to step 2 ▶

✗ No:

Indigenous Child Placement Principle (s83 of the *Child Protection Act 1999*) does not apply

STEP 2
Involvement of a recognised entity (RE) s83(2) and (3)

Has the recognised entity been given an opportunity to participate in the decision-making process?

✓ Yes: compliance

go to step 3 ▶

✗ No:

If the placement was made due to urgent circumstances, was the recognised entity consulted as soon as practicable after the decision was made?

✓ Yes: compliance

✗ No: non-compliance

STEP 3
Hierarchy of placement options s83(4) and (6)

Were any family members identified as placement options?

✓ Yes: compliance

go to step 4 ▶

✗ No:

Were any community/language group members identified as placement options?

✓ Yes: compliance

go to step 4 ▶

✗ No:

Were any compatible Indigenous carers identified as placement options?

✓ Yes: compliance

go to step 4 ▶

✗ No:

Were any other Indigenous carers identified as placement options?

✓ Yes: compliance

go to step 4 ▶

✗ No:

Were any non-Indigenous carers living near the child's family or community/language group members identified as placement options?

✓ Yes: compliance

go to step 4 ▶

✗ No:

Were other placements considered?

✓ Yes: compliance

go to step 4 ▶

STEP 4
Proper consideration of placement options s83(5)

Has proper consideration been given to

- The placement option's ability to ensure optimal retention of relationships with parents, siblings and people of significance, and
- The views of the recognised entity?

✓ Yes:

and placement option was suitable

compliance

go to step 5 (if carer is non-Indigenous) ▶

✓ Yes:

but placement option was not suitable

◀ go back to step 3

✗ No: non-compliance

STEP 5
Assessment of non-Indigenous carers' commitment s83(7)

Has proper consideration been given to the non-Indigenous carer's commitment to

- Facilitating contact between child and the child's family?
- Helping maintain contact with community or language group?
- Helping maintain connection with culture?
- Preserving and enhancing child's sense of Aboriginal or Torres Strait Islander cultural identity?

✓ Yes: compliance

✗ No: non-compliance

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Foreword

The context of child protection for Aboriginal and Torres Strait Islander children and young people has significantly evolved over the past few decades. This shift has taken Queensland from a devastating practice of removal to a necessary recognition of the importance of raising children within their family, community and culture where they are no longer able to remain safely in the care of their biological parents.

The Indigenous Child Placement Principle was embedded in section 83 of the *Child Protection Act 1999* to prescribe a process that must be followed by the Department of Communities when making out-of-home care placement decisions for Aboriginal and Torres Strait Islander children and young people, to help maintain their connection to family, community and culture.

As the Commissioner for Children and Young People, I have been tasked with a legislative responsibility to monitor the Department of Communities' compliance with section 83 of the *Child Protection Act 1999*. This report represents the second audit I have conducted in fulfilling this responsibility.

Compliance with section 83 of the *Child Protection Act 1999* is achieved when a small number of discrete steps are each observed and actioned appropriately in the placement decision making process. These decisions must always represent the best interests of the child concerned.

My inaugural *Indigenous Child Placement Principle Audit Report 2008* made 28 recommendations to the former Department of Child Safety to improve compliance with section 83 of the *Child Protection Act 1999*. Those recommendations were aimed at enhancing departmental policies, procedures and systems to help support child safety officer decision making and record keeping.

My current Indigenous Child Placement Principle Audit 2010/11 has an expanded scope and is comprised of three key components, which together provide a more complete view of the administration of section 83 of the *Child Protection Act 1999*, and what it can achieve for Aboriginal and Torres Strait Islander children and young people in out-of-home care. This has involved auditing:

- the Department of Communities' **mechanisms supporting compliance** with section 83 of the *Child Protection Act 1999* (the policies, procedures and record keeping infrastructure in place), based on a targeted evaluation of implementation of the 28 recommendations made in the inaugural audit
- the Department of Communities' **practice compliance** with section 83 of the *Child Protection Act 1999*, based on an assessment of its electronic records and surveys of the Child Safety Officers and Recognised Entities involved in the 388 placement decisions made in 2008/09 comprising the audit sample, and
- the **outcomes achieved** for children and young people in out-of-home care, based on their reported connection to family, community and culture.

The audit logic being that, if the Department of Communities has sufficient **mechanisms supporting compliance** in place, there will be increased **practice compliance** with section 83 of the *Child Protection Act 1999*, which will in turn lead to better **outcomes achieved** for Aboriginal and Torres Strait Islander children and young people in out-of-home care.

This second audit has demonstrated that compliance with each step required by section 83 of the *Child Protection Act 1999* is quite good. However, when viewed together, complete compliance with all required steps was only achieved in 15% of the sample, an improvement on the findings of the inaugural audit.

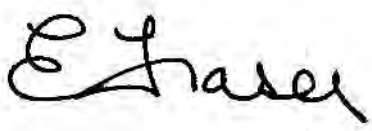
Low compliance can be attributed in part to the Department of Communities' delays in implementing the majority of the inaugural recommendations relating to improved policy, practice and record keeping before the audit sample was extracted. Specifically, nine of the 28 inaugural recommendations are now being implemented. As such, record keeping was again a significant issue impacting on my capacity to adequately assess compliance, with records either not available or not containing sufficient rationale about the placement decision making process. The audit findings are therefore not reflective of the improvement that was anticipated to occur with complete implementation of the inaugural recommendations.

My compliance assessment is also complemented by some very positive findings about the outcomes experienced by Aboriginal and Torres Strait Islander children and young people in out-of-home care, relevant to their connection to family, community and culture. A key finding is that 89% of children and young people were reported as having some level of parental contact, the most common frequency identified as weekly contact (41%).

Those children and young people placed with Indigenous carers reported better outcomes compared to those placed with non-Indigenous carers. A key finding in this regard is that they exhibited more weekly contact with their traditional language/tribal/totem group (41% greater) than those placed with a non-Indigenous carer.

I have received invaluable assistance from an Advisory Committee in this audit. This panel of external experts in child protection and/or Aboriginal and Torres Strait Islander health and wellbeing provided advice to me on key issues relevant to the audit. The Advisory Committee was comprised of representatives from the Queensland Aboriginal and Torres Strait Islander Child Protection Peak Inc, Foster Care Queensland, the Remote Area Aboriginal and Torres Strait Islander Child Care, the Department of Communities and the Indigenous Studies Unit at the University of Queensland. I am grateful for the contribution of these experts, which has provided a transparent mechanism for me to seek advice on specific complex and/or sensitive issues during the audit. I would like to thank the Recognised Entities and Child Safety Officers who completed the online surveys that form part of the audit.

Last, but certainly not least, I offer my sincere thanks to the many Aboriginal and Torres Strait Islander children and young people who gave their time to the Commission's Community Visitors to help increase my understanding of how well their connections to family, community and culture are being maintained while in care. I will do my utmost to make their feedback known and translated into action.



Elizabeth Fraser

Commissioner for Children and Young People and Child Guardian

Executive Summary

The purpose of this report is to detail the findings of the Commission's second audit of compliance with section 83 of the *Child Protection Act 1999* by the Department of Communities. The audit process has explored three key areas, namely:

- the Department of Communities' **mechanisms supporting compliance** with section 83 of the *Child Protection Act 1999* (the policies, procedures and record keeping infrastructure in place), based on a targeted evaluation of implementation of the 28 recommendations made in the inaugural audit to enhance these elements
- the Department of Communities' **practice compliance** with section 83 of the *Child Protection Act 1999*, based on an assessment of its electronic records and surveys of the Child Safety Officers and Recognised Entities involved in the 388 placement decisions made in 2008/09 comprising the audit sample, and
- the **outcomes achieved** for children and young people in out-of-home care relevant to their maintained connection to family, community and culture as a result of the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999*.

Each component of the audit was informed and guided by an Advisory Committee comprised of experts in child protection and/or Aboriginal and Torres Strait Islander health and wellbeing.

Overall, the audit findings indicate that there is a need for the Department of Communities to continue to strengthen the **mechanisms supporting compliance.** Doing so will assist Child Safety Officers in their **practice compliance** with section 83 of the *Child Protection Act 1999*. In turn, this will likely contribute to better **outcomes achieved** for Aboriginal and Torres Strait Islander children and young people in out-of-home care (in relation to their connection to family, community and culture).

The Commission has made 10 new recommendations to address areas requiring improvement, in addition to the nine recommendations that are currently being implemented from the inaugural audit.

Part A – The Department of Communities' mechanisms supporting compliance with section 83 of the *Child Protection Act 1999*

Part A of this report monitors the Department of Communities' **mechanisms supporting compliance** with section 83 of the *Child Protection Act 1999* (the policies, procedures and record keeping infrastructure in place), based on a targeted evaluation of implementation of the 28 recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* which identified the need to enhance these elements.

Overall, the Department of Communities has implemented 19 of the 28 inaugural recommendations intended to enhance the mechanisms supporting compliance with section 83 of the *Child Protection Act 1999*.

In summary, of the 19 recommendations implemented to date:

- 15 recommendations related to improving guidance in the Department of Communities' policies and procedures to support compliance

- three recommendations were aimed at enhancing the Department of Communities' record keeping practices in its Integrated Client Management System (ICMS) to support compliance, and
- one recommendation related to the Department of Communities considering the creation of specialist positions to assist in placements for Aboriginal and Torres Strait Islander children and young people.

Nine recommendations are currently being implemented with a planned implementation timeframe of March/April 2012. Of these:

- eight relate to enhancing the Department of Communities' record keeping practices in its ICMS to support compliance, and
- one relates to the Department of Communities rolling out comprehensive training for Child Safety Officers (following the implementation of all of the Commission's inaugural recommendations).

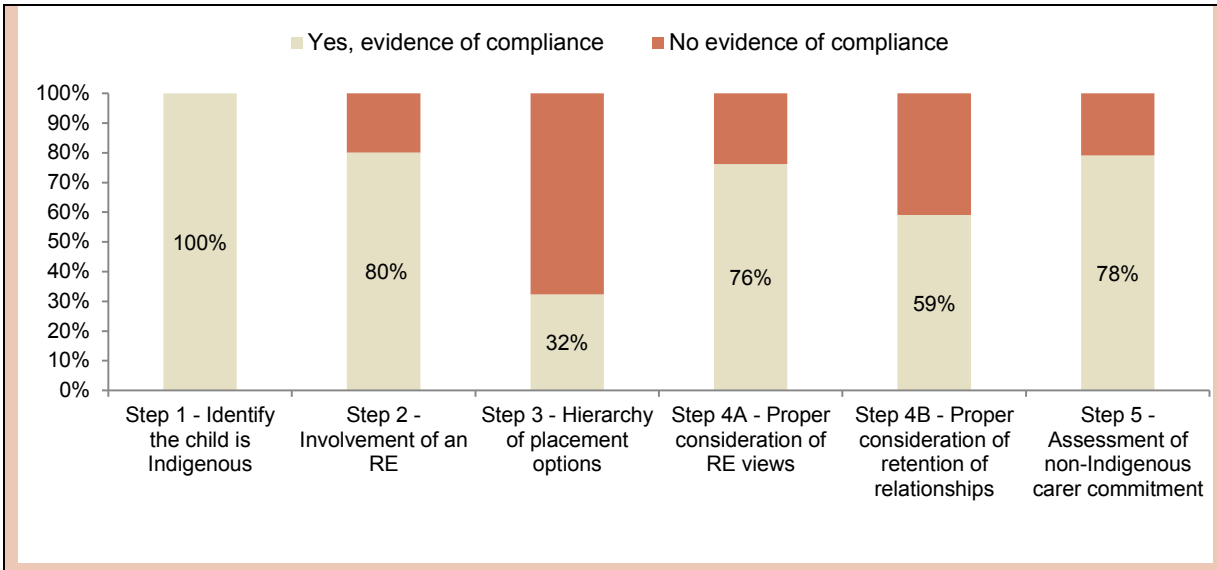
The Commission will monitor the Department of Communities' implementation of the remaining nine recommendations in accordance with the nominated timeframes.

Part B – Department of Communities' practice compliance with section 83 of the *Child Protection Act 1999*

Part B of this report monitors the Department of Communities' **practice compliance** with section 83 of the *Child Protection Act 1999*. This assessment is based on a triangulation of data from its electronic records and surveys of the Child Safety Officers and Recognised Entities involved in the 388 placement decisions made for Aboriginal and Torres Strait Islander children and young people in 2008/09 which comprise the audit sample.

Analysis of these three information sources revealed that there has been an improvement in the Department of Communities' practice compliance with section 83 of the *Child Protection Act 1999* since the inaugural audit in 2008 (15% compliance across all required steps this audit compared to no record of complete compliance in the 2008 audit).

Where evidence was available to make an assessment against the Compliance Assessment Tool, the Department of Communities' compliance with most of the individual steps required by section 83 of the *Child Protection Act 1999* was identified as positive.



However, complete compliance with all required steps of the Compliance Assessment Tool was not as strong and was established for 58 (or 15%) of the 388 placement decisions comprising the audit sample. This finding suggests that while compliance with each step of the Compliance Asessment Tool is good when viewed in isolation, Child Safety Officers need to improve compliance with all necessary steps.

Low overall compliance can be attributed in part to delays in the Department of Communities implementing the recommendations of the inaugural (2008) audit.

Once the suite of inaugural recommendations are implemented in their entirety, Child Safety Officers will be provided with both increased mechanisms for support and better record keeping opportunities which would enhance practice compliance with section 83 of the *Child Protection Act 1999*.

Part C – Outcomes achieved as a result of the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999*

Part C of this report monitors the **outcomes achieved** for Aboriginal and Torres Strait Islander children and young people in out-of-home care relevant to their connection to family, community and culture as a result of the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999*.

This analysis is based on data contained in the Commission's Jigsaw information management system. This data was collected by Commission Community Visitors (CVs) in targeted interactions with 1109 Aboriginal and Torres Strait Islander children and young people in out-of-home care during July 2010.

CV data indicated that overall, Aboriginal and Torres Strait Islander children and young people in out-of-home care are experiencing positive outcomes in regard to their contact with family and community and their opportunity to participate in cultural activities and events. This finding suggests that while technical compliance with section 83 of the *Child Protection Act 1999* remains low, positive outcomes are still being achieved for Aboriginal and Torres

Strait Islander children and young people in out-of-home care. Key findings indicate that:

- 89% of children and young people were reported as having some level of parental contact, the most common frequency reported to be weekly contact (41%)
- 80% of children and young people were reported as satisfied with parental contact
- 93% of children and young people were reported to be having some level of contact with other family members, the most common frequency of contact reported to be weekly contact (56%)
- 89% of children and young people were reported to be satisfied with their contact with other family members
- 70% of children and young people were reported to be having some level of contact with their traditional language/tribal/totem group, the most common frequency for contact reported to be weekly contact (40%)
- 91% of children and young people were reported to be satisfied with their contact with their traditional language/tribal/totem group, and
- 96% of children and young people were reported to be offered at least one type of cultural activity/resource.

However, improving compliance with section 83 of the *Child Protection Act 1999* will help to ensure that Aboriginal and Torres Strait Islander children and young people are placed in the most culturally appropriate placements related to their specific needs and family structure.

As part of the assessment of outcomes achieved, the Commission compared the experiences of children and young people placed with Indigenous and non-Indigenous carers. Aboriginal and Torres Strait Islander children and young people placed with Indigenous carers demonstrate the same, or better, outcomes across every measure of family and community contact and experience greater opportunities to participate in cultural activities and events.

Specifically, Aboriginal and Torres Strait Islander children and young people placed with an Indigenous carer were reported to have:

- Greater satisfaction with parental contact than those placed with a non-Indigenous carer
- More weekly contact with other family members than those placed with a non-Indigenous carer
- More weekly contact with their traditional language/tribal/totem group than those placed with a non-Indigenous carer, and
- More opportunities to participate in every type of cultural activity/resource offered than those placed with a non-Indigenous carer.

This is a significant finding and highlights the importance of efforts by the Department of Communities to recruit Indigenous carers and the need for continuing focus for compliance with Step 5 in the placement process when Indigenous carers are not available.

The 10 recommendations made by the Commission in this audit are summarised in the following table.

Table 1: Summary of recommendations made in this audit report

Number	Proposed recommendations
1 Record keeping	The Department of Communities adhere to the nominated timeframes assigned to the nine recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* that are currently being implemented, or establish (by the end of April 2012) another mandatory recording keeping process to enable it to monitor and manage compliance with each of the five steps.
2 Practice support	The Department of Communities consider ways to strengthen its practice and record keeping related to the application of section 83 of the *Child Protection Act 1999* by communicating the findings of this audit and the Compliance Assessment Tool to its Child Safety Officers as the basis upon which its future efforts will be assessed. A documented communication plan is to be developed by the end of April 2012.
3 Record keeping	The Department of Communities commit to a timeframe for enhancing ICMS to make completion of the 'Recognised Entity/Child Placement Principle' form mandatory when making a placement decision for an Aboriginal or Torres Strait Islander child or young person, and advise of this timeframe by the end of April 2012.
4 Practice support	The Department of Communities review and (by the end of April 2012) clarify its practice guidance regarding the application of section 83 of the *Child Protection Act 1999* to respite placements for Aboriginal and Torres Strait Islander children and young people.
5 Record keeping	The Department of Communities collaborate with Recognised Entities, either through their peak representative body, the Queensland Aboriginal and Torres Strait Islander Child Protection Peak, or at a local level, to confirm information sharing needs and processes in regard to placement decisions for Aboriginal and Torres Strait Islander children and young people and to confirm the record keeping requirements and obligations of both. An agreed outcome is to be documented by the end of April 2012.
6 Practice support	The Department of Communities clarify (by the end of April 2012) in the relevant policy and procedural documents that placement decisions must be reviewed within a specified amount of time where emergency placements are made for Aboriginal and Torres Strait Islander children and young people and section 83 of the *Child Protection Act 1999* is unable to be applied.
7 Record keeping	The Department of Communities establish an appropriate record keeping mechanism, in ICMS or otherwise, to record: • when and why emergency placements are made for Aboriginal and Torres Strait Islander children and young people and section 83 of the *Child Protection Act 1999* is unable to be applied, and • the timeframe that the placement decision was reviewed within, and • the outcome. Advice is required by the end of April 2012 of the proposed approach and timeframe required to implement.
8 Practice support	The Department of Communities explore ways to strengthen information gathering, and provision to Aboriginal and Torres Strait Islander children and young people, about their Mob, and advise of the proposed strategies by the end of April 2012.
9 Carer support	The Department of Communities continue its Indigenous carer recruitment efforts and by the end of April 2012 include key findings from this report in its training and support of all carers in helping drive cultural outcomes for Aboriginal and Torres Strait Islander children and young people in out-of-home care.
10 Practice support	The Department of Communities use the information in this report to help identify where strengths and weaknesses in regional service delivery exist in regards to Aboriginal and Torres Strait Islander children and young people's family and community contact and opportunity to participate in cultural activities/events, and advise by the end of April 2012 of proposed strategies.

Chapter 1

Introduction and Background

1.1 Purpose of the Indigenous Child Placement Principle

The Indigenous Child Placement Principle was established in the 1980s in recognition of the devastating and intergenerational impacts of the systematic removal and assimilation of Aboriginal and Torres Strait Islander children and young people, and in response to the large number of Aboriginal and Torres Strait Islander children and young people in the child protection system, particularly those placed in non-Indigenous care.[1]

The adoption of the Indigenous Child Placement Principle reflected a necessary change in understanding and approach as to what constitutes the 'best interests' of Aboriginal and Torres Strait Islander children and young people in a child protection and wellbeing context.[2]

The Indigenous Child Placement Principle is founded on the understanding that it is in the best interests of Aboriginal and Torres Strait Islander children and young people to be raised within, or in connection with, their own family, community and culture where they are no longer able to remain safely in the care of their biological parents.[3]

Aboriginal and Torres Strait Islander children and young people continue to be over-represented in the child protection system in Queensland, highlighting compliance with the Indigenous Child Placement Principle as a key practice approach to helping maintain connection to family, community and culture. A profile illustrating the continued over-representation of Aboriginal and Torres Strait Islander children and young people is provided in Chapter 2 of this report.

1.2 History of the Indigenous Child Placement Principle

Table 2 provides an overview of the history of the Indigenous Child Placement Principle.

Table 2: History of the Indigenous Child Placement Principle

Year	Event
1975	*Commission of Inquiry into the Nature and Extent of the Problems Confronting Youth in Queensland* identifies the potential adverse consequences of placing Aboriginal and Torres Strait Islander children in unsuitable out-of-home care environments and recommends that the (then) Department of Children's Services adopt the policy of using Aboriginal and Torres Strait Islander employees in placement decisions and case planning.
1976	First Australian Conference on Adoption raises concerns about the large number of

[1] *Aboriginal and Torres Strait Islander Child Placement Principle* fact sheet, Department of Child Safety, and page 4 of the *Aboriginal and Torres Strait Islander Child Placement Principle Discussion Paper*, Department of Child Safety.
[2] *The Aboriginal Child Placement Principle Research Report 7*, 1997, New South Wales Law Reform Commission.
[3] Page 4 of the *Aboriginal and Torres Strait Islander Child Placement Principle Discussion Paper*, Department of Child Safety.

	Aboriginal children in the care of 'white' families.
1978	*Indian Child Welfare Act 1978* is introduced in the United States of America. The legislation contains a hierarchy of placement options for Indian children that is similar to the Indigenous Child Placement Principle.
1980	Department of Aboriginal Affairs (Commonwealth) publishes policy guidelines about adoption and fostering of Aboriginal children. The guidelines place a high priority on maintaining Aboriginal children in their family and community environment.
1984	Queensland Government adopts the Indigenous Child Placement Principle as policy.
1989	Royal Commission into Aboriginal Deaths in Custody affirms the need for the Indigenous Child Placement Principle to be implemented in legislation. It also identifies that Queensland failed to properly implement the Indigenous Child Placement Policy and this resulted in "large scale institutionalisation and removal of Aboriginal and Torres Strait Islander children from their communities".
1999	Indigenous Child Placement Principle inserted into *Child Protection Act 1999*.
2001	Review of Queensland children in care by former Department of Families reveals that approximately 25% of the Aboriginal and Torres Strait Islander children in the review were identified as having limited or non-existent contact with or understanding about their culture and heritage.
2004	Crime and Misconduct Commission's report *Protecting children: An inquiry into abuse of children in foster care* identifies need for the Commission, through its Child Guardian function, to monitor compliance with the Indigenous Child Placement Principle.
2006	The *Child Safety Amendment Act 2005* amended section 83 of the *Child Protection Act 1999.* Section 83(6) and 83(7) were inserted which relate to non-Indigenous carers.
2008	The Commission conducts its inaugural audit of compliance with section 83 of the *Child Protection Act 1999*, and makes 28 recommendations for improvement.

1.3 Legislative basis for the Indigenous Child Placement Principle

All Australian jurisdictions have now adopted the Indigenous Child Placement Principle in legislation to varying degrees.

The Indigenous Child Placement Principle has been given legislative basis in Queensland in section 83 of the *Child Protection Act 1999*.[4]

The Honourable Anna Bligh, in her capacity as Queensland's Minister for Families, Youth and Community Care and Minister for Disability Services, made the following comment in her Member's Speech of 10 November 1998 in relation to the *Child Protection Bill 1998*:

> *One of the most unacceptable issues facing child protection in Queensland is the significant overrepresentation of Indigenous children in the State's care. It is therefore imperative that the bill entrenches the Child Placement Principle, which requires that departmental officers consult with appropriate agency or community representatives when making decisions about Aboriginal and Torres Strait Islander children, and must ensure the maintenance of Indigenous children's cultural identity.*

[4] Formerly section 80 in the original enactment of the *Child Protection Act 1999* and later renumbered to section 83 in the 28 April reprint of the *Child Protection Act 1999*.

Accordingly, section 83 of the *Child Protection Act 1999* outlines a prescriptive decision making process that the Department of Communities must adhere to when making a placement decision involving an Aboriginal or Torres Strait Islander child or young person. This process involves proper consideration of the following four key elements before an Aboriginal or Torres Strait Islander child or young person is placed in out-of-home care:

- A hierarchy of placement options
- Recognised Entities' involvement in the placement decision
- Retention of family and community relationships, and
- Non-Indigenous carers' commitment.

However, section 5 of the *Child Protection Act 1999* stipulates that the paramount consideration in making a placement decision for any child is always the welfare and best interests of the child, meaning that, for example, placements must still be assessed and accredited to confirm they are safe.

Section 83 of the *Child Protection Act 1999*

(1) This section applies if the child is an Aboriginal or a Torres Strait Islander child.

(2) The chief executive must ensure a recognised entity for the child is given an opportunity to participate in the process for making a decision about where or with whom the child will live.

(3) However, if because of urgent circumstances the chief executive makes the decision without the participation of a recognised entity for the child, the chief executive must consult with a recognised entity for the child as soon as practicable after making the decision.

(4) In making a decision about the person in whose care the child should be placed, the chief executive must give proper consideration to placing the child, in order of priority, with—
(a) a member of the child's family; or
(b) a member of the child's community or language group; or
(c) another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group; or
(d) another Aboriginal person or Torres Strait Islander.

(5) Also, the chief executive must give proper consideration to—
(a) the views of a recognised entity for the child; and
(b) ensuring the decision provides for the optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom.

(6) If the chief executive decides there is no appropriate person mentioned in subsection (4)(a) to (d) in whose care the child may be placed, the chief executive must give proper consideration to placing the child, in order of priority, with—
(a) a person who lives near the child's family; or

(b) a person who lives near the child's community or language group.

(7) Before placing the child in the care of a family member or other person who is not an Aboriginal person or Torres Strait Islander, the chief executive must give proper consideration to whether the person is committed to—
(a) facilitating contact between the child and the child's parents and other family members, subject to any limitations on the contact under section 87; and
(b) helping the child to maintain contact with the child's community or language group; and
(c) helping the child to maintain a connection with the child's Aboriginal or Torres Strait Islander culture; and
(d) preserving and enhancing the child's sense of Aboriginal or Torres Strait Islander identity.

1.4 Commission's legislated role to monitor compliance

The Commission has a legislated oversight role in relation to monitoring and auditing the Department of Communities' compliance with section 83 of the *Child Protection Act 1999*.

In January 2004, the Crime and Misconduct Commission report *Protecting Children: An inquiry into abuse of children in foster care* stated:

> *The Child Placement Principle constitutes a fundamental recognition of the important and unique aspects of Indigenous culture. Giving effect to this recognition is central to a viable child protection service.* [5]

To strengthen oversight of this important aspect of child protection services, the Crime and Misconduct Commission made a recommendation "that Department of Child Safety's compliance with the Indigenous Child Placement Principle be periodically audited and reported on by the Child Guardian."[6]

This recommendation was embedded in section 18(1)(c)[7] of the *Commission for Children and Young People and Child Guardian Act 2000* (the Commission's Act), which requires the Commission "to monitor compliance by the chief executive (child safety) with the *Child Protection Act 1999*, section 83."

Chapter 3 of the Commission's Act enables the Commission, in performing its monitoring functions, to form views and make recommendations for improvement in relation to case-specific and systemic issues and refer such recommendations to the service provider and the relevant Minister. Accordingly, the inaugural *Indigenous Child Placement Principle Audit Report 2008* and the current *Indigenous Child Placement Principle Audit Report 2010* give effect to the Commission's legislative role to monitor compliance with section 83 of the *Child Protection Act 1999*.

[5] Page 235 of *Protecting Children: An inquiry into abuse of children in foster care, Crime and Misconduct Commission*, Brisbane, 2004.
[6] Page 234, Recommendation 8.4, of *Protecting Children: An inquiry into abuse of children in foster care*, Crime and Misconduct Commission, Brisbane, 2004.
[7] Formerly section 15AA(1)(c) of the *Commission for Children and Young People and Child Guardian Act 2000*.

1.4.1 The inaugural *Indigenous Child Placement Principle Audit Report 2008*

The *Indigenous Child Placement Principle Audit Report 2008* was the Commission's inaugural audit of compliance with section 83 of the *Child Protection Act 1999*. The inaugural report, among other things, was intended to assist in positioning Queensland as the first state able to report on compliance across the requirements of the Indigenous Child Placement Principle, rather than just an administrative count of Indigenous children placed with Indigenous kin or carers.[8]

The inaugural report made 28 recommendations to the former Department of Child Safety to improve compliance with section 83 of the *Child Protection Act 1999.*

The recommendations were targeted at departmental policies, procedures and systems relating to decision making and information capture required by section 83 of the *Child Protection Act 1999*, as limitations had been identified through the Commission's review of these key elements that were considered significant.

The Commission also assessed a snapshot of the former Department of Child Safety's compliance with section 83 of the *Child Protection Act 1999*, relating to a sample of 82 placement decisions involving 28 Aboriginal and Torres Strait Islander children and young people in out-of-home care. This compliance exercise was undertaken based on a review of the information and decisions recorded on the child's case files and enabled a new Compliance Assessment Tool (discussed in further detail in Part B of this report and contained inside the front cover) to be trialled, which views the process of compliance as comprising five key steps.

Findings from this snapshot assessment of compliance revealed that of the 82 placement decisions reviewed, there were no records evidencing compliance with all requirements of section 83 of the *Child Protection Act 1999* in any one case.

Key feedback and learnings from the inaugural audit highlighted the importance of not only monitoring compliance with section 83 of the *Child Protection Act 1999* in future audits, but also monitoring the cultural outcomes experienced by Aboriginal and Torres Strait Islander children and young people placed in out-of-home care.

1.4.2 The current Indigenous Child Placement Principle Audit 2010/11

The current Indigenous Child Placement Principle Audit 2010/11 was comprised of three key components. These components will be addressed in this report in the below order following a profile of the Aboriginal and Torres Strait Islander children and young people in the child protection system during the reference period for the audit.

A decsription of the audit methodology is detailed in Appendix 1.

[8] Public reporting on compliance with the Indigenous Child Placement Principle has historically been administrative in nature, reporting the number of Aboriginal and Torres Strait Islander children and young people placed with Indigenous or kinship carers (an outcome of the decision making process) rather than reporting the number of placement decisions that complied with each requirement of the decision making process.

Part A (Chapter 2) Mechanisms supporting compliance	This component relates to monitoring the Department of Communities' **mechanisms supporting compliance** with section 83 of the *Child Protection Act 1999* (the policies, procedures and record keeping infrastructure in place), based on an evaluation of implementation of the 28 recommendations made in the inaugural (2008) audit.
Part B (Chapter 3) Practice compliance	This component relates to monitoring the Department of Communities' **practice compliance** with section 83 of the *Child Protection Act 1999*, based on an assessment of its electronic records and surveys of the Child Safety Officers and Recognised Entities involved in the 388 placement decisions from 2008/09 that comprise the audit sample.
Part C (Chapter 4) Outcomes achieved	This component relates to monitoring the **outcomes achieved** for children and young people in out-of-home care, relevant to their connection to family, community and culture as a result of the Department of Communities' placement decisions.

The audit was informed and guided by an Advisory Committee of experts in child protection and/or Aboriginal and Torres Strait Islander health and wellbeing. The Advisory Committee was established under Chapter 7 of the Commission's Act to provide a formal and transparent mechanism to allow the Commission to consult with and obtain advice from external experts on key issues relevant to the audit, while at the same time preserving the independence of the Commission's oversight role.

Committee membership was comprised of the Assistant Commissioner for Children and Young People and Child Guardian, as chair, accompanied by representatives from the following key stakeholders to the audit:

- Remote Area Aboriginal and Torres Strait Islander Child Care
- Queensland Aboriginal and Torres Strait Islander Child Protection Peak
- Foster Care Queensland
- Aboriginal and Torres Strait Islander Studies Unit, University of Queensland, and
- Department of Communities.

The committee met on four separate occasions and was consulted periodically out-of-session to provide advice and guide the development and progress of the audit. It was also invited to comment on the development of findings and recommendations in this report.

Chapter 2

Profile of Aboriginal and Torres Strait Islander children and young people in the child protection system living away from home

Key messages

As at 30 June 2009 (the reference period for this audit):

- The proportion of Aboriginal and Torres Strait Islander children and young people living away from home was 35% (an increase from 26% in 2006), however only 14% of carer families were Indigenous.
- The majority (87%) of Aboriginal and Torres Strait Islander children and young people were placed in home-based care.
- The proportion of Aboriginal and Torres Strait Islander children and young people placed with a kinship or Indigenous carer (administrative count of compliance) was 58.2%, a decrease from 64.1% in 2006.

2.1 The importance of the profile

The profile provides context to the operation of section 83 of the *Child Protection Act 1999*. It does so by highlighting other system-level information regarding Aboriginal and Torres Strait Islander children and young people in the child protection system who were living away from home during the reference period for this audit (2008/09).[9]

In particular, it illustrates the over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system living away from home, highlighting the importance of compliance with section 83 of the *Child Protection Act 1999* to ensure maintained connection to family, community and culture for this over-represented cohort.

[9] The profile is based on the Department of Communities' administrative data about the child protection system. It looks at Aboriginal and Torres Strait Islander children and young people who are living away from home (all placements) rather than in out-of-home care (foster, kinship, provisional and residential care) to provide a more complete picture of the over-representation of Aboriginal and Torres Strait Islander children in the child protection system.

2.2 Profile demographics

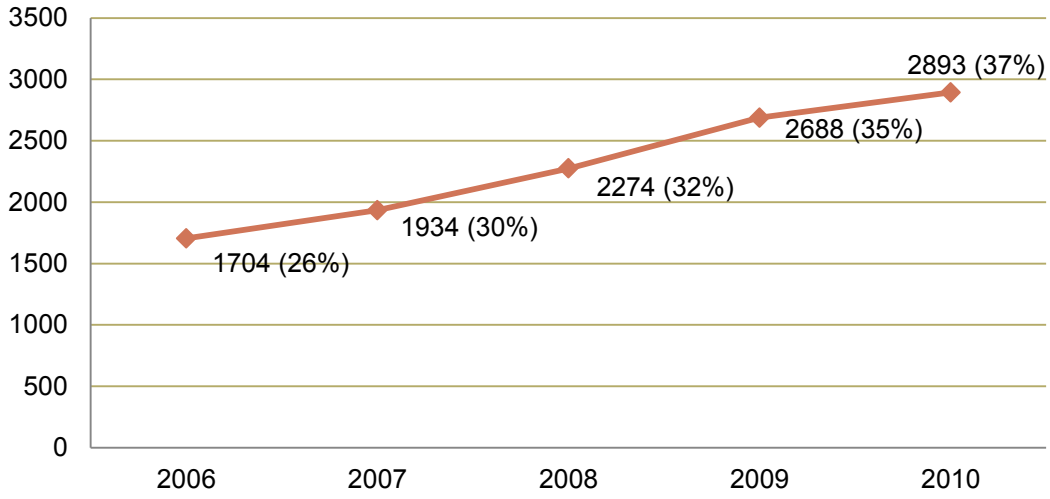
Aboriginal and Torres Strait Islander children and young people living away from home in Queensland

The Department of Communities defines 'living away from home' as "the provision of care outside the home to children who are in need of protection or who require a safe placement while their protection and safety needs are assessed. Living away from home refers to children in out-of-home care (foster care, approved kinship care, provisionally approved care and residential care services) and other locations such as hospitals, Queensland youth detention centres, independent living as at midnight on the reference day."[10]

In 2009, Aboriginal and Torres Strait Islander children and young people represented 6.5% of all children and young people in Queensland,[11] yet represented 35% of all children and young people in the child protection system who were living away from home.

Figure 1 illustrates the continued increase in the over-representation of Aboriginal and Torres Strait Islander children and young people living away from home over the past five years, from 26% to 37%.

Figure 1: Proportion of Aboriginal and Torres Strait Islander children and young people living away from home from 2006 to 2010

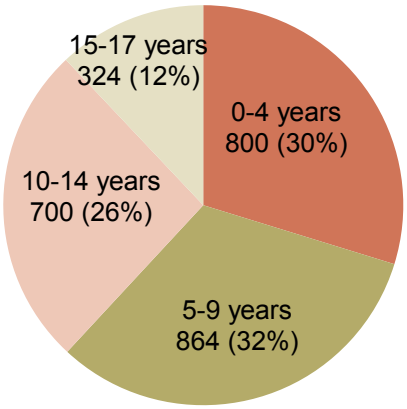


Age

Figure 2 provides an age breakdown of the 2688 Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009.

[10] http://www.communities.qld.gov.au/childsafety/about-us/our-performance/glossary-of-terms as at 4 July 2011.
[11] Page 10 of *Snapshot 2010: Children and young people in Queensland*, Commission for Children and Young People and Child Guardian, Brisbane 2010.

Figure 2: Age breakdown of Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009



Gender

Table 3 illustrates an almost even gender breakdown of the 2688 Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009.

Table 3: Gender breakdown of Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009

Gender	Number	Percentage
Males	1323	49%
Females	1365	51%
Total	2688	100%

Order type

Figure 3 illustrates the breakdown of order types for the 2688 Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009.

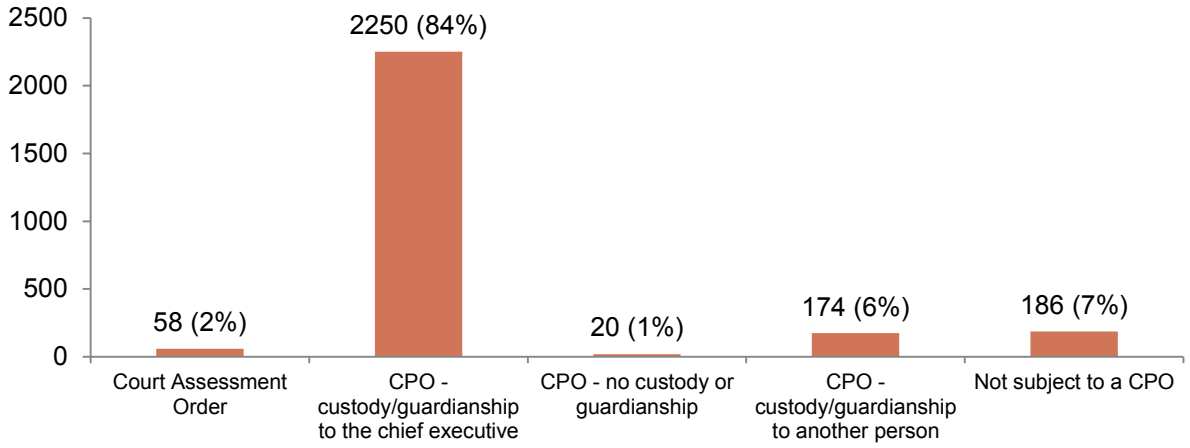
Child protection orders (CPOs) are court orders issued under the *Child Protection Act 1999* for the protection of children and young people aged up to 17 years inclusive. They are issued when the child is in need of protection and does not have a parent willing and able to protect the child from harm.[12]

However, "a child protection order is not sought if there are other ways to protect the child, such as working with the consent of the family to resolve the problems that led to harm or risk of harm, or connecting the family to a community support agency."[13]

[12] Part 3 of the *Child Protection Act 1999*.
[13] http://www.communities.qld.gov.au/childsafety/about-us/our-performance/summary-statistics/child-protection-orders as at 4 July 2011.

The majority (84%) of children and young people living away from home were under a child protection order with custody or guardianship to the Chief Executive. This represents the cohort of Aboriginal and Torres Strait Islander children and young people to whom section 83 of the *Child Protection Act 1999* specifically applies.

Figure 3: Breakdown of order type for Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009



Placement type

Figure 4 illustrates the placement breakdown for the 2688 Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009.

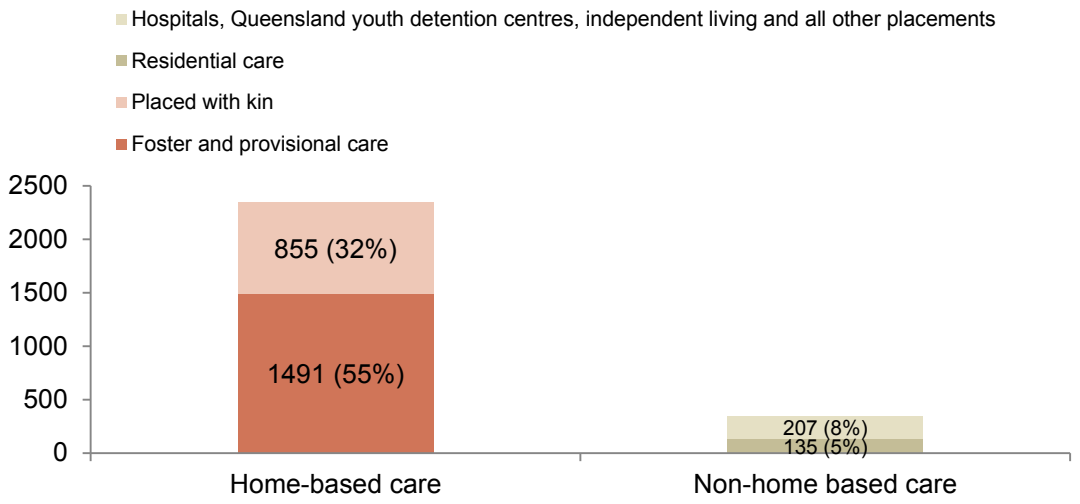
Placement types can be broken down into two main categories:

- Home-based care – foster care, kinship care and provisionally approved care, and
- Non-home based care - residential care and other care services (hospitals, Queensland youth detention centres, independent living and all other placements).

The majority (87%) of Aboriginal and Torres Strait Islander children and young people were placed in home-based care, approximately one third of which were placed with kin (32%).[14]

[14] Placed with kin includes children living with a kinship carer, and children living with a foster carer or provisionally approved carer where a family relationship exists between the carer and child.

Figure 4: Breakdown of placement type for Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009

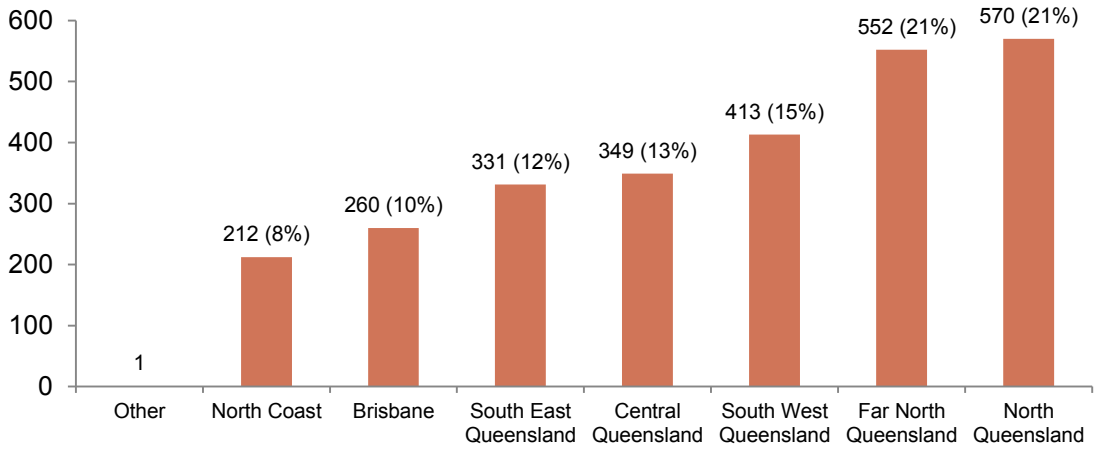


Regional distribution of children

Figure 5 illustrates the breakdown of the 2688 Aboriginal and Torres Strait Islander children and young people living away from home by the Department of Communities' Regions as at 30 June 2009.

North Queensland Region and Far North Queensland Region demonstrated the greatest number of Aboriginal and Torres Strait Islander children and young people living away from home.

Figure 5: Regional distribution of Aboriginal and Torres Strait Islander children and young people living away from home as at 30 June 2009



Distribution of children by Child Safety Service Centre

Table 4 illustrates the breakdown of the 2688 Aboriginal and Torres Strait Islander children and young people living away from home by Child Safety Service Centre as at 30 June 2009.

The Cape York and Torres Strait Islands Child Safety Service Centre demonstrated the highest number of Aboriginal and Torres Strait Islander children and young people living away from home.

Table 4: Distribution of Aboriginal and Torres Strait Islander children and young people living away from home per Child Safety Service Centre as at 30 June 2009

Child Safety Service Centre	Number	Percentage
Brisbane Region		
Alderley	11	4
Chermside	22	8
Forest Lake	55	21
Fortitude Valley	26	10
Inala	40	15
Mount Gravatt	28	11
Stones Corner	50	19
Wynnum	28	11
Total	**260**	**100**
Central Queensland Region		
Bundaberg	25	7
Emerald	12	3
Gladstone	67	19
Maryborough	35	10
Rockhampton North	42	12
Rockhampton South	102	29
South Burnett	66	19
Total	**349**	**100**
Far North Queensland Region		
Atherton	110	20
Cairns North	144	26
Cairns South	63	11
Cape York and Torres Strait Islands	206	37
Innisfail	29	5
Total	**552**	**100**
North Coast Region		
Caboolture	53	25
Caloundra	23	11
Gympie	38	18
Maroochydore	24	11
Pine Rivers	45	21
Redcliffe	29	14
Total	**212**	**100**

North Queensland Region		
Aitkenvale	51	9
Gulf	115	20
Mackay	103	18
Mount Isa	112	20
Thuringowa	84	15
Townsville	105	18
Total	**570**	**100**
South East Queensland Region		
Beaudesert	29	9
Beenleigh	45	14
Browns Plains	26	8
Labrador	13	4
Logan and Brisbane West	1	0
Logan Central	33	10
Loganlea	52	16
Mermaid Beach	45	14
Nerang	18	5
Redlands	36	11
Woodridge	33	10
Total	**331**	**100**
South West Queensland Region		
Goodna	38	9
Ipswich North	97	23
Ipswich South	48	12
Roma	45	11
Toowoomba North	116	28
Toowoomba South	69	17
Total	**413**	**100**
Other	**1**	**100**
State-wide total	**2688**	**100**

Indigenous carer families

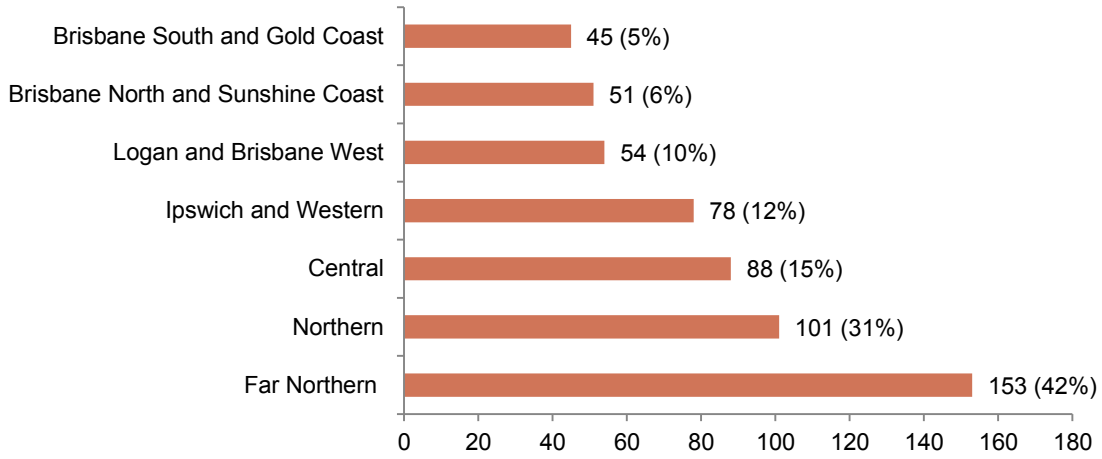
There were 570 carer families where at least one or more carers in the family identified as Aboriginal and/or Torres Strait Islander as at 30 June 2009, representing 14% of all (4082) carer families. Of these:

- 235 (41%) were foster carers
- 234 (41%) were kinship carers, and
- 101 (18%) were provisionally approved carers.

This averages one Indigenous carer family for every four Aboriginal and Torres Strait Islander children and young people.

Figure 6 illustrates the Regional breakdown of Indigenous carer families. In Far Northern Region, Indigenous carer families represent 42% of all carer families.[15]

Figure 6: Regional distribution of Indigenous carer families as at 30 June 2009



2.3 Administrative compliance with section 83 of the Child Protection Act 1999

Administrative compliance

Public reporting on compliance with the Indigenous Child Placement Principle has historically been administrative in nature, reporting the number of Aboriginal and Torres Strait Islander children and young people placed with Indigenous or kinship carers.

The Commission does not consider the proportion of Aboriginal and Torres Strait Islander children and young people placed with Indigenous o kinship carers to be a complete record of compliance with the Indigenous Child Placement Principle (as prescribed in section 83 of the *Child Protection Act 1999*). Rather, this represents a separate and distinct administrative measure that reports on the outcome of the decision making process, contrasted to reporting the number of placement decisions that complied with all requirements of the decision making process prescribed in section 83 of the *Child Protection Act 1999*.

Administrative compliance in Queensland in 2009

Table 5 illustrates the breakdown of Aboriginal and Torres Strait Islander children and young people in out-of-home care in 2009, by Indigenous status and relationship of carer.[16] It shows that the proportion of Aboriginal and Torres Strait Islander children and young people in out-of-home care placed with a kinship or Indigenous carer (administrative measure of compliance) was 58.2%.

[15] It was not possible to compare the number of Aboriginal and Torres Strait Islander children and young people to Indigenous carer families for each Department of Communities Region, as carer families have been broken down by former Department of Communities Zones and children have been broken down by the new Department of Communities Regions.

[16] This measure of administrative compliance is based on 'out-of-home care' figures and excludes 'other' placements in hospitals, Queensland youth detention centres, independent living and all other placements.

Table 5: Breakdown of administrative compliance as at 30 June 2009

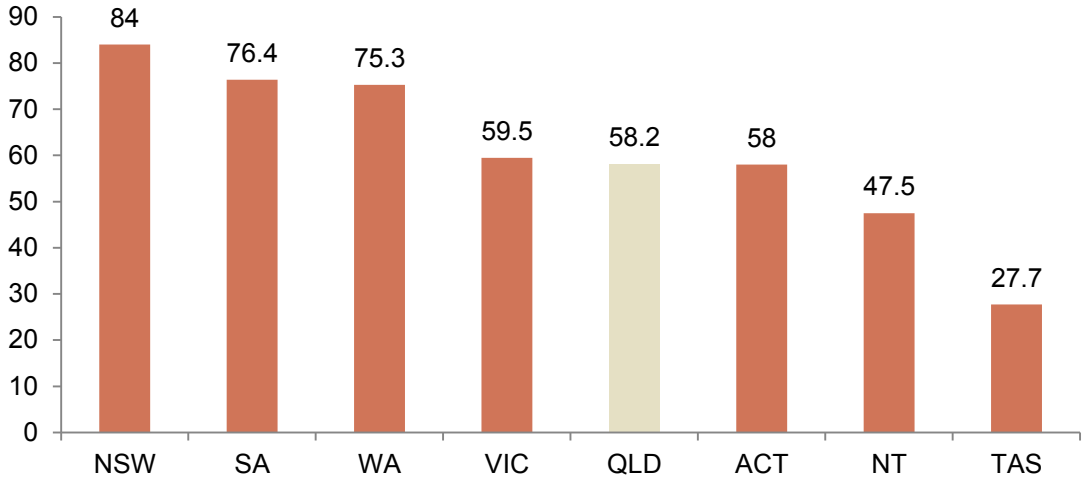
Type of placement	
Number of Indigenous children	**Number**
Placed with kinship or Indigenous carers	
Indigenous relative/kin	590
Non-Indigenous relative/kin	265
Other Indigenous caregivers	566
Indigenous residential care services	24
Total placed with kinship or Indigenous carers	1445
Not placed with kinship or Indigenous carers	
Other non-Indigenous caregivers	925
In non-Indigenous residential care	111
Total not placed with kinship or Indigenous carers	1036
Total Indigenous children in out-of-home care	2481
As a proportion of all Indigenous children in out-of-home care	**Percent**
Placed with kinship or Indigenous carers	
Indigenous relative/kin	23.8
Non-Indigenous relative/kin	10.7
Other Indigenous caregivers	22.8
Indigenous residential care services	1.0
Total placed with kinship or Indigenous carers	58.2
Not placed with kinship or Indigenous carers	
Other non-Indigenous caregivers	37.3
In non-Indigenous residential care	4.5
Total not placed with kinship or Indigenous carers	41.8
Total Indigenous children in out-of-home care	**100.0**

Administrative compliance in Australian states and territories in 2009

Figure 7 illustrates the proportion of administrative compliance with the Indigenous Child Placement Principle (as adopted in the relevant legislation) in each Australian state and territory as at 30 June 2009.[17] It shows that Queensland is fifth nation-wide in terms of the proportion of Aboriginal and Torres Strait Islander children and young people placed with an Indigenous or kinship carer.

[17] Page 67 of the *Child Protection Australia 2008-09*, Australian Institute of Health and Welfare, Canberra, 2010.

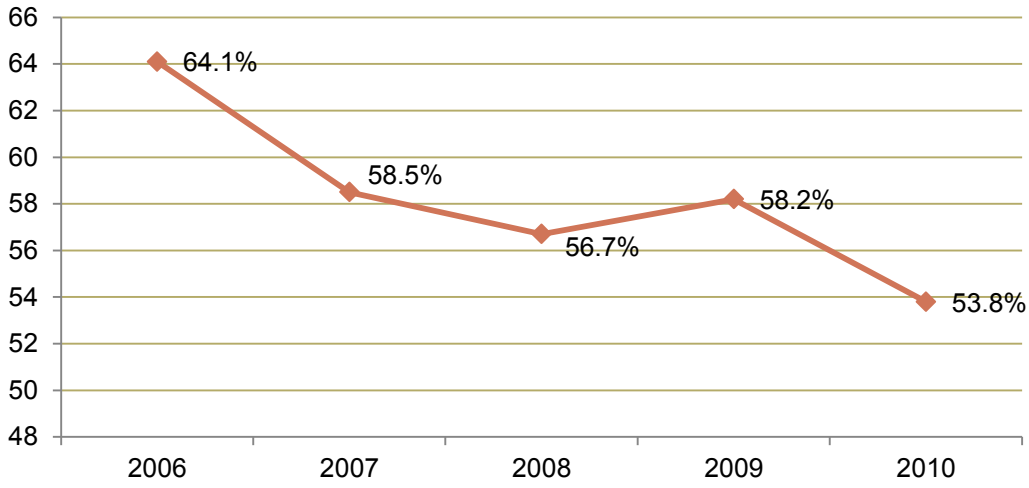
Figure 7: Proportion of administrative compliance by Australian state and territory as at 30 June 2009



Administrative compliance in Queensland in the last five years

Figure 8 illustrates the proportion of administrative compliance with section 83 of the *Child Protection Act 1999* in Queensland over time. It shows a decline of more than 10% in the proportion of Aboriginal and Torres Strait Islander children and young people placed with Indigenous or kinship carers over the last five years.

Figure 8: Administrative compliance in Queensland from 2006 to 2010



Chapter 3

Part A - The Department of Communities' mechanisms supporting compliance with section 83 of the *Child Protection Act 1999*

Key messages

- Overall, the Department of Communities has implemented 19 of the 28 recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* to improve the mechanisms supporting compliance with section 83 of the *Child Protection Act 1999* (policies, procedures and record keeping).
- All 15 recommendations intended to enhance the Department of Communities' policies and procedures to support compliance with section 83 of *the Child Protection Act 1999* have been implemented.
- Three of the 11 recommendations intended to enhance the Department of Communities' record keeping in ICMS to support compliance with section 83 of the *Child Protection Act 1999* have been implemented. Implementation of the remaining eight ICMS related recommendations is underway with enhancements scheduled for production in March 2012.
- One recommendation related to the Department of Communities rolling out comprehensive training for Child Safety Officers following the implementation of all of the Commission's recommendations is currently being implemented with completion scheduled for April 2012.
- One recommendation related to the Department of Communities considering the creation of specialist positions to assist in placements for Aboriginal and Torres Strait Islander children and young people has been implemented.

3.1 Importance of monitoring the Department of Communities' implementation of the 28 inaugural recommendations

The 28 recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* proposed a series of improvements to the Department of Communities' policy, procedural and record keeping infrastructure to assist Child Safety Officers to comply with section 83 of the *Child Protection Act 1999*.

Through the audit the 28 inaugural recommendations were confirmed as relevant in terms of the mechanisms to support compliance with section 83 of the *Child Protection Act 1999*.

3.2 Implementation of the 28 inaugural recommendations

The Department of Communities has provided updates to the Commission on the implementation of the 28 inaugural recommendations and these updates were shared with the Advisory Committee. The most recent update provided a summary of the action taken by the Department of Communities against each recommendation and included documentary evidence of implementation where relevant. This information has been summarised in Appendix 2, which also provides a comprehensive breakdown of the Commission's evaluation of the Department of Communities' implementation of the 28 inaugural recommendations.

The Advisory Committee considered the information and materials provided by the Department of Communities at its fourth meeting on 15 March 2011 and provided advice to the Commissioner regarding its assessment of implementation.

The Advisory Committee members were satisfied that the Department of Communities had implemented all policy/procedural related recommendations and that adequate policies and procedures were in place to support Child Safety Officers in the application of section 83 of the *Child Protection Act 1999*. However, it was established that there was still some way to go in terms of implementing recommendations related to enhancing record keeping functionality in ICMS, with a majority of ICMS related recommendations found to be outstanding.

Informed by this advice, the Commission made a provisional recommendation to the Department of Communities to address this issue:

> *If the Department of Communities is unable to commit to a timeframe for implementing the recommendations made in the inaugural Indigenous Child Placement Principle Audit Report 2008 that remain outstanding, particularly the enhancements to ICMS to improve mandatory record keeping in relation to the application of section 83 of the Child Protection Act 1999, it must identify (within three months) another mandatory recording keeping process to enable it to monitor and manage its compliance with each of the five steps.*

The Department of Communities responded that further work had been undertaken in prioritising and planning the implementation of the outstanding inaugural recommendations since the Commission's assessment of implementation:

> *Enhancements to ICMS, relevant to the implementation of recommendations from the Indigenous Child Placement Principle Audit Report 2008, are scheduled to enter production in March 2012.*

The Department of Communities also provided revised information about the additional action taken against each outstanding recommendation (summarised in Appendix 2) and included documentary evidence of implementation where relevant. This advice and evidence indicated that the Department of Communities has prioritised and planned the ICMS enhancements proposed by the recommendations and has nominated a timeframe for implementation.

Based on the Department of Communities' updates, and the Advisory Committee's advice on the extent of implementation, the Commission has concluded that all of the inaugural recommendations that relate to enhancing the guidance contained in departmental policies and procedures to support compliance with section 83 of the *Child Protection Act 1999* have been implemented. However, implementation is still underway for the majority of recommendations that

relate to enhancing information capture in ICMS to support compliance with section 83 of the *Child Protection Act 1999*. Specifically, the Commission makes the following assessment.

Implementation status of the 28 inaugural recommendations

- The Department of Communities has implemented 19 of the 28 recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* to improve the mechanisms for compliance with section 83 of the *Child Protection Act 1999* (the policies, procedures and record keeping infrastructure in place).
- All 15 recommendations intended to enhance the Department of Communities' policies and procedures to support compliance with section 83 of *the Child Protection Act 1999* have been implemented.
- Three of the 11 recommendations intended to enhance the Department of Communities' record keeping in ICMS to support compliance with section 83 of the *Child Protection Act 1999* have been implemented. Implementation of the remaining eight ICMS related recommendations is underway with enhancements scheduled for production in March 2012.
- One recommendation related to the Department of Communities rolling out comprehensive training for Child Safety Officers following the implementation of all of the Commission's recommendations is currently being implemented with completion scheduled for April 2012.
- One recommendation related to the Department of Communities considering the creation of specialist positions to assist in placements for Aboriginal and Torres Strait Islander children and young people has been implemented.

Table 6 provides a summary of the Commission's assessment of the Department of Communities' implementation of the 28 inaugural recommendations and highlights the nature of each recommendation made and its implementation status.

Importantly, many of the 28 inaugural recommendations made by the Commission were reinforced by recommendations made in the Aboriginal and Torres Strait Islander Kinship Reconnection Project report in 2010, prepared by the Placements for Aboriginal and Torres Strait Islander Working Group (Appendix 4 provides an overview of the links between recommendations). The aim of that Project was to improve kinship connections for the 26 children and young people comprising the Project sample and identify practice improvements and models of service delivery to better connect them to their family, community and culture.

The Project report similarly made recommendations proposing the Department of Communities enhance guidance to assist Child Safety Officers in the application of section 83 of the *Child Protection Act 1999*. Specifically, recommendations related to establishing cultural identity, identifying and recording family and cultural information, and considering and making placement decisions in accordance with section 83 of the *Child Protection Act 1999*.

The Project report also identified that the steps taken to identify a culturally appropriate placement in line with section 83 of the *Child Protection Act 1999,* and the outcomes of these steps, were not clearly documented, with recommendations made to enhance the Department of Communities' record keeping.

Accordingly, this audit has concluded that the inaugural recommendations remain relevant. As such, it is essential that the Department of Communities adhere to its nominated timeframes for the inaugural recommendations that are currently being implemented (particularly the enhancements to ICMS to improve mandatory record keeping), or establish another mandatory record keeping process to enable it to better monitor and manage its compliance with section 83 within three months.

Recommendation 1

The Department of Communities adhere to the nominated timeframes assigned to the nine recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008* that are currently being implemented, or establish (by the end of April 2012) another mandatory recording keeping process to enable it to monitor and manage compliance with each of the five steps.

Table 6: Summary of the Commission's evaluation of the Department of Communities' implementation of the 28 inaugural recommendations

Rec.	Policy/procedural related	Record keeping (in ICMS) related	Other	Status
1	Yes	-	-	Implemented
2	Yes	-	-	Implemented
3	Yes	-	-	Implemented
4	-	Yes	-	Implementation underway
5	Yes	-	-	Implemented
6	Yes	-	-	Implemented
7	Yes	-	-	Implemented
8	-	Yes	-	Implemented
9	Yes	-	-	Implemented
10	-	Yes	-	Implementation underway
11	Yes	-	-	Implemented
12	-	Yes	-	Implemented
13	-	Yes	-	Implementation underway
14	Yes	-	-	Implemented
15	-	Yes	-	Implementation underway
16	Yes	-	-	Implemented
17	-	Yes	-	Implementation underway
18	Yes	-	-	Implemented
19	-	Yes	-	Implemented
20	Yes	-	-	Implemented

21	-	Yes	-	Implementation underway
22	Yes	-	-	Implemented
23	Yes	-	-	Implemented
24		Yes	-	Implementation underway
25	Yes	-	-	Implemented
26	-	-	Training related	Implementation underway
27	-	-	Position creation related	Implemented
28	-	Yes	-	Implementation underway
Total	**15**	**11**	**2**	**28**
Total implemented	**15**	**3**	**1**	**19**

Chapter 4

Part B - The Department of Communities' practice compliance with section 83 of the *Child Protection Act 1999*

Key messages

- The Department of Communities' practice compliance with most of the individual steps required by section 83 of the *Child Protection Act 1999* was identified as positive, where evidence was available to make an assessment against the Compliance Assessment Tool.[18]
- Complete compliance with all steps of the Compliance Assessment Tool was established for 58 (or 15%) of the 388 placement decisions comprising the audit sample. This represents an improvement since the inaugural *Indigenous Child Placement Principle Audit Report 2008* which found no record of complete compliance with section 83 of the *Child Protection Act 1999* (across a smaller sample).
- While compliance with individual steps of the Compliance Assessment Tool was good when viewed in isolation, the Department of Communities needs to improve compliance with all steps to improve complete compliance.
- The low outcome of complete compliance can be attributed in part to delays in the Department of Communities implementing the recommendations of the inaugural audit.
- There is a need for strengthened training to improve practice compliance with section 83 of the *Child Protection Act 1999* and the outcomes of this audit should assist staff in understanding the importance of the issue.

4.1 Importance of monitoring the Department of Communities' compliance with section 83 of the Child Protection Act 1999

The Commission's mandate to monitor the Department of Communities' compliance with section 83 of the *Child Protection Act 1999* is integral to maintaining a focus on this important area of service delivery. Identifying areas of strength or areas requiring improvement in terms of practice compliance with section 83, also supports departmental efforts to improve outcomes for Aboriginal and Torres Strait Islander children and young people in out-of-home care.

Appropriate record keeping should provide critical insights of both the outcome of a placement decision for an Aboriginal and Torres Strait Islander child or young person, and the process and rationale behind the decision. Without evidence of how each step required by section 83 of the *Child Protection Act 1999* is applied to the decision making process for a placement, compliance cannot be measured, confirmed or said to have occurred.

[18] A tool that summarises the key requirements of section 83 of the *Child Protection Act 1999* and was endorsed by the Advisory Committee as the framework for assessing compliance for this audit.

4.2 Process for assessing compliance

Information was triangulated from three data sources used to inform the audit (Child Safety Officer surveys, Recognised Entity surveys and ICMS records).[19] This information was used to determine whether the decision making process undertaken for each of the 388 placement decisions comprising the audit sample was compliant with the five requisite steps of the Compliance Assessment Tool (Appendix 5).

4.3 Assessing compliance with each of the five steps of the Compliance Assessment Tool using the three data sources

For each of the 388 placement decisions, an assessment of compliance was made for each step of the Compliance Assessment Tool using the three separate data sources. This resulted in three unique assessments of compliance with each step, one for each data source. The counting rules that were used to inform the application of the Compliance Assessment Tool are outlined in Appendix 5.

The three assessments of compliance were then reconciled to provide an overall assessment of compliance with each step (based on all information available). The counting rules that were used to inform this process are outlined in Appendix 6 and the complete results of this assessment are contained in Appendix 7.

The assessment of compliance with each step of the Compliance Assessment Tool follows. In summary, provided one of the available sources evidenced compliance, this was recorded in the positive, even where a conflicting source existed. In essence, the Department of Communities has been provided with the benefit of the doubt in the assessment process.

Step 1 – Identify the child is Indigenous

Section 83 of the *Child Protection Act 1999*

(1) This section applies if the child is an Aboriginal or Torres Strait Islander child.

Threshold for assessing compliance with Step 1

Compliance with section 83(1) of the *Child Protection Act 1999*, Step 1 of the Compliance Assessment Tool, occurs if a child is identified as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander.

Compliance with Step 1

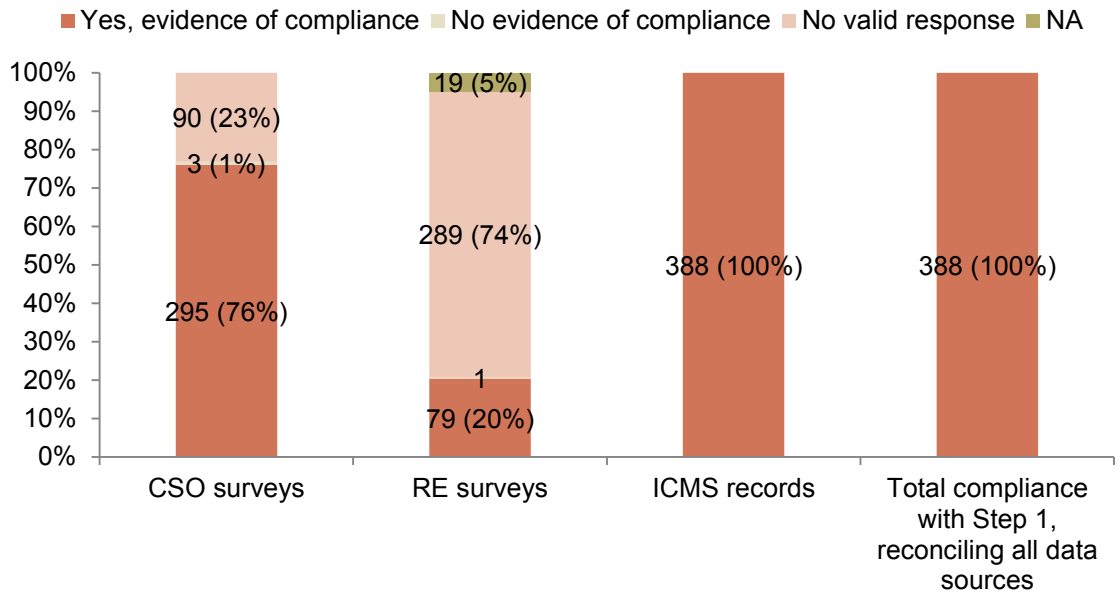
As illustrated in Figure 9, all of the children and young people who were the subject of the 388 placement decisions comprising the audit sample were identified to be Aboriginal and/or Torres Strait Islander, therefore all placement decisions demonstrated compliance with Step 1 of the Compliance Assessment Tool.[20]

[19] Refer to the Audit Methodology for additional detail about the methodology established for Part B of the audit.
[20] The total figure was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step.

What this indicates

Strong compliance with Step 1 indicates that the Department of Communities is performing well in identifying the cultural status of Aboriginal and Torres Strait Islander children and young people who come into contact with the child protection system.

Figure 9: Placement decisions that demonstrated compliance with Step 1 of the Compliance Assessment Tool[21]



Step 2 – Involvement of a Recognised Entity

Section 83 of the *Child Protection Act 1999*

(2) The chief executive must ensure a recognised entity for the child is given an opportunity to participate in the process for making a decision about where or with whom the child will live.
(3) However, if because of urgent circumstances the chief executive makes the decision without the participation of a recognised entity for the child, the chief executive must consult with a recognised entity for the child as soon as practicable after making the decision.

Threshold for assessing compliance with Step 2

Compliance with section 83(2) and (3) of the *Child Protection Act 1999*, Step 2 of the Compliance Assessment Tool, occurs where there is evidence that the Recognised Entity was provided an opportunity to participate in the placement decision, or was consulted as soon as practicable after the placement decision was made in urgent circumstances.

[21] Percentages may not add up to 100% owing to rounding.

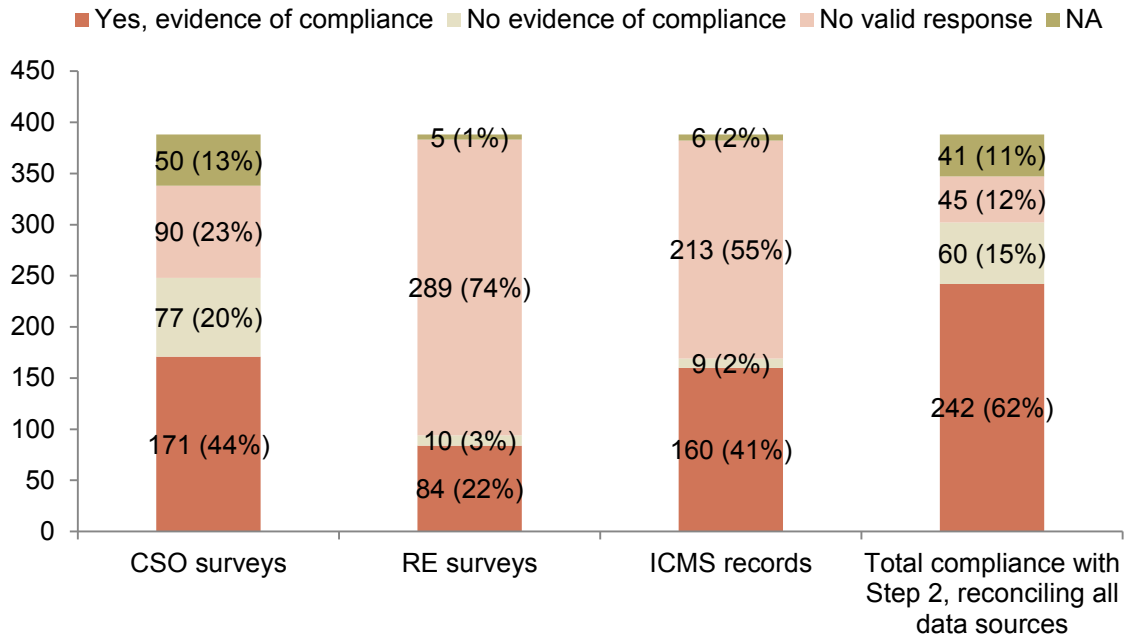
Compliance with Step 2

As illustrated in Figure 10, 242 (or 62% of 388) placement decisions demonstrated that the Recognised Entity was provided an opportunity to participate in the placement decision, or was consulted as soon as practicable after the placement decision was made in urgent circumstances, therefore demonstrating compliance with Step 2 of the Compliance Assessment Tool in these cases.[22]

What this indicates

This compliance finding indicates that Child Safety Officers are aware of the need to involve or consult with Recognised Entities. However there is need for improved practice and/or record keeping.

Figure 10: Placement decisions that demonstrated compliance with Step 2 of the Compliance Assessment Tool[23]



Step 3 – Hierarchy of placement options

Section 83 of the *Child Protection Act 1999*

(4) In making a decision about the person in whose care the child should be placed, the chief executive must give proper consideration to placing the child, in order of priority, with—

(a) a member of the child's family; or

(b) a member of the child's community or language group; or

(c) another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group; or

(d) another Aboriginal person or Torres Strait Islander.

[22] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.
[23] Percentages may not add up to 100% owing to rounding.

(6) If the chief executive decides there is no appropriate person mentioned in subsection (4)(a) to (d) in whose care the child may be placed, the chief executive must give proper consideration to placing the child, in order of priority, with—
(a) a person who lives near the child's family; or
(b) a person who lives near the child's community or language group.

Threshold for assessing compliance with Step 3

Compliance with section (4) and (6) of the *Child Protection Act 1999*, Step 3 of the Compliance Assessment Tool, occurs where there is evidence that each level of the prescribed hierarchy of placement options (outlined above) was considered in order until the placement decision was made.

Compliance with Step 3

As illustrated in Figure 11:

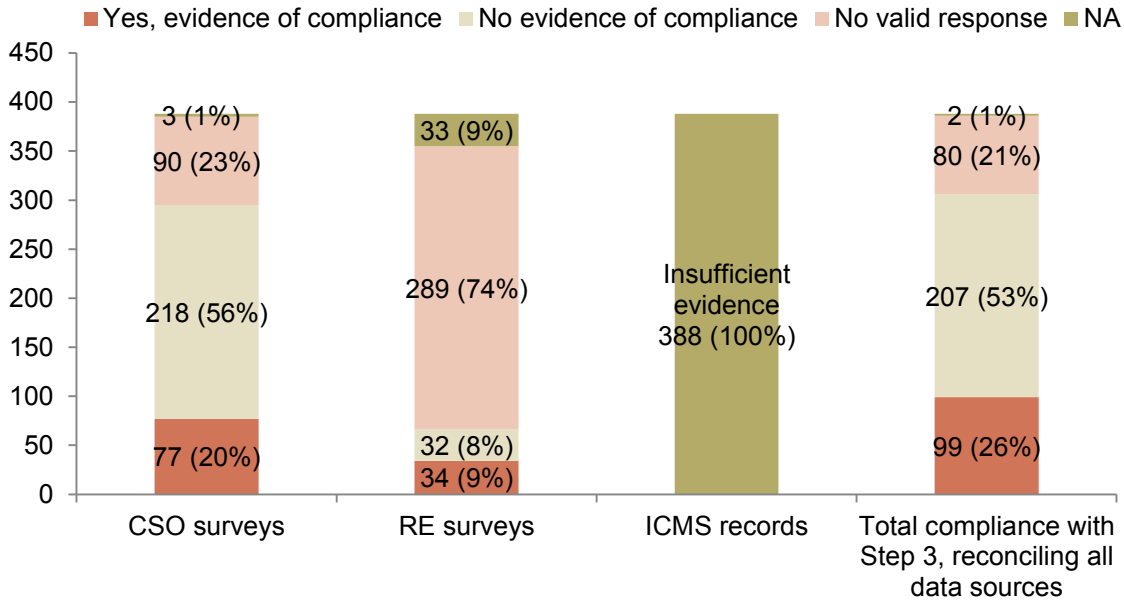
- There were 99 (or 26% of 388) placement decisions that demonstrated that each level of the prescribed hierarchy of placement options was considered in order until the placement decision was made. Therefore demonstrating compliance with Step 3 in these cases.[24]
- ICMS records did not capture sufficient rationale about the identification and consideration of placement options to inform the assessment of compliance with Step 3 at all.

What this indicates

- This compliance finding indicates that there is need for improved practice and/or record keeping in relation to the identification, consideration and assessment of placement options in accordance with the prescribed hierarchy outlined in section 83(4) and (6) of the *Child Protection Act 1999*.
- The record keeping limitations identified in the inaugural audit and this current audit about monitoring compliance with Step 3 still remain and require action by the Department of Communities.

[24] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.

Figure 11: Placement decisions that demonstrated compliance with Step 3 of the Compliance Assessment Tool[25]



Step 4 – Proper consideration of placement options

Section 83 of the *Child Protection Act 1999*

(5) Also, the chief executive must give proper consideration to—

(a) the views of a recognised entity for the child; and

(b) ensuring the decision provides for the optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom.

Threshold for assessing compliance with Step 4

For the purposes of this audit, Step 4 of the Compliance Assessment Tool has been further broken down to identify the extent of compliance with the two aspects of this Step:

- Step 4A – Proper consideration of the Recognised Entity's views, and
- Step 4B – Proper consideration of the placement option's ability to ensure optimal retention of relationships with key people.

Compliance with section 83(5) of the *Child Protection Act 1999*, Step 4 of the Compliance Assessment Tool, occurs where there is evidence of:

- Consideration of the Recognised Entity's views (Step 4A), and
- Assessment of a placement option's ability to retain the child's relationships with parents, siblings and people of significance (Step 4B).

[25] Percentages may not add up to 100% owing to rounding.

Step 4A

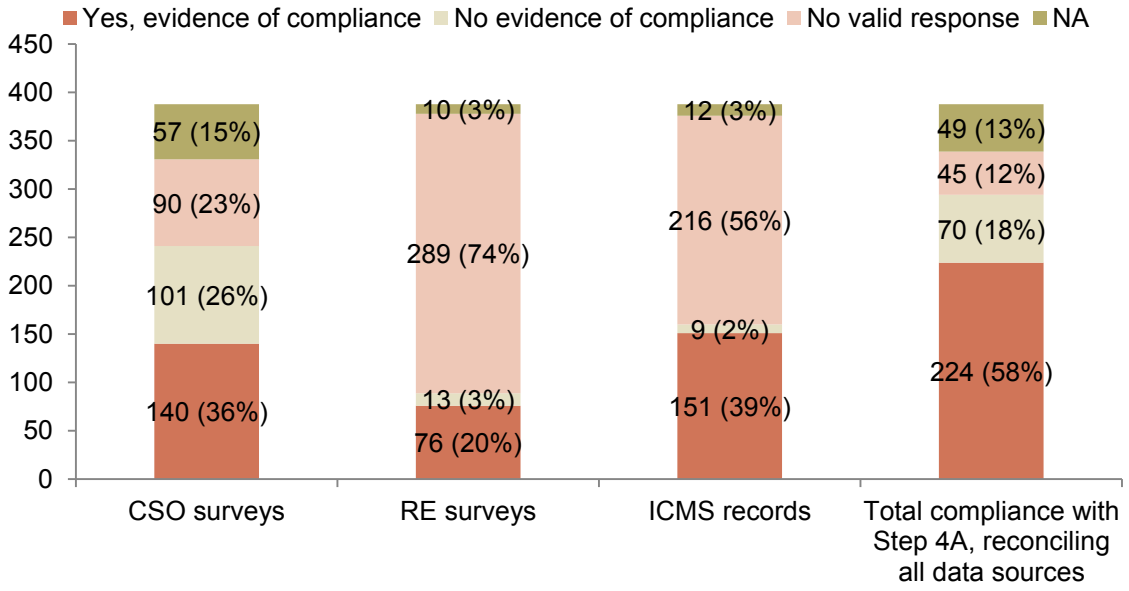
Compliance with Step 4A

As illustrated in Figure 12, there were 224 (or 58% of 388) placement decisions that demonstrated consideration of the Recognised Entity's views, therefore demonstrating compliance with Step 4A of the Compliance Assessment Tool in these cases.[26]

What this indicates

This compliance finding indicates that in a large number of placement decisions the Recognised Entity's views are being properly considered by the Department of Communities. However there is need for further improved practice and/or record keeping.

Figure 12: Placement decisions that demonstrated compliance with Step 4A of the Compliance Assessment Tool[27]



Step 4B

Compliance with Step 4B

- As illustrated in Figure 13, there were 180 (or 46% of 388) placement decisions that demonstrated evidence of an assessment of a placement option's ability to retain the child's relationships with their parents, siblings and people of significance, therefore demonstrating compliance with Step 4B of the Compliance Assessment Tool in these cases.[28]
- Figure 13 further illustrates that ICMS records did not capture sufficient rationale about the assessment of a placement option's ability to retain the child's relationships with their parents, siblings and people of significance to inform the assessment of compliance

[26] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.
[27] Percentages may not add up to 100% owing to rounding.
[28] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.

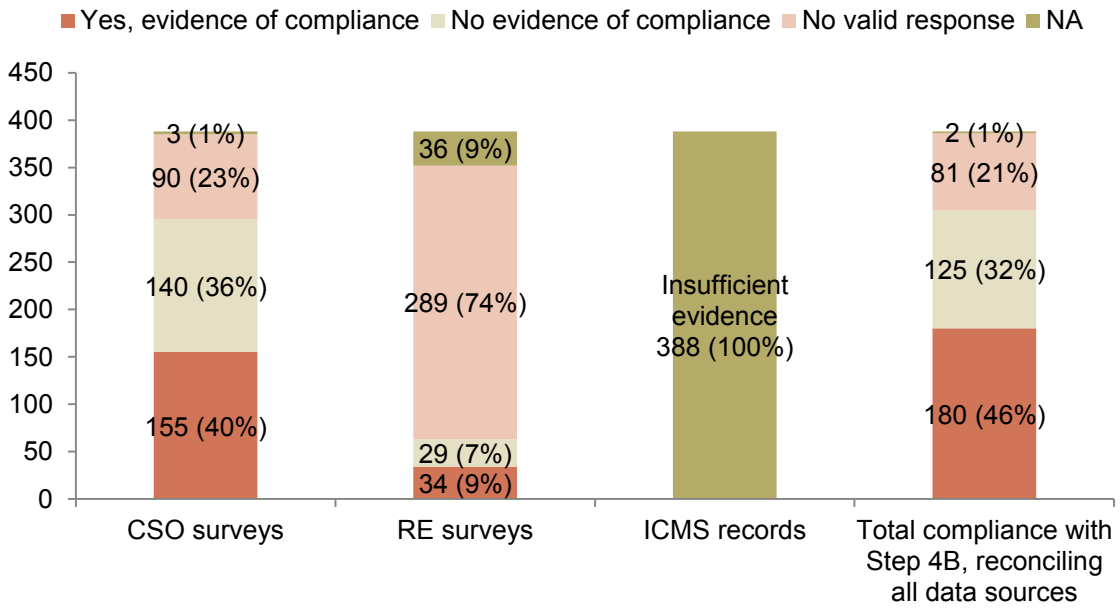
with Step 4B.

- As illustrated in Figure 14, a further breakdown of compliance with Step 4B demonstrated that Child Safety Officers are doing well at assessing the placement option's ability to retain some, but not all, of the child's relationships with family and people of significance (as relevant).[29]

What this indicates

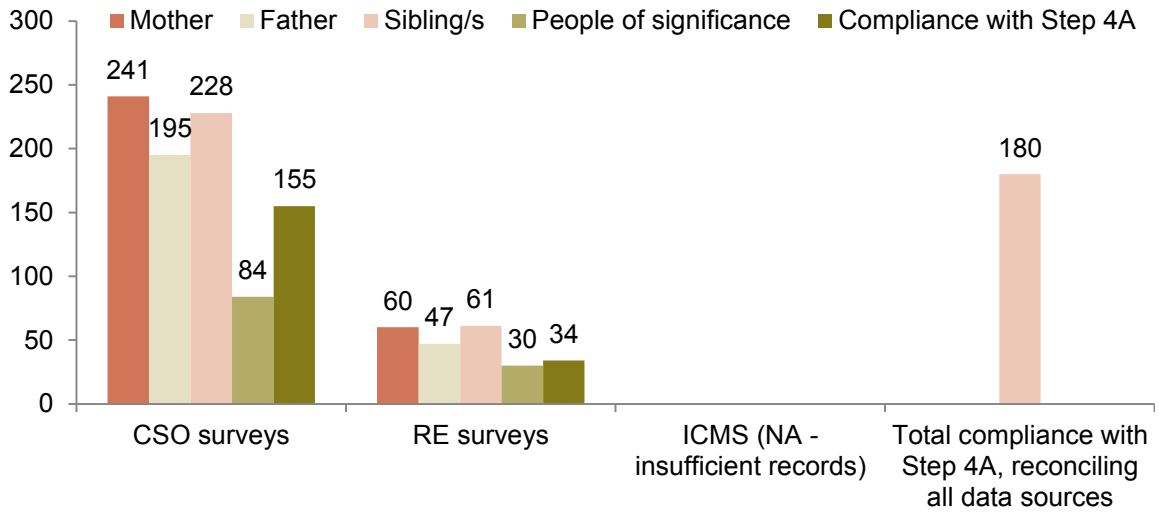
- This compliance finding indicates that there is need for improved practice and/or record keeping in regard to assessing a placement option's ability to retain the child's relationships with all (not just some) of their parents, siblings and people of significance (as relevant).[30]
- The record keeping limitations identified in the inaugural audit and this current audit about monitoring compliance with Step 4B still remain and require action by the Department of Communities.

Figure 13: Placement decisions that demonstrated compliance with Step 4B of the Compliance Assessment Tool[31]



[29] All 'relevant' relationships excludes where consideration of a relationship will not be appropriate ie. where a person is deceased, a father is unknown, the child does not have any siblings etc.
[30] Ibid.
[31] Percentages may not add up to 100% owing to rounding.

Figure 14: Breakdown of compliance with Step 4B of the Compliance Assessment Tool



Step 5 – Assessment of non-Indigenous carer's commitment

Section 83 of the *Child Protection Act 1999*

(7) Before placing the child in the care of a family member or other person who is not an Aboriginal person or Torres Strait Islander, the chief executive must give proper consideration to whether the person is committed to—

(a) facilitating contact between the child and the child's parents and other family members, subject to any limitations on the contact under section 87; and

(b) helping the child to maintain contact with the child's community or language group; and

(c) helping the child to maintain a connection with the child's Aboriginal or Torres Strait Islander culture; and

(d) preserving and enhancing the child's sense of Aboriginal or Torres Strait Islander identity.

Threshold for assessing compliance with Step 5

Compliance with section 83(7) of the *Child Protection Act 1999*, Step 5 of the Compliance Assessment Tool, occurs where there is evidence of an assessment of the non-Indigenous carer's commitment to:

- facilitating contact between the child and the child's parents and other family members
- helping the child to maintain contact with the child's community or language group
- helping the child to maintain a connection with the child's Aboriginal or Torres Strait Islander culture, and
- preserving and enhancing the child's sense of Aboriginal or Torres Strait Islander identity.

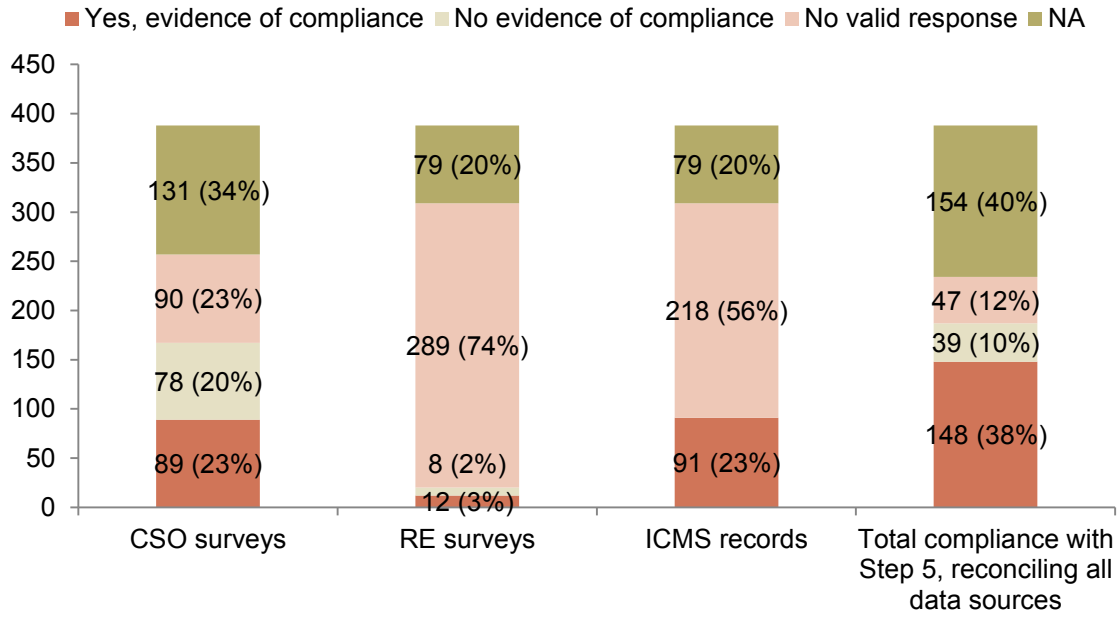
Compliance with Step 5

As illustrated in Figure 15, there were 148 (or 38% of 388) placement decisions that demonstrated an assessment of the non-Indigenous carer's commitment to maintaining the child's connection to family, community and culture. Therefore, demonstrating compliance with Step 5 of the Compliance Assessment Tool in these cases.[32]

What this indicates

This compliance finding indicates that there is need for improved practice and/or record keeping in regard to assessment of the non-Indigenous carer's commitment to maintaining the child's connection to family, community and culture.

Figure 15: Placement decisions that demonstrated compliance with Step 5 of the Compliance Assessment Tool[33]



[32] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.
[33] Percentages may not add up to 100% owing to rounding.

4.4 Overall compliance with each step

Overall compliance with each step of the Compliance Assessment Tool has been broken down in two ways:

(i) For all 388 placement decisions comprising the audit sample,[34] and
(ii) For the valid placement decisions for each step (ie. excluding the placement decisions that were not applicable for a particular step or had no valid response submitted).

Overall compliance has been broken down this way for completeness to:

- Firstly, provide a picture of compliance for all 388 placement decisions comprising the audit sample, and
- Secondly, formulate a comparative assessment of compliance based on placement decisions that actually had information available to inform an assessment.

(i) Overall compliance for all 388 placement decisions comprising the audit sample[35]

For all 388 placement decisions

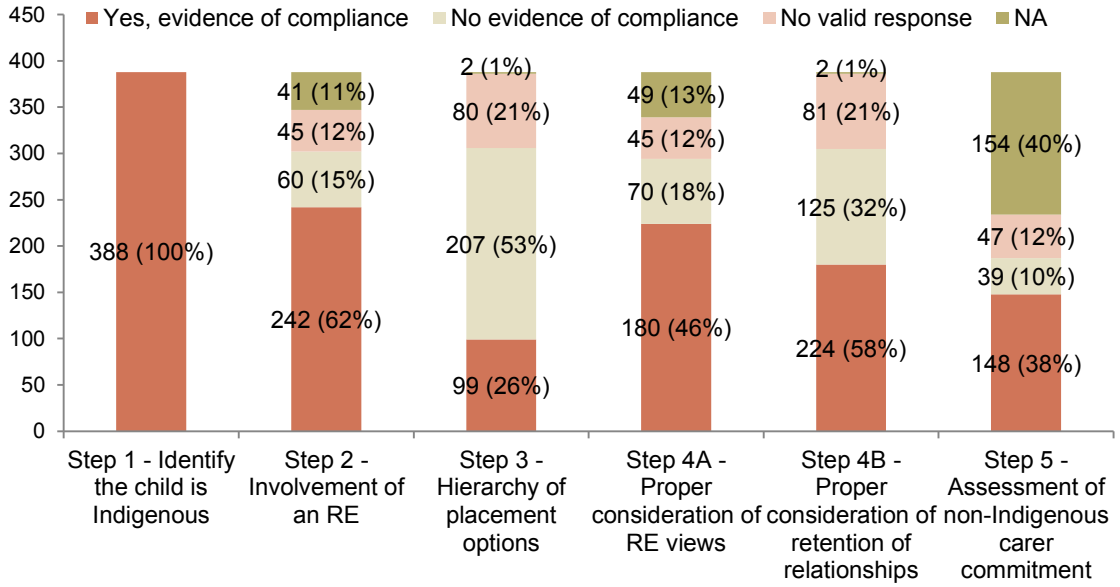
- As illustrated in Figure 16, there were varied levels of compliance across the five steps of the Compliance Assessment Tool. However, Step 1 (identifying the child is Indigenous) was the only step in which all of the 388 placement decisions comprising the audit sample demonstrated compliance.[36]
- At least 12% of all placement decisions, excluding Step 1, had no valid response provided across all data sources to inform an assessment of compliance.

What this indicates

- This compliance finding indicates that there are practice and record keeping issues relevant to compliance with all but one step of the Compliance Assessment Tool, Step 1 – identifying the child is Indigenous.
- The absence of sufficient records for more than 12% of the placement decisions comprising the audit sample limits the Commission's ability to assess the Department of Communities' compliance with the steps required by section 83 of the *Child Protection Act 1999*. It also raises questions about the Department of Communities' ability to make appropriate decisions about service delivery and support gaps.

[34] The 15% compliance referred to throughout this report relates to the assessment of all 388 placement decisions comprising the audit sample, as represented in Figure 16.
[35] The 15% compliance referred to throughout this report relates to the assessment of all 388 placement decisions comprising the audit sample, as represented in Figure 16.
[36] The total figure of compliance was calculated by reconciling the three assessments of compliance with each step (based on each data source) to provide an overall assessment of compliance with each step. This total figure will not evenly add up to the sum of compliance across the three data sources owing to overlap in the placement decisions that a survey response or ICMS record was provided for.

Figure 16: Placement decisions that demonstrated compliance with each of the five steps of the Compliance Assessment Tool[37]



(ii) Overall compliance for all valid placement decisions for each step (excluding the placement decisions that were not applicable for a particular step or had no valid response submitted)

For all valid placement decisions

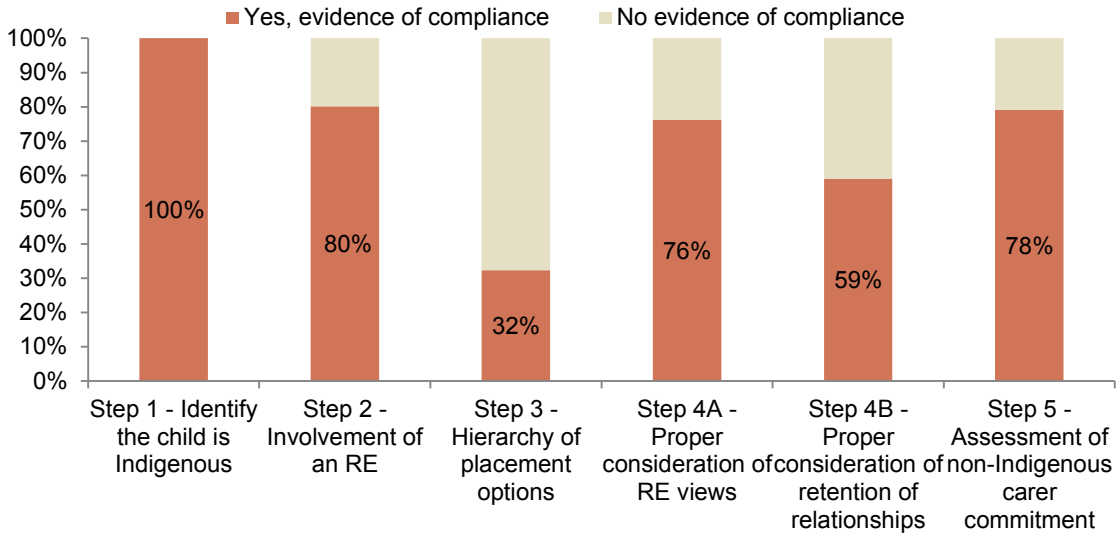
- As illustrated in Figure 17, an assessment of compliance based on all valid placement decisions for each step[38] indicated that strong compliance findings were evident across most steps of the Compliance Assessment Tool where the step was applicable and evidence was available to inform an assessment of compliance.
- Comparatively, Figure 17 (based on all valid placement decisions) indicates stronger findings of compliance across each step compared to Figure 16 (based on all 388 placement decisions).

What this indicates

- Figure 17 indicates that Child Safety Officers are doing well in complying with most steps of the Compliance Assessment Tool, where evidence is available to inform an assessment. However, there remains a need for improved practice and/or record keeping across all but one step, Step 1.
- The contrast in findings of compliance between Figures 16 and 17 confirms that poor record keeping of compliance with the steps required by section 83 of the *Child Protection Act 1999* leads to a poor assessment of compliance, owing to an absence of evidence that the appropriate decision-making process has been followed. This again highlights the importance of implementing improved record keeping practices to strengthen the assessment of compliance.

[37] Percentages may not add up to 100% owing to rounding.
[38] Excluding the placement decisions from Figure 16 that were not applicable for a particular step or had no valid response submitted.

Figure 17: Placement decisions that demonstrated compliance with each of the five steps of the Compliance Assessment Tool as a proportion of total valid responses



4.5 Assessing complete compliance across all steps of the Compliance Assessment Tool

The overall assessments of compliance with each step of the Compliance Assessment Tool were drawn together to make a final assessment of complete compliance with section 83 of the *Child Protection Act 1999* for each of the 388 placement decisions comprising the audit sample.

The counting rules used were as follows:

- Yes – there was evidence of complete compliance across all steps of the Compliance Assessment Tool.
- No – there was no evidence of complete compliance across all steps of the Compliance Assessment Tool (based on the information sources available). This may not infer that compliance did not occur, but that there was no record of it.
- No valid response – there was insufficient evidence for one or more steps of the Compliance Assessment Tool, therefore a final assessment of complete compliance could not be made.

Complete compliance

As illustrated in Figure 18:

- Complete compliance was established for 58 (or 15%) of the placement decisions.
- There were 255 (or 66%) placement decisions that did not evidence complete compliance.
- A final assessment of complete compliance could not be made for 75 (or 19%) placement decisions owing to insufficient evidence.

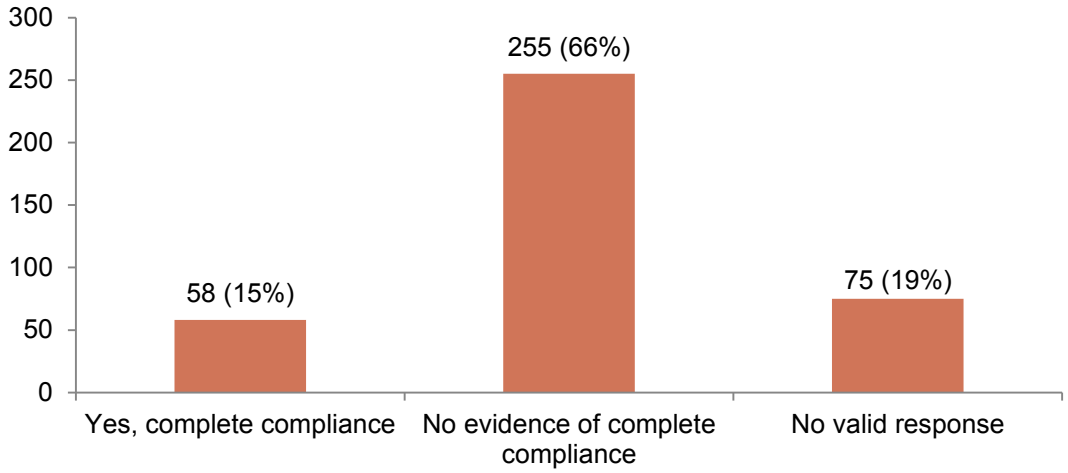
What this indicates

- This compliance finding indicates an improvement since the inaugural *Indigenous Child Placement Principle Audit Report 2008*

which found no record of complete compliance with section 83 of the *Child Protection Act 1999* (across a small sample).

- It suggests that while compliance with individual steps of the Compliance Assessment Tool is good when viewed in isolation (Figure 17), Child Safety Officers need to improve recording compliance with all steps to achieve complete compliance (Figure 18).
- There is need for further improvement to practice and/or record keeping by the Department of Communities to achieve complete compliance with section 83 of the *Child Protection Act 1999*.

Figure 18: Final assessment of complete compliance with section 83 of the *Child Protection Act 1999*[39]



4.6 Impact on compliance findings

It is important to note that the policy and procedural recommendations from the inaugural *Indigenous Child Placement Principle Audit Report 2008* have recently been implemented. During the audit, it was identified that these recommendations were predominantly not implemented at the time the audit sample was extracted and analysed.

In the absence of complete implementation of the inaugural recommendations, additional recommendations will not be made to address previously identified issues. The Commission will evaluate the adequacy of implementation of the complete suite of inaugural recommendations as part of the next audit.

Recommendation 2

The Department of Communities consider ways to strengthen its practice and record keeping related to the application of section 83 of the *Child Protection Act 1999* by communicating the findings of this audit and the Compliance Assessment Tool to its Child Safety Officers as the basis upon which its future efforts will be assessed. A documented communication plan is to be developed by the end of April 2012.

[39] Percentages may not add up to 100% owing to rounding.

The Department of Communities' response to the recommendation

Accepted.

4.7 Key findings

A number of key findings were evident in the assessment of compliance with section 83 of the *Child Protection Act 1999*. Specific recommendations have been made where relevant to address these newly identified issues.

Availability of necessary ICMS records

The 'Recognised Entity/Child Placement Principle' ICMS form was provided for 173 placement decisions (or 45% of 388). This form was understood by the Commission to be mandatory when a placement decision is made for an Aboriginal or Torres Strait Islander child or young person to capture information about compliance with section 83 of the *Child Protection Act 1999*.

The absence of this form for more than half of all placement decisions comprising the audit sample limited the availability of information that could be used to assess the Department of Communities' compliance with section 83 of the *Child Protection Act 1999*.

Advice from the Department of Communities on 6 December 2010 indicated that the 'Recognised Entity/Child Placement Principle' ICMS form is not currently mandatory when placement decisions are made for Aboriginal and Torres Strait Islander children and young people. The Child Safety Practice Manual requires Child Safety Officers to record and capture all outcomes of the decision making process in the ICMS form. However, there is currently a system limitation in ICMS which does not mandate the completion of the ICMS form.

The Department of Communities further advised that a priority system enhancement has been requested to correct the system limitation. However, the correction was not expected to be completed within 2010-11.

Recommendation 3

The Department of Communities commit to a timeframe for enhancing ICMS to make completion of the 'Recognised Entity/Child Placement Principle' form mandatory when making a placement decision for an Aboriginal or Torres Strait Islander child or young person, and advise of this timeframe by the end of April 2012.

The Department of Communities' response to the recommendation

Enhancements to ICMS to make the completion of the 'Recognised Entity/ Child Placement Principle' form mandatory for Aboriginal and Torres Strait Islander children is scheduled to enter production in March 2012.

The form will be automatically created, on creation of placement events for Aboriginal and Torres Strait Islander children and allocated to the case manager. A reminder to complete the form will also appear when an Authority to Care is being approved and the placement event will not close until this form is completed.

Recording of cultural status in ICMS records

Cultural status could not be identified in the specific ICMS records provided for 21 children and young people comprising the audit sample. In these cases, cultural status was confirmed with the Department of Communities through reference to record keeping elsewhere in ICMS or hard copy records. The absence of this information in the forms provided to the Commission may be in part due to point-in-time information capture in ICMS. Meaning, at the time the form was completed in ICMS the child's cultural status may not have been confirmed.

The Commission made a finding that monitoring of compliance with section 83 of the *Child Protection Act 1999* would be assisted if information about cultural status was also recorded in the 'Recognised Entity/Child Placement Principle' ICMS form. This would ensure that all necessary information to inform an assessment of compliance would be contained in a single point of record keeping (once the inaugural recommendations have been implemented in their entirety).

The Commission made a provisional recommendation to the Department of Communities to address this:

> *The Department of Communities commit to a timeframe for enhancing the 'Recognised Entity/Child Placement Principle' form in ICMS to contain information about the identification of the child's cultural status, to ensure that all necessary information to inform an assessment of compliance with section 83 of the Child Protection Act 1999 is contained in a single point of record keeping, and advise of this timeframe within three months.*

The Department of Communities provided the following response:

> *Relevant demographic information about children used to inform placement decisions is currently recorded within ICMS. The key locations for recording the child and their family's cultural status are the Person Profile and the Cultural Support Plan within the Case Plan. Recording this information in these locations is considered the appropriate record keeping method.*

The Department of Communities further identified that this issue had been factored into recent planned enhancements to ICMS in the following ways:

- The 'Recognised Entity/Child Placement Principle' form will be automatically created when placement events are created for Aboriginal and/or Torres Strait Islander children
- To close a placement event for an Aboriginal and/or Torres Strait Islander child, a 'Recognised Entity /Child Placement Principle' form must be completed, and

- A warning will appear when attempting to close the placement event which contains a 'Recognised Entity/Child Placement Principle' form where the child is not listed as Aboriginal and/or Torres Strait Islander. The Child Safety Officer will accordingly be directed to update the child's cultural status on their Profile tab prior to closing the placement event.

This advice indicates that ICMS functionality will ensure an appropriate record keeping link between establishing the child's cultural status and completing the necessary 'Recognised Entity/Child Placement Principle' form. Accordingly, the Commission is satisfied that the identified issue has been proactively addressed by the Department of Communities and the recommendation is no longer necessary.

The application of section 83 of the *Child Protection Act 1999* to respite placements

A theme evident in the survey responses provided by Child Safety Officers was that there was uncertainty regarding whether section 83 of the *Child Protection Act 1999* applied to respite placements.

The audit also highlighted that the *Child Protection Act 1999* does not provide prescriptive guidance about the application of section 83 to respite placements. Recent changes to the Child Safety Practice Manual (CSPM) specify that where respite for a child incorporates an out-of-home care placement the Child Safety Officer should seek a placement that is consistent with the Indigenous Child Placement Principle for an Aboriginal or Torres Strait Islander child. However, the CSPM does not mandate this practice.[40]

Advice from the Department of Communities, through its membership in the Advisory Committee, indicated that respite is a planned event over a period of time and so it needs to factor in compliance with section 83 of the *Child Protection Act 1999*.

Accordingly, the application of section 83 of the *Child Protection Act 1999* to respite placements has been identified as an area of service delivery that requires clarification to support practice.

Recommendation 4

The Department of Communities review and (by the end of April 2012) clarify its practice guidance regarding the application of section 83 of the *Child Protection Act 1999* to respite placements for Aboriginal and Torres Strait Islander children and young people.

The Department of Communities' response to the recommendation

Accepted.

Enhancements to ICMS in relation to placements will also apply to decisions for respite placements.

These enhancements include amendments to the 'Recognised Entity/Child Placement

[40] Chapter 5, Section 2.6 of the Child Safety Practice Manual.

Principle' form to record;

- *the question "Has proper consideration been given to the placements ability to ensure optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom?*
- *on answering no to the above question, reasons why proper consideration was not given must be entered*

These are scheduled to enter production in March 2012. Each placement option will identify their relationship priority based on section 83 (4 & 6) of the Child Protection Act 1999.

Information discrepancy between Child Safety Officers and Recognised Entities

The compliance findings indicated discrepancies between the Department of Communities' information sources (the Child Safety Officer survey responses and ICMS records) and the information provided by Recognised Entities.

Specifically, there were 60 placement decisions where there was a discrepancy between the information provided by the Department of Communities (either in ICMS records or Child Safety Officer survey responses) and the information provided by Recognised Entities in regard to at least one step of the Compliance Assessment Tool. In these cases, compliance was inferred where at least one data source indicated that compliance had occurred, based on advice from the Advisory Committee.

The lack of unanimity between information gathered from the Department of Communities and Recognised Entities indicates need for improvement in participation and information sharing processes.

Recommendation 5

The Department of Communities collaborate with Recognised Entities, either through their peak representative body, the Queensland Aboriginal and Torres Strait Islander Child Protection Peak, or at a local level, to confirm information sharing needs and processes in regard to placement decisions for Aboriginal and Torres Strait Islander children and young people and to confirm the record keeping requirements and obligations of both. An agreed outcome is to be documented by the end of April 2012.

The Department of Communities' response to the recommendation

Accepted.

Information discrepancy between ICMS records and Child Safety Officers

The compliance findings indicated discrepancies between the Department of Communities' two information sources – the ICMS records and the Child Safety Officer survey responses.

Specifically, there were 67 cases where there was a discrepancy between the information provided by the Child Safety Officer in their survey response and the information contained in the ICMS record in regard to at least one step of the Compliance Assessment Tool. In these cases, ICMS was determined to be the key record, based on advice from the Advisory Committee.

The lack of consistency in information contained in the Department of Communities' data sources indicates the need for improvement in record keeping practices. However, an additional recommendation will not be made to address record keeping issues as the ICMS related recommendations from the inaugural audit which are currently being implemented will address these record keeping limitations.

Capacity to comply with section 83 of the *Child Protection Act 1999*

The audit findings identified evidence of compliance across all steps in 15% of cases.

Discussions with Advisory Committee members about this indicated that compliance with section 83 of the *Child Protection Act 1999* may not always be achievable where emergency placements are required for Aboriginal and Torres Strait Islander children and young people.

The Department of Communities' policies and procedures provide clear direction about the need to review placement decisions where the child has not been placed with an Aboriginal and/or Torres Strait Islander carer. However, they do not specify the timeframe that a placement decision must be reviewed within where section 83 of the *Child Protection Act 1999* has been unable to be applied to an emergency placement.

Additionally, current record keeping infrastructure does not capture the cases where a placement decision has been made in urgent circumstances and has been unable to comply with all requirements of section 83 of the *Child Protection Act 1999,* or the timeframe within which the decision is reviewed and compliance subsequently achieved.

Recommendation 6

The Department of Communities clarify (by the end of April 2012) in the relevant policy and procedural documents that placement decisions must be reviewed within a specified amount of time where emergency placements are made for Aboriginal and Torres Strait Islander children and young people and section 83 of the *Child Protection Act 1999* is unable to be applied.

The Department of Communities' response to the recommendation

All placement decisions are reviewed during the case planning review process on a six monthly basis, emergency placements are reviewed as part of day to day case work activities when seeking alternative placement options for all children in out of home care.

The Commission considered the Department of Communities' response and has determined that the recommendation remains relevant as there needs to be specific guidance in the Department of Communities' policies/procedures to direct practice in this area.

Recommendation 7

The Department of Communities establish an appropriate record keeping mechanism, in ICMS or otherwise, to record:

- when and why emergency placements are made for Aboriginal and Torres Strait Islander children and young people and section 83 of the *Child Protection Act 1999* is unable to be applied, and
- the timeframe that the placement decision was reviewed within, and
- the outcome.

Advice is required by the end of April 2012 of the proposed approach and timeframe required to implement.

The Department of Communities' response to the recommendation

An enhancement to ICMS, making the question "was this placement due to urgent circumstances?" and the "rationale for placement decision" text box mandatory within the 'Recognised Entity/ Child Placement Principle' form, for all placements, is scheduled to enter production in March 2012.

The remaining aspects of this recommendation will be considered, as relevant, to the implementation of recommendation seven. The current method for recording review of the child's needs, including placement, is the Review Report, Child Strength and Needs Assessment and the Case Plan.

Chapter 5

Part C - The outcomes achieved as a result of the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999*

Key messages

- Overall, Aboriginal and Torres Strait Islander children and young people reported positive outcomes in relation to contact with family and community and opportunities to participate in cultural activities and events (as intended by section 83 of the *Child Protection Act 1999*).
- Aboriginal and Torres Strait Islander children and young people placed with an Indigenous carer reported more positive outcomes in relation to contact with family and community and opportunities to participate in cultural activities and events, compared to those placed with a non-Indigenous carer.
- State wide analysis revealed that there was mixed findings in terms of contact with family and community. Children within the Commission's Brisbane West Community Visitor Zone reported the most positive outcomes in relation to opportunities to participate in cultural activities and events.

5.1 The importance of monitoring outcomes

Key learnings from the inaugural *Indigenous Child Placement Principle Audit Report 2008* highlighted potential to complement monitoring compliance with section 83 of the *Child Protection Act 1999*, by assessing the outcomes experienced by Aboriginal and Torres Strait Islander children and young people placed in out-of-home care in accordance with section 83.

Assessing the outcomes of Aboriginal and Torres Strait Islander children and young people in out-of-home care (relevant to their maintained connection to family, community and culture) also assists in overcoming some of the record keeping limitations identified in auditing the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999*.

5.2 The framework for monitoring outcomes

The Commission established four key areas of focus to facilitate targeted monitoring of the outcomes experienced by Aboriginal and Torres Strait Islander children and young people placed in out-of-home care.[41] These key areas of focus were informed by a literature review and direct engagement with Aboriginal and Torres Strait Islander children and young people, and are:

- Family contact
- Contact with community/people of significance
- Participation in cultural activities/events, and
- Cultural identity.

[41] Refer to the Audit Methodology for detail about the Commission's process for establishing the key areas of focus.

These areas of focus provide the reporting framework for this component of the audit.

5.3 Process for assessing the outcomes

In July 2010, the Commission assessed the outcomes experienced by 1109 Aboriginal and Torres Strait Islander children and young people in out-of-home care visited by the Commission's Community Visitors (CVs).[42]

The assessment was based on CV reports, which are completed after each visit with a child or young person to verify that they are safe, are receiving appropriate care, to advocate on their behalf to help resolve any concerns or grievances and to offer support if required. These reports are based on an independent assessment made by the CV. Information and evidence used to formulate the CV's assessment is derived from multiple sources, including engagement and one-on-one discussions with the child during the visit, the CV's observations during the visit and/or statements made by the child's carer about the child.

The CVs were asked to ensure they captured all necessary information in their CV reports for July 2010 to inform the Commission's assessment of the outcomes experienced by Aboriginal and Torres Strait Islander children and young people relevant to their connection to family, community and culture.

Based on advice from the Advisory Committee, findings from the CV reports were further analysed to compare the outcomes experienced by Aboriginal and Torres Strait Islander children and young people placed with an Indigenous carer with those placed with a non-Indigenous carer. Outcomes were also assessed across the state by CV Zones (Appendix 8 shows CV Zones).[43]

The findings reported are for the total number of valid responses provided for each question. Accordingly, the category 'all children' refers to all children and young people who had a valid response recorded for a particular question.

Reference is also made in this part of the report to CV engagement with 136 Aboriginal and Torres Strait Islander children and young people in August and September 2009 in relation to cultural identity.[44] This was a smaller sample of Aboriginal and Torres Strait Islander children and young people who participated in a unique series of questions relevant to their culture. This smaller sample was used, along with a literature review and Advisory Committee input, to establish the four key areas of focus.

[42] Refer to the Audit Methodology for detail about the information captured by the CVs.
[43] CV Zones do not align with the Department of Communities' Regions and cannot be directly compared.
[44] This sample was comprised of Aboriginal and/or Torres Strait Islander children and young people aged 10 to 17 on a Child Protection Order.

5.4 Demographics of the 1109 Aboriginal and/or Torres Strait Islander children and young people visited in July 2010

Placement type

There were 1109 Aboriginal and Torres Strait Islander children and young people visited in July 2010. Of these, 115 (10%) were placed in a 'visitable site'[45] and 994 (90%) were placed in a 'visitable home'.[46]

Of the 994 Aboriginal and Torres Strait Islander children and young people visited by a CV in a visitable home in July 2010:

- 277 (28%) were placed with an Aboriginal and/or Torres Strait Islander carer[47]
- 470 (47%) were placed with a non-Indigenous carer, and
- 247 (25%) were placed with carers whose Indigenous status required clarification.[48]

Gender

Of the 1109 Aboriginal and Torres Strait Islander children and young people visited by a CV in July 2010, 553 were male and 556 were female.

Age

Almost two thirds of the children and young people visited by a CV in July 2010 were aged 9 or under, as illustrated in the age breakdown in Table 7.

Table 7: Age breakdown of Aboriginal and Torres Strait Islander children and young people in out-of-home care visited by a CV in July 2010[49]

Age group	Number	Percentage
0 to 4	301	27%
5 to 9	401	36%
10 to 14	301	27%
15 to 17	106	10%
Total	1109	100%

[45] A 'visitable site' is a site in which the CVs have legislative authority (in accordance with section 89 of the Commission's Act) to visit children and young people placed in care. This entails a site where a child is residing in a residential facility or detention centre, or at an authorised mental health service under the *Mental Health Act 2000*.

[46] A 'visitable home' is a home in which the CVs have legislative authority (in accordance with section 89 of the Commission's Act) to visit children and young people placed in care. This entails a home in which a child who is in the custody or guardianship of the chief executive (child safety) has been placed in the care of an approved carer or someone else other than the parent of the child, or a home in which a child who is under a care agreement has been placed with someone other than the parent of the child.

[47] This category includes all placements where the child was placed with at least one Aboriginal and/or Torres Strait Islander carer.

[48] Information about the carer's cultural status is sourced from the Department of Communities based on their records at a point in time as part of monthly information sharing with the Commission.

[49] Percentages may not add up to 100% owing to rounding.

5.5 Key Area of Focus 1 - Family contact

5.5.1 Contact with parents

Key findings

- 89% of children and young people were reported as having some level of parental contact, the most common frequency identified as weekly contact (41%).
- 80% of children and young people were reported as satisfied with parental contact. However, satisfaction with parental contact was 11% greater for children and young people placed with an Indigenous carer (85%) in comparison to those placed with a non-Indigenous carer (74%).

Frequency of parental contact

Figure 19 illustrates the following findings regarding the frequency of parental contact.

All children[50]

Of the 819 valid responses:[51]

- 89% of all children and young people were reported to be having some level of parental contact.[52]
- The most common frequency of parental contact reported was weekly contact (41%).[53]

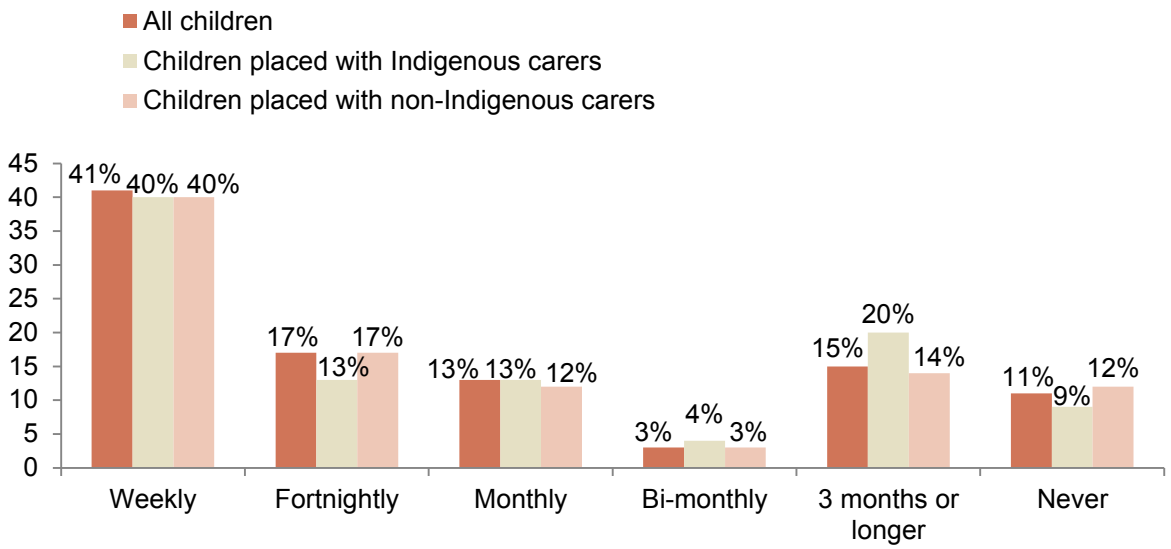
Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 208 and 345 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[54]

- 91% of children and young people placed with an Indigenous carer were reported to be having some level of parental contact, similar to 88% of those placed with a non-Indigenous carer.[55]
- The most common frequency of parental contact reported was weekly contact for children and young people placed with either an Indigenous or a non-Indigenous carer (40% for both).[56]

[50] Refers to all 819 children and young people who had a valid response provided for them for the question.
[51] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[52] 731 of 819 valid responses.
[53] 339 of 819 valid responses.
[54] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[55] 189 of 208 valid responses and 302 of 345 valid responses respectively.
[56] 84 of 208 valid responses and 139 of 345 valid responses respectively.

Figure 19: Breakdown of frequency of parental contact[57]



Commission Community Visitor Zones

State wide analysis revealed that:

- Brisbane West Zone was reported to have the highest proportion of weekly parental contact (60%) and Sunshine Coast Zone was reported to have the lowest proportion (14%).[58]
- Sunshine Coast Zone was also reported as having the highest proportion of parental contact not occurring (21%).[59]

Child's satisfaction with parental contact

Figure 20 illustrates the following findings regarding satisfaction with parental contact.

All children[60]

Of the 519 valid responses:[61]

- 80% of all children and young people were reported to be satisfied with parental contact.[62]
- 17% of all children and young people were reported to want more contact with their parents.[63]

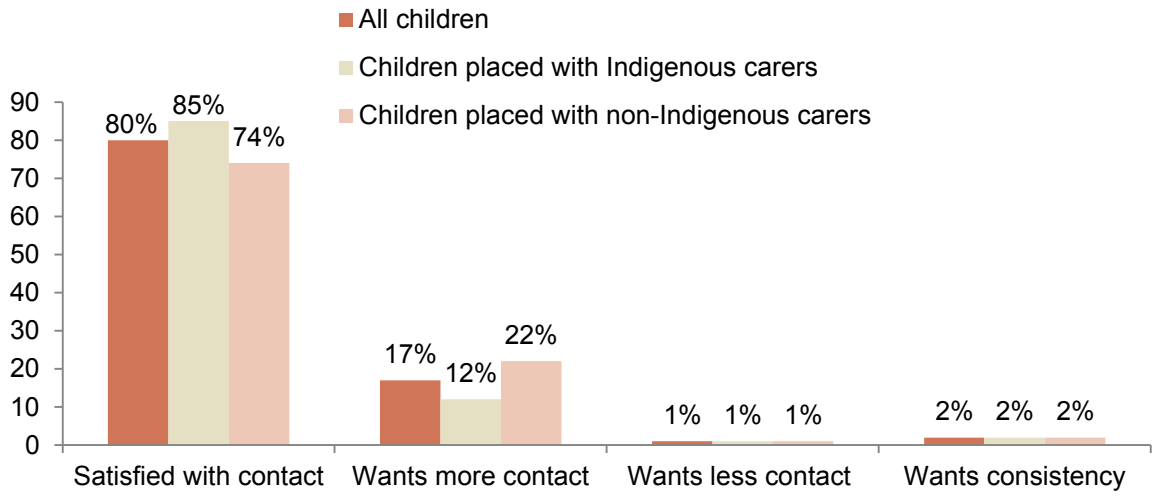
[57] Percentages may not add up to 100% owing to rounding.
[58] Brisbane North – 43% of 37 valid responses; Brisbane South – 53% of 43 valid responses; Brisbane West – 60% of 72 valid responses; Central North – 32% of 85 valid responses; Central South – 47% of 53 valid responses; Far Northern – 35% of 124 valid responses; Gold Coast – 39% of 36 valid responses; Ipswich – 49% of 63 valid responses; Logan – 34% of 29 valid responses; Moreton and South Burnett – 36% of 47 valid responses; Northern – 57% of 115 valid responses; Sunshine Coast – 14% of 42 valid responses; Toowoomba and Western – 26% of 73 valid responses.
[59] Brisbane North – 5% of 37 valid responses; Brisbane South – 7% of 43 valid responses; Brisbane West – 10% of 72 valid responses; Central North – 9% of 85 valid responses; Central South – 8% of 53 valid responses; Far Northern – 4% of 124 valid responses; Gold Coast – 11% of 36 valid responses; Ipswich – 11% of 63 valid responses; Logan – 17% of 29 valid responses; Moreton and South Burnett – 11% of 47 valid responses; Northern – 20% of 115 valid responses; Sunshine Coast – 21% of 42 valid responses; Toowoomba and Western – 8% of 73 valid responses.
[60] Refers to all 519 children and young people who had a valid response provided for them for the question.
[61] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[62] 417 of 519 valid responses.
[63] 87 of 519 valid responses.

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 135 and 196 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[64]

- Satisfaction with parental contact was reported to be 11% greater for children and young people placed with an Indigenous carer (85%) compared to those placed with a non-Indigenous carer (74%).[65]

Figure 20: Breakdown of child's satisfaction with parental contact[66]



Commission Community Visitor Zones

State wide analysis revealed that:

- Toowoomba and Western Zone was reported to have the highest proportion of child satisfaction with parental contact (95%) and Brisbane South Zone and Sunshine Coast Zone was reported to have the lowest proportion (63% each).[67]
- In a little more than half of the Community Visitor Zones (Brisbane North, Brisbane South, Central North, Far Northern, Ipswich, Logan, Sunshine Coast) at least one fifth of children and young people were reported as wanting more contact with their parents.[68]

[64] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[65] 115 of 135 valid responses and 146 of 196 valid responses respectively.
[66] Percentages may not add up to 100% owing to rounding.
[67] Brisbane North – 71% of 21 valid responses; Brisbane South – 63% of 16 valid responses; Brisbane West – 88% of 43 valid responses; Central North – 76% of 46 valid responses; Central South – 73% of 37 valid responses; Far Northern – 74% of 93 valid responses; Gold Coast – 92% of 25 valid responses; Ipswich – 74% of 43 valid responses; Logan – 75% of 16 valid responses; Moreton and South Burnett – 79% of 29 valid responses; Northern – 93% of 82 valid responses; Sunshine Coast – 63% of 24 valid responses; Toowoomba and Western – 95% of 44 valid responses.
[68] Brisbane North – 29% of 21 valid responses; Brisbane South – 38% of 16 valid responses; Brisbane West – 7% of 43 valid responses; Central North – 22% of 46 valid responses; Central South – 19% of 37 valid responses; Far Northern – 20% of 93 valid responses; Gold Coast – 8% of 25 valid responses; Ipswich – 26% of 43 valid responses; Logan – 25% of 16 valid responses; Moreton and South Burnett – 17% of 29 valid responses; Northern – 7% of 82 valid responses; Sunshine Coast – 25% of 24 valid responses; Toowoomba and Western – 5% of 44 valid responses.

Barriers to contact with parents

All children[69]

Of the 402 valid responses provided about contributing factors for non-contact with a parent, key issues reported were:[70]

- The parent was unwilling to maintain contact (116 or 29%)
- Distance/travel issues (67 or 17%)
- The child was unwilling to maintain contact (38 or 9%)
- The parent was incarcerated (29 or 7%)
- The parent's health/personal issues (26 or 6%)
- Contact was considered not to be in the child's best interests (by either the Department of Communities or the carer) (25 or 6%)
- The parent was not locatable or unknown (22 or 5%)
- The parent was deceased (20 or 5%)
- Service delivery issues (by the Department of Communities or another agency) (10 or 2%).[71]

5.5.2 Contact with other family members

Key findings

- 93% of all children and young people were reported to be having some level of contact with other family members.
- The most common frequency of contact with other family members was reported to be weekly contact (56%). However, weekly contact was 21% greater for children and young people placed with an Indigenous carer (67%) in comparison to those placed with a non-Indigenous carer (46%).
- 89% of children and young people were reported to be satisfied with their contact with other family members. However, 11% wanted more contact.

Frequency of contact with other family members

Figure 21 illustrates the following findings regarding the frequency of contact with other family members.

All children[72]

Of the 769 valid responses provided:[73]

- 93% of all children and young people were reported to be having some level of contact with other family members.[74]

[69] Refers to all 402 children and young people who had a valid response provided for them for the question.
[70] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[71] Numbers may not add up due to more than 1 comment being provided in some cases and some responses not identifying any barriers. Service delivery issues included cases where the child did not currently have a Child Safety Officer, the Child Safety Officer not attending planned supervised visits, the Child Safety Officer not providing information when it was requested, and the Child Safety Officer not organising contact when it was requested.
[72] Refers to all 769 children and young people who had a valid response provided for them for the question.
[73] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.

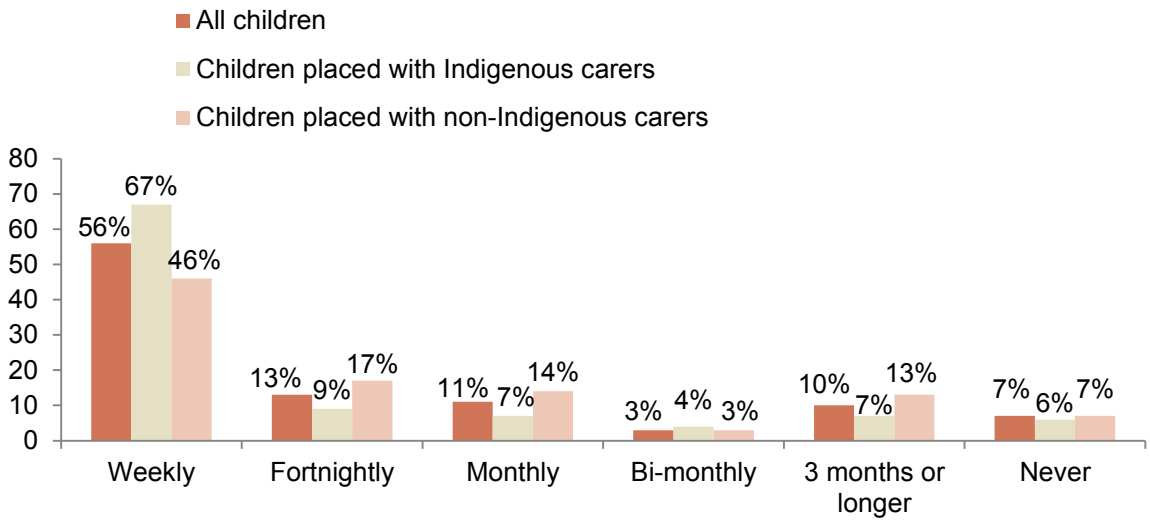
- The most common frequency of contact with other family members reported was weekly contact (56%).[75]

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 210 and 323 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[76]

- 94% of children and young people placed with an Indigenous carer were reported to be having some level of contact with other family members, similar to 93% of children placed with a non-Indigenous carer.[77]
- Weekly contact was reported to be 21% greater for children and young people placed with an Indigenous carer (67%) in comparison to those placed with a non-Indigenous carer (46%).

Figure 21: Breakdown of frequency of contact with other family members[78]



Commission Community Visitor Zones

State wide analysis revealed that:

- Northern Zone was reported to have the highest proportion of weekly contact between the child and other family members (69%) and Toowoomba and Western Zone was reported to have the lowest proportion (24%).[79]

[74] 714 of 769 valid responses.
[75] 430 of 769 valid responses.
[76] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[77] 197 of 210 valid responses and 301 of 323 valid responses respectively.
[78] Percentages may not add up to 100% owing to rounding.
[79] Brisbane North – 65% of 46 valid responses; Brisbane South – 59% of 46 valid responses; Brisbane West – 52% of 61 valid responses; Central North – 65% of 71 valid responses; Central South – 41% of 51 valid responses; Far Northern – 64% of 117 valid responses; Gold Coast – 38% of 32 valid responses; Ipswich – 57% of 51 valid responses; Logan – 56% of 27 valid responses; Moreton and South Burnett – 58% of 45 valid responses; Northern – 69% of 118 valid responses; Sunshine Coast – 47% of 45 valid responses; Toowoomba and Western – 24% of 59 valid responses.

Child's satisfaction with contact with other family members

Figure 22 illustrates the following findings regarding satisfaction with contact with other family members.

All children[80]

Of the 551 valid responses provided:[81]

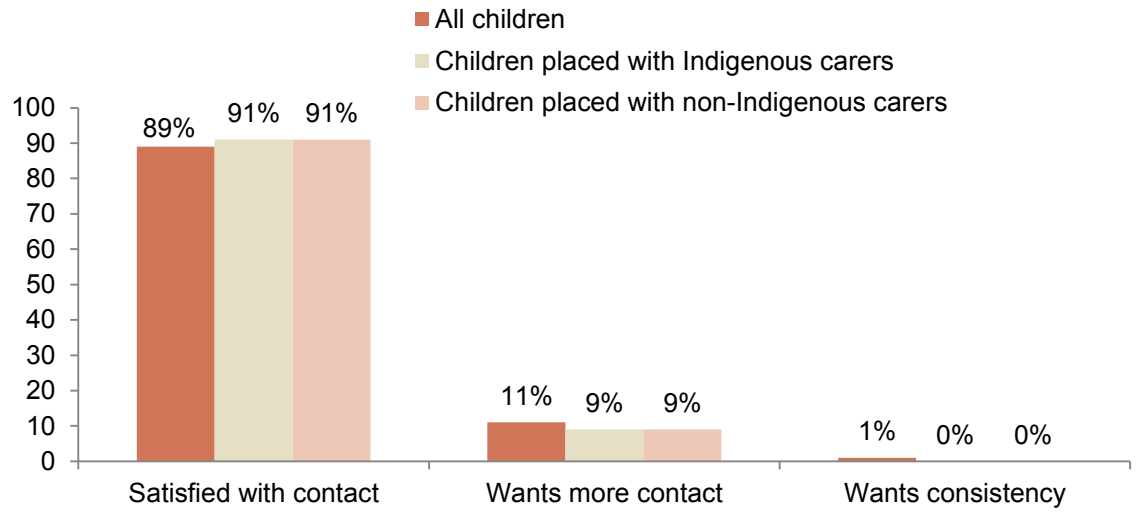
- 89% of all children and young people were reported to be satisfied with their contact with other family members.[82]
- 11% of all children and young people were reported to want more contact with other family members.[83]

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 153 and 215 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[84]

- Satisfaction with contact with other family members was reported to be equal for children and young people placed with either an Indigenous carer or a non-Indigenous carer (91% for both).[85]

Figure 22: Breakdown of child's satisfaction with contact with other family members[86]



[80] Refers to all 551 children and young people who had a valid response provided for them for the question.
[81] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[82] 489 of 551 valid responses.
[83] 58 of 551 valid responses.
[84] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[85] 139 of 153 valid responses and 195 of 215 valid responses respectively.
[86] Percentages may not add up to 100% owing to rounding.

Commission Community Visitor Zones

State wide analysis revealed that:

- Northern Zone was reported to have the highest proportion of child satisfaction with contact with other family members (99%) and Far Northern Zone was reported to have the lowest proportion (78%).[87]

Barriers to contact with other family members

All children[88]

Of the 320 valid responses provided about contributing factors for non-contact with other family members, the key issues reported were:[89]

- Distance/travel issues (30 or 9%)
- The child was unwilling to maintain contact (13 or 4%)
- The child's family was unwilling to maintain contact (12 or 4%).[90]

5.6 Key Area of Focus 2 - Contact with community/people of significance

5.6.1 Contact with traditional language/tribal/totem group

Key findings

- 70% of children and young people were reported to be having some level of contact with their traditional language/tribal/totem group. However, contact was 31% greater for children and young people placed with an Indigenous carer (84%) compared to those placed with a non-Indigenous carer (53%).
- The most common frequency for contact with the child's traditional language/tribal/totem group was reported to be weekly contact (40%). However, weekly contact was 41% greater for children and young people placed with an Indigenous carer (63%) compared to those placed with a non-Indigenous carer (22%).
- Almost half (47%) of children and young people placed with a non-Indigenous carer were reported to have no contact with their traditional language/tribal/totem group.
- 91% of children and young people were reported to be satisfied with their contact with their traditional language/tribal/totem group.
- 19% of responses reported about contributing factors for non-contact with the child's traditional language/tribal/totem group indicated limitations in knowledge of the child's traditional language/tribal/totem group.

[87] Brisbane North – 85% of 26 valid responses; Brisbane South – 92% of 24 valid responses; Brisbane West – 93% of 41 valid responses; Central North – 89% of 46 valid responses; Central South –93% of 40 valid responses; Far Northern – 78% of 105 valid responses; Gold Coast – 83% of 18 valid responses; Ipswich – 87% of 39 valid responses; Logan – 82% of 11 valid responses; Moreton and South Burnett – 92% of 36 valid responses; Northern – 99% of 96 valid responses; Sunshine Coast – 83% of 30 valid responses; Toowoomba and Western – 92% of 39 valid responses.

[88] Refers to all 320 children and young people who had a valid response provided for them for the question.

[89] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.

[90] Numbers may not add up due to more than 1 comment being provided in some cases and some responses not identifying any barriers.

Frequency of contact with traditional language/tribal/totem group

Figure 23 illustrates the following findings regarding the frequency of contact with the child's traditional language/tribal/totem group.

All children[91]

Of the 467 valid responses provided:[92]

- 70% of all children and young people were reported to be having some level of contact with their traditional language/tribal/totem group.[93]
- The most common frequency of contact with the child's traditional language/tribal/totem group was reported to be weekly contact (40%).[94]
- Almost one third (30%) of all children and young people were reported not to be having any contact with their traditional language/tribal/totem group.[95]

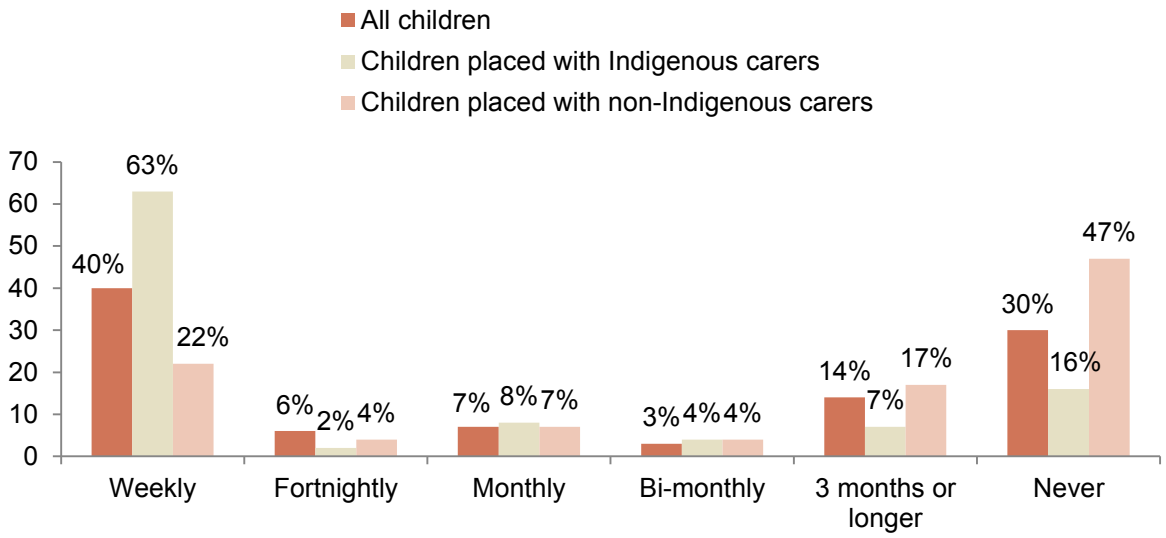
Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 150 and 175 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[96]

- 84% of children and young people placed with an Indigenous carer were reported to be having some level of contact with their traditional language/tribal/totem group, contrasted to 53% of those placed with a non-Indigenous carer.[97]
- Weekly contact with the child's traditional language/tribal/totem group was reported to be almost three times greater for children and young people placed with an Indigenous carer (63%) compared to those placed with a non-Indigenous carer (22%).[98]
- Almost half of children and young people placed with a non-Indigenous carer (47%) were reported to be having no contact with their traditional language/tribal/totem group, almost three times greater than those placed with an Indigenous carer (16%).[99]

[91] Refers to all 467 children and young people who had a valid response provided for them for the question.
[92] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[93] 327 of 467 valid responses.
[94] 188 of 467 valid responses.
[95] 140 of 467 valid responses.
[96] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[97] 126 of 150 valid responses and 93 of 175 valid responses respectively.
[98] 94 of 150 valid responses and 38 of 175 valid responses respectively.
[99] 82 of 175 valid responses and 24 of 150 valid responses respectively.

Figure 23: Breakdown of frequency of contact with the child's traditional language/tribal/totem group[100]



Commission Community Visitor Zones

State wide analysis revealed that:

- Ipswich Zone (69%) was reported to have the highest proportion of weekly contact between the child and their traditional language/tribal/totem group and Moreton and South Burnett Zone was reported to have the lowest proportion (9%).[101]
- Gold Coast Zone (67%) was reported to have the highest proportion of contact not occurring with the child's traditional language/tribal/totem group, with Far Northern Zone reported to have the lowest proportion of contact not occurring (5%).[102]

Child's satisfaction with contact with traditional language/tribal/totem group

Figure 24 illustrates the following findings regarding satisfaction with contact with the child's traditional language/tribal/totem group.

All children[103]

Of the 313 valid responses provided:[104]

- 91% of all children and young people were reported to be satisfied with contact with their traditional language/tribal/totem group.[105]

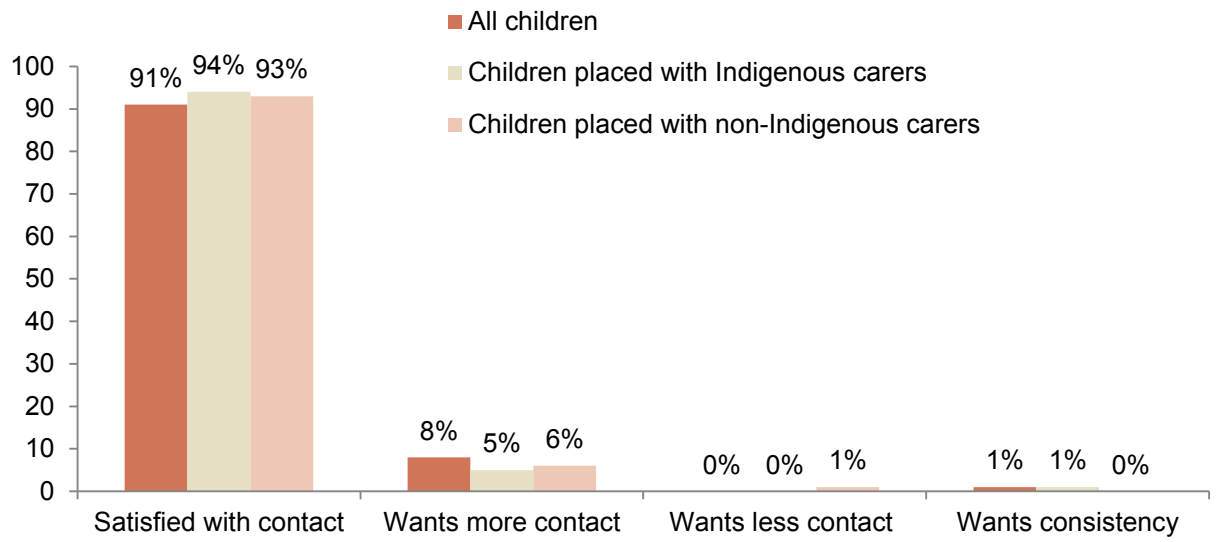
[100] Percentages may not add up to 100% owing to rounding.
[101] Brisbane North – 31% of 32 valid responses; Brisbane South – 59% of 27 valid responses; Brisbane West – 56% of 27 valid responses; Central North – 35% of 43 valid responses; Central South –29% of 34 valid responses; Far Northern – 44% of 85 valid responses; Gold Coast – 10% of 21 valid responses; Ipswich – 69% of 16 valid responses; Logan – 29% of 7 valid responses; Moreton and South Burnett – 9% of 23 valid responses; Northern – 59% of 90 valid responses; Sunshine Coast – 15% of 33 valid responses; Toowoomba and Western – 34% of 29 valid responses.
[102] Brisbane North – 34% of 32 valid responses; Brisbane South – 15% of 27 valid responses; Brisbane West – 30% of 27 valid responses; Central North – 30% of 43 valid responses; Central South –35% of 34 valid responses; Far Northern – 5% of 85 valid responses; Gold Coast – 67% of 21 valid responses; Ipswich – 19% of 16 valid responses; Logan – 29% of 7 valid responses; Moreton and South Burnett – 61% of 23 valid responses; Northern – 31% of 90 valid responses; Sunshine Coast – 55% of 33 valid responses; Toowoomba and Western – 31% of 29 valid responses.
[103] Refers to all 313 children and young people who had a valid response provided for them for the question.
[104] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[105] 286 of 313 valid responses.

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 104 and 98 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[106]

- Satisfaction with contact with the child's traditional language/tribal/totem group was reported to be almost equal for children and young people placed with an Indigenous carer compared to those placed with a non-Indigenous carer (94% and 93% respectively).[107]

Figure 24: Breakdown of child's satisfaction with contact with their traditional language/tribal/totem group[108]



Commission Community Visitor Zones

State wide analysis revealed that:

- High rates of child satisfaction with contact with their traditional language/tribal/totem group was reported across the state with 100% satisfaction reported in Brisbane West, Central South, Ipswich, and Toowoomba and Western Zone.[109]

[106] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[107] 98 of 104 valid responses and 91 of 98 valid responses respectively.
[108] Percentages may not add up to 100% owing to rounding.
[109] Brisbane North – 78% of 18 valid responses; Brisbane South – 86% of 14 valid responses; Brisbane West – 100% of 21 valid responses; Central North – 90% of 29 valid responses; Central South –100% of 21 valid responses; Far Northern – 85% of 78 valid responses; Gold Coast – 83% of 12 valid responses; Ipswich – 100% of 12 valid responses; Logan – 86% of 7 valid responses; Moreton and South Burnett – 92% of 12 valid responses; Northern – 98% of 61 valid responses; Sunshine Coast – 93% of 14 valid responses; Toowoomba and Western – 100% of 14 valid responses.

Barriers to contact with the child's traditional language/tribal/totem group

All children[110]

Of the 255 valid responses provided about contributing factors for non-contact with the child's traditional language/tribal/totem group, the key issues reported were:

- Limitations in knowledge of the child's traditional language/tribal/totem group (49 or 19%)
- The child was unwilling to maintain contact (22 or 9%)
- Distance/travel issues (22 or 9%)
- Cultural identity issues (12 or 5%).[111]

5.7 Key Area of Focus 3 - Participation in cultural activities/events

Key findings

- 96% of children and young people were reported to be offered at least one type of cultural activity/resource.
- Children and young people placed with an Indigenous carer were reported to be more likely to be offered each type of activity/resource to assist in maintaining their connection to culture.
- State wide analysis revealed that Brisbane West Community Visitor Zone demonstrated the highest proportion of almost each type of activity/resource offered to children and young people.
- Of the children and young people who were asked whether they were satisfied with the support they received from their carer to participate in cultural activities and maintain links with their culture, 97% indicated they were satisfied.
- Of the children and young people who were asked whether they were satisfied with the support they received from their Child Safety Officer to participate in cultural activities and maintain links with their culture, 87% indicated they were satisfied.
- Of the carers who were asked whether they were satisfied with the support they received from the Child Safety Officer to meet the child's needs for cultural experiences and community contact, 77% indicated they were adequately supported, with carers in Brisbane West Community Visitor Zone indicating 100% satisfaction with support.

Activities/resources offered to the child

Four per cent of children and young people were reported not to be offered any activities/resources to assist in maintaining their connection to culture.[112]

[110] Refers to all 255 children and young people who had a valid response provided for them for the question.
[111] Numbers may not add up due to more than 1 comment being provided in some cases and some responses not identifying any barriers. Service delivery issues included cases where the child did not currently have a Child Safety Officer, the Child Safety Officer not attending planned supervised visits, the Child Safety Officer not providing information when it was requested, and the Child Safety Officer not organising contact when it was requested.
[112] 40 of the 1109 valid responses.

Figure 25 illustrates the following findings about activities/resources offered to the child.

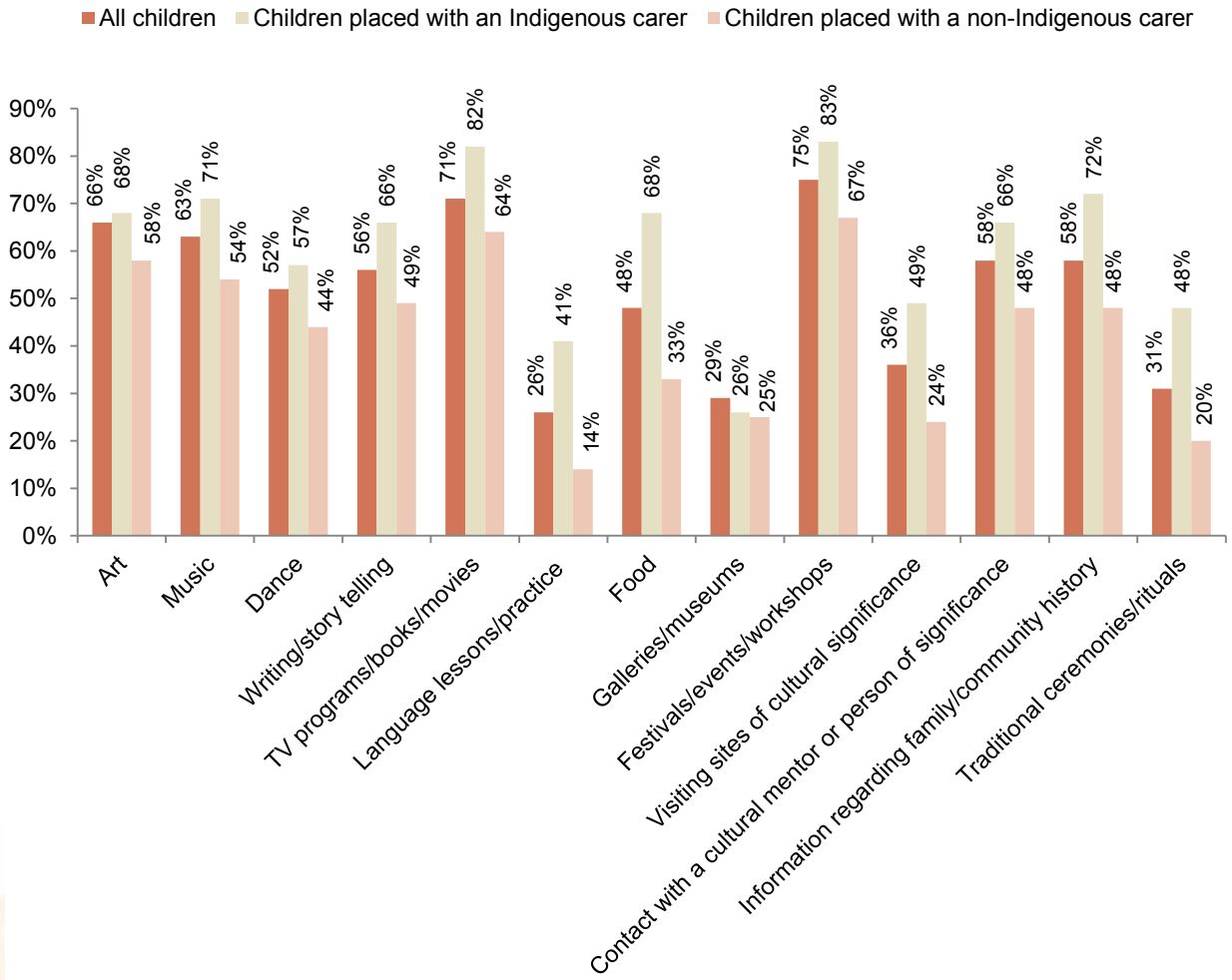
All children

- The most common resources/activities offered were reported to be opportunities to attend festivals/events/workshops or receive/utilise television programs/books/movies.

Children placed with an Indigenous carer versus a non-Indigenous carer

- Children and young people placed with an Indigenous carer were reported to be more likely to be offered each type of activity/resource compared to children placed with a non-Indigenous carer.

Figure 25: Percentage breakdown of cultural activities/resources the child has been offered



Commission Community Visitor Zones

State wide analysis revealed that:

- Brisbane West Zone was reported to have the highest proportion of the following activities/resources offered: Art (87%), music (90%), dance (84%), writing/story telling (88%), language lessons/practice (59%), galleries/museums (81%), visiting sites of cultural significance (78%), contact with a cultural mentor (84%), traditional ceremonies/rituals (69%).
- Gold Coast Zone was reported to have the lowest proportion of the following activities/resources offered: Art (26%), music (10%), dance (5%), culturally appropriate food (0%), galleries/museums (5%), festivals/events/workshops (46%), visiting sites of cultural significance (9%), information regarding family/community history (23%), traditional ceremonies/rituals (0%).

Child wanting to participate in an activity/resource not offered to them

All children

- There were 4% of children and young people that were reported as wanting to participate in a cultural activity/resource that was not offered to them.[113]
- The most common interest for children was reported to be having information about their family/community history (8 or 30%).[114]

Child's satisfaction with the support they receive to participate in activities and maintain links with their culture

Satisfied with support from carer:

All children[115]

Of the 450 valid responses provided:[116]

- 97% of all children and young people were reported to be satisfied with the support they received from their carer to participate in activities and maintain links with their culture.[117]

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 130 and 157 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[118]

- Satisfaction with the support received from the carer to participate in activities and maintain links with their culture was reported to be similar for children and young people placed with an Indigenous carer (98%) compared to those placed with a non-Indigenous carer (96%).[119]

[113] 27 of 680 valid responses.
[114] Where issues of this nature have been identified, CVs advocated to the Department of Communities to address the situation.
[115] Refers to all 450 children and young people who had a valid response provided for them for the question.
[116] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[117] 437 of 450 valid responses.
[118] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[119] 128 of 130 valid responses and 151 of 157 valid responses respectively.

Commission Community Visitor Zones

State wide analysis revealed that:

- Almost half of the Community Visitor Zones were reported to have 100% child satisfaction with the support they received from their carer to participate in activities and maintain links with their culture (Brisbane North, Central South, Logan, Moreton and South Burnett, Northern, Toowoomba and Western).[120]

Satisfied with support from Child Safety Officer:

All children[121]

Of the 349 valid responses provided:[122]

- 87% of all children and young people were reported to be satisfied with the support they received from their Child Safety Officer to participate in activities and maintain links with their culture.[123]

Children placed with an Indigenous carer versus a non-Indigenous carer

Of the 94 and 117 valid responses for children and young people placed with an Indigenous or non-Indigenous carer respectively:[124]

- Satisfaction with the support received from the Child Safety Officer to participate in activities and maintain links with their culture was reported to be similar for children and young people placed with a non-Indigenous carer (91%) compared to those placed with an Indigenous carer (88%).[125]

Commission Community Visitor Zones

State wide analysis revealed that:

- Northern Zone and Brisbane West Zone (98% each) were reported to have the highest proportion of child satisfaction with the support they received from their Child Safety Officer to participate in activities and maintain links with their culture. Brisbane South Zone demonstrated the lowest proportion (69%).[126]

[120] Brisbane North – 100% of 21 valid responses; Brisbane South – 95% of 21 valid responses; Brisbane West – 98% of 45 valid responses; Central North – 95% of 44 valid responses; Central South –100% of 31 valid responses; Far Northern – 93% of 84 valid responses; Gold Coast – 94% of 18 valid responses; Ipswich – 97% of 32 valid responses; Logan – 100% of 10 valid responses; Moreton and South Burnett – 100% of 24 valid responses; Northern – 100% of 64 valid responses; Sunshine Coast – 95% of 21 valid responses; Toowoomba and Western – 100% of 35 valid responses.

[121] Refers to all 349 children and young people who had a valid response provided for them for the question.

[122] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.

[123] 303 of 349 valid responses.

[124] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.

[125] 106 of 117 valid responses and 83 of 94 valid responses respectively.

[126] Brisbane North – 90% of 20 valid responses; Brisbane South – 69% of 13 valid responses; Brisbane West – 98% of 44 valid responses; Central North – 87% of 30 valid responses; Central South –71% of 21 valid responses; Far Northern – 70% of 63 valid responses; Gold Coast – 95% of 19 valid responses; Ipswich – 95% of 21 valid responses; Logan – 75% of 4 valid responses; Moreton and South Burnett – 88% of 16 valid responses; Northern – 98% of 56 valid responses; Sunshine Coast – 79% of 14 valid responses; Toowoomba and Western – 96% of 28 valid responses.

Carer's satisfaction with the support they receive to meet the child's needs to participate in activities and maintain links with their culture

All carers[127]

Of the 692 valid responses provided:[128]

- 77% of all carers were reported to be feeling adequately supported by the Child Safety Officer to meet the child or young person's needs for cultural experiences and community contact.[129]

Indigenous carers versus non-Indigenous carers

Of the 172 and 280 valid responses for Indigenous or non-Indigenous carers respectively:[130]

- Satisfaction with the support received from the Child Safety Officer to meet the child or young person's needs for cultural experiences and community contact was reported to be similar for Indigenous carers (80%) compared to non-Indigenous carers (75%).[131]

Commission Community Visitor Zones

State wide analysis revealed that:

- Brisbane West Zone (100%) was reported to have the highest proportion of carers feeling adequately supported by the Child Safety Officer to meet the child or young person's needs for cultural experiences and community contact and Brisbane South Zone demonstrated the lowest proportion (46%).[132]

Barriers to participation in cultural activities

All children

Of the 136 valid responses provided about factors impacting on participation in cultural activities, the key issues reported were:[133]

- The child's age (16 or 12%), and
- The child was unwilling to participate (13 or 10%).[134]

[127] Refers to all 692 children and young people who had a valid response provided for them for the question.
[128] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[129] 535 of 692 valid responses.
[130] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[131] 138 of 172 valid responses and 211 of 280 valid responses respectively.
[132] Brisbane North – 93% of 46 valid responses; Brisbane South – 46% of 26 valid responses; Brisbane West – 100% of 70 valid responses; Central North – 82% of 62 valid responses; Central South – 63% of 43 valid responses; Far Northern – 56% of 128 valid responses; Gold Coast – 92% of 26 valid responses; Ipswich – 85% of 59 valid responses; Logan – 75% of 12 valid responses; Moreton and South Burnett – 78% of 41 valid responses; Northern – 89% of 93 valid responses; Sunshine Coast – 66% of 38 valid responses; Toowoomba and Western – 77% of 48 valid responses.
[133] The total number of valid responses excludes those cases where the CV was unable to collect information for the child relevant to the question due to the CV's capacity, the child's willingness to engage, the relevance of the question to the child, or the child's ability to communicate due to age or disability.
[134] Numbers may not add up due to more than one comment being provided in some cases and some responses not identifying any barriers.

5.8 Key Area of Focus 4 - Cultural identity

Key findings

- Of the 136 children and young people who were asked about their Mob, 48% indicated some sense of knowing who their Mob is.
- Of the children and young people who indicated they knew who their Mob is, 68% expressed feeling connected to their Mob.
- Of the children and young people who indicated they did not know who their Mob is, 54% expressed that it was important to them to know who their Mob is.

Questions specific to cultural identity were not captured in July 2010 as occurred for the other sections of this chapter. However, relevant information was captured in August and September 2009. Specifically, CVs engaged with 136 Aboriginal and Torres Strait Islander children and young people in detail about their connection to their Mob.[135] Findings are discussed below.

Identification of Mob

- When asked 'Who is your Mob?', almost half (65 of 136, or 48%) of the children and young people reported that they had some sense of who their Mob is. Responses were varied with children identifying their Mob through reference to their Mob, country, totem, family, foster family and the broad locality of where their Mob was from (i.e. Cairns).
- Two (1%) children reported that they were not sure who their Mob is.
- Half (69) of the children and young people reported that they did not have a sense of who their Mob is.

Connection to Mob

Of the 62 (46% of 136) children and young people who specifically reported knowing who their Mob is:

- 42 (68%) reported that they felt connected.
- 13 (21%) reported that they did not feel connected.
- One (2%) reported that their link to their Mob is important but feels that casual meetings with their distant family is fine.
- One (2%) reported that they can be connected if they choose to be.
- Two (3%) reported not knowing if they were connected to their Mob.
- Three (5%) did not respond.

Importance of knowing Mob

Of the 69 (51% of 136) children and young people who reported not knowing who their Mob is:

- 37 (54%) reported that it was important to know who their Mob is.
- 22 (32%) reported that it was not important to know who their Mob is.
- Three (4%) reported not knowing if it was important to them to know who their Mob is.

[135] The sample represented a response rate of approximately 18% of the 747 Aboriginal and Torres Strait Islander children and young people in out-of-home care for the month, aged 10 to 17 and on a Child Protection Order, and being visited by the Commission's CVs as at 1 September 2009.

- Seven (10%) did not provide a response that indicated whether it was important to them.

5.9 Key findings

All children

- Overall, Aboriginal and Torres Strait Islander children demonstrated positive outcomes in relation to contact with family and community and opportunity to participate in cultural activities and events. These results are very encouraging, however, there is still scope for improvement to ensure Aboriginal and Torres Strait Islander children and young people experience optimal maintained connection with their family, community and culture.
- 19% of responses provided about contributing factors for non-contact with the child's traditional language/tribal/totem group indicated limitations in knowledge of the child's traditional language/tribal/totem group and 51% of children and young people who were asked about their Mob did not know who their Mob is. This indicates a need for strengthened information gathering, and information provision to Aboriginal and Torres Strait Islander children and young people, about their Mob.

Recommendation 8

The Department of Communities explore ways to strengthen information gathering, and provision to Aboriginal and Torres Strait Islander children and young people, about their Mob, and advise of the proposed strategies by the end of April 2012.

The Department of Communities' response to the recommendation

Accepted.

Children placed with Indigenous carers versus non-Indigenous carers

- Aboriginal and Torres Strait Islander children placed with an Indigenous carer demonstrated the same or better outcomes across every measure of family and community contact and opportunity to participate in cultural activities and events, compared to those placed with a non-Indigenous carer.

Recommendation 9

The Department of Communities continue its Indigenous carer recruitment efforts and by the end of April 2012 include key findings from this report in its training and support of all carers in helping drive cultural outcomes for Aboriginal and Torres Strait Islander children and young people in out-of-home care.

The Department of Communities' response to the recommendation

Accepted.

Across the state

- State wide analysis revealed that there was mixed findings in terms of contact with family and community. However, Aboriginal and Torres Strait Islander children and young people placed in the Brisbane West Community Visitor Zone reported the most positive outcomes in relation to their opportunities to participate in cultural activities and events.

Recommendation 10

The Department of Communities use the information in this report to help identify where strengths and weaknesses in regional service delivery exist in regards to Aboriginal and Torres Strait Islander children and young people's family and community contact and opportunity to participate in cultural activities/events, and advise by the end of April 2012 of proposed strategies.

The Department of Communities' response to the recommendation

Accepted.

Appendix 1

Audit methodology

Key learnings from the inaugural *Indigenous Child Placement Principle Audit Report 2008* highlighted the importance of an audit methodology involving multiple sample sources of information to provide the clearest possible picture of compliance. Accordingly, a unique methodology was established for each component of the audit factoring in these key learnings. Expert input was also sought from an Advisory Committee established under the Commission's Act. The Advisory Committee's input helped the Commission establish a robust and credible methodology for undertaking the audit.

1.1 Methodology for Part A - The Department of Communities' mechanisms supporting compliance with section 83 of the Child Protection Act 1999

1.1.1 Established methodology

A significant emphasis for the inaugural (2008) audit was placed upon evaluating the mechanisms supporting compliance with section 83. This resulted in 28 formal recommendations under the Commission's Act. As such, the methodology established by the Commission for auditing the mechanisms supporting compliance with section 83 of the *Child Protection Act 1999* focussed on evaluating the Department of Communities' implementation of the 28 inaugural recommendations. This approach entailed:

- The Department of Communities providing a final implementation report to the Commission for evaluation, along with evidence of implementation
- The Commission seeking the Advisory Committee's input on the extent and adequacy of implementation of each of the 28 inaugural recommendations, drawing upon their expertise in child protection and/or Aboriginal and Torres Strait Islander health and wellbeing, and
- The Commission taking into consideration the Department of Communities' report and the Advisory Committee's input to make a final assessment of the implementation status of each of the 28 inaugural recommendations.

1.1.2 Information gathered to inform evaluation of implementation

The Department of Communities provided its final report to the Commission on the implementation of the 28 inaugural recommendations on 23 December 2010.

The report provided a summary of the action taken by the Department of Communities against each recommendation and included documentary evidence of implementation where relevant. This information has been summarised in Appendix 2.

The Department of Communities provided further advice of action completed or underway relevant to the inaugural recommendations when the Commission provided it with a provisional copy of the report for natural justice purposes. This additional advice, and accompanying evidence, was also taken into consideration by the Commission and is summarised as relevant in Appendix 2.

Part A of this report discusses the findings relevant to the Commission's evaluation of the Department of Communities' implementation of the 28 inaugural recommendations using the methodology and information sources outlined.

1.2 Methodology for Part B – The Department of Communities' practice compliance with section 83 of the Child Protection Act 1999

1.2.1 Established methodology

The methodology established by the Commission for monitoring the practice compliance with section 83 of the *Child Protection Act 1999* entailed:

- Analysis of the Department of Communities' electronic records for a random sample of 388[136] placement decisions made for Aboriginal and Torres Strait Islander children and young people in the custody or guardianship of the Chief Executive in 2008/09, and
- Surveying Recognised Entities and Child Safety Officers who were involved in the 388[137] placement decisions comprising the audit sample.

The methodology involved using each information source to evaluate the decision making process for each placement decision to determine compliance across all steps of the Compliance Assessment Tool (Appendix 5). This tool summarises the key requirements of section 83 of the *Child Protection Act 1999* and was endorsed by the Advisory Committee as the framework for assessing compliance.

1.2.2 Process for establishing the methodology

Agreement on the use of the Compliance Assessment Tool as the framework for assessing compliance

The Compliance Assessment Tool was developed, tested and published as part of the inaugural *Indigenous Child Placement Principle Audit Report 2008* as a way to assess compliance with section 83 of the *Child Protection Act 1999*.

Compliance with section 83 of the *Child Protection Act 1999* occurs when there is compliance with each discrete step of the Compliance Assessment Tool. The Compliance Assessment Tool identifies the following five-step decision making process as integral to achieving compliance with section 83 of the *Child Protection Act 1999*:

[136] The final audit sample was reduced to 388 placement decisions from the agreed 400 placement decisions owing to the exclusion of 12 outliers (4 were outside the audit reference period (2008/09), 7 required further confirmation of the child's cultural status and one was identified as a repeat).
[137] Ibid.

- Step 1 – Identification of the child's Indigenous status (in accordance with section 83(1) of the *Child Protection Act 1999*)
- Step 2 – Giving a Recognised Entity the opportunity to participate in the placement decision making process (in accordance with section 83(2) and 83(3) of the *Child Protection Act 1999*)
- Step 3 – Identification of placement options (in accordance with the hierarchy set out in section 83(4) and 83(6) of the *Child Protection Act 1999*)
- Step 4 – Proper consideration of placement options and the views of the Recognised Entity (in accordance with section 83(5) of the *Child Protection Act 1999*)
- Step 5 – Assessing non-Indigenous carers' commitment to supporting the placement (in accordance with section 83(7) of the *Child Protection Act 1999*).[138]

For the purpose of this audit, Step 4 of the Compliance Assessment Tool has been further broken down to identify the extent of compliance with the two aspects of this step:

- Step 4A – Proper consideration of the Recognised Entity's views, and
- Step 4B – Proper consideration of the placement option's ability to ensure optimal retention of relationships with key people.

The Compliance Assessment Tool was endorsed by the Advisory Committee for use in the Indigenous Child Placement Principle Audit 2010/11 as an appropriate tool for assessing compliance with section 83 of the *Child Protection Act 1999*.

Agreement on information available to inform the audit

Availability of information from the Department of Communities

The Department of Communities (through its membership in the Advisory Committee) advised that ICMS had some capacity to report on the outcomes of decision making in accordance with section 83 of the *Child Protection Act 1999*. However, ICMS remains an end-point recording tool rather than a framework that guides and captures the complete decision making process. Advice indicated that not all essential fields necessary to assess complete compliance with section 83 of the *Child Protection Act 1999* were mandatory in the system and therefore the information captured in ICMS would be unlikely to address all elements of the five step Compliance Assessment Tool.

The Department of Communities further advised that it would be possible to extract information from the Placement Agreement and Case Plan records (which occur after placement decision making) that would assist in filling some of the gaps in the information available to assess compliance with section 83 of the *Child Protection Act 1999*. However, it was acknowledged that this would not allow assessment of complete compliance with section 83 relevant to the actual placement decision making processes of Child Safety Officers.

The Commission sought advice from the Department of Communities about the efficacy of adopting the approach of the inaugural audit and once again assessing compliance through conducting hard copy case file reviews. The Department of Communities advised that there would be no way of assuring hard copy record keeping practices would meet the needs of this process. Accordingly, this approach would have been a manually intensive task for both the Commission and the Department of Communities but could not be assured to provide a valid representation of compliance and would potentially highlight the same record keeping issues that were identified in the inaugural audit.

[138] Step 5 only applies to placement decisions involving non-Indigenous carers.

Taking into consideration the advice provided by the Department of Communities, it was evident that a complete assessment of compliance with section 83 of the *Child Protection Act 1999*, across all steps of the Compliance Assessment Tool, was unlikely to be achievable within the limits of information available from the Department of Communities (either in ICMS or hard copy case files or both).

Availability of information from external agencies

The Advisory Committee was asked to provide advice on the efficacy of the Commission assessing compliance with section 83 of the *Child Protection Act 1999* by requesting and assessing information available in ICMS (within current limitations of information availability) in conjunction with information that could be canvassed from the Commission's Community Visitor (CV) function and other Advisory Committee members, depending on availability.

Non-departmental Advisory Committee members endorsed this approach and advised of their agencies' capacity to contribute data and information. Specifically, the Queensland Aboriginal and Torres Strait Islander Child Protection Peak advised there was capacity for Recognised Entities to contribute information about the placement decisions comprising the audit to complement departmental data.

Departmental members of the Advisory Committee also suggested a multi-faceted approach to assessing the Department of Communities' compliance with section 83 of the *Child Protection Act 1999* to potentially fill current gaps in information availability. It was suggested that the Commission supplement ICMS data with comprehensive sources, including hard copy case files and qualitative interviews with Child Safety Officers, Recognised Entities, families and children.

The Commission considered the advice provided by the Advisory Committee in establishing the audit methodology for monitoring compliance with section 83 of the *Child Protection Act 1999*, to provide the most robust evidence base possible within the context of information limitations. A decision was made to analyse the Department of Communities' electronic records for a random sample and conduct surveys of the Child Safety Officers and Recognised Entities involved in the placement decisions comprising the sample.

Agreement on sample size

A random audit sample size of 400 placement decisions made in 2008/09 was agreed with the Department of Communities to be representative, based on its preliminary estimation (at the time the audit methodology was established) that between 1000 and 2000 placement decisions were made for Aboriginal and Torres Strait Islander children and young people in the custody or guardianship of the Chief Executive in 2008/09.

Specific advice was that a sample size of between 290 and 340 placement decisions would "provide for the department and the public a high degree of confidence that these cases would represent the broader population of placement decisions."[139]

[139] Advice provided by Mr Brad Swan, Deputy Director-General, Child Safety, Youth and Families, Community Participation, Department of Communities on 18 December 2009.

Following a preliminary review of the audit sample, 12 placement decisions were excluded as outliers, reducing the final audit sample to 388 placement decisions.[140]

The Department of Communities later advised (once final figures were generated from ICMS) that the actual number of placement decisions made for Aboriginal and Torres Strait Islander children and young people in the custody or guardianship of the Chief Executive in 2008/09 was 4341 placement decisions, an increase on the original estimate of between 2000 and 3000 placement decisions.[141]

The Department of Communities commented that despite the larger than expected number of placement decisions, the current audit sample remained "a valid and representative sample of all placement decisions made in 2008-09. Using a five per cent confidence interval, a sample size of 364 is adequate for a population of 4000. At a seven per cent confidence interval, a sample size as low as 194 is considered sufficient."[142]

The final sample size of 388 placement decisions represents 9% of all (4341) placement decisions made for Aboriginal and Torres Strait Islander children and young people in the custody or guardianship of the Chief Executive in 2008/09.

1.2.3 Information requested to inform the assessment of compliance

Information requested

The Commission issued the Department of Communities with a request for information under the former Chapter 2, section 18, of the *Commission for Children and Young People and Child Guardian Act 2000*.[143]

The information requested to inform the Commission's assessment of compliance with section 83 of the *Child Protection Act 1999* was:

> *All electronic records captured in ICMS, relating to a random sample (to be generated by the Department) of 400 placement decisions made for Aboriginal and Torres Strait Islander children and young people in the 2008/09 financial period (meaning, those children on a child protection order, in the custody or guardianship of the chief executive, who were known to be Indigenous at the time of the placement decision),[144] that will inform assessment of compliance against the five steps identified in the Compliance Assessment Tool (as attached). Based on current advice, this entails information recorded only in the following ICMS printouts:*
>
> *1.1 Case Plan form (containing the cultural support plan)*
>
> *1.2 Recognised Entity /Child Placement Principle form*
>
> *1.3 Recognised Entity Participation form*
>
> *1.4 Placement Agreement form.*

[140] Of the 12 outliers excluded, four were outside the audit reference period (2008/09), seven required further confirmation of the child's cultural status and one was identified as a repeat.
[141] Advice provided by the Department of Communities on 13 July 2010.
[142] Advice provided by the Department of Communities on 13 July 2010.
[143] Now section 40 of the *Commission for Children and Young People and Child Guardian Act 2000*.
[144] This level of detail was included at the Department of Communities' request to streamline the data extraction process from ICMS.

Additionally, agreement was reached with the Department of Communities that the Commission would electronically survey Child Safety Officers for one month in regard to their decision making processes for the placement decisions comprising the audit sample. The Commission also discussed and reached agreement with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak on the same methodology for surveying Recognised Entities. A telephone participation option was additionally made available for Recognised Entities who may not have the resources necessary to participate in the survey electronically.

1.2.4 Information received to inform assessment of compliance

ICMS records

Relevant ICMS forms were provided by the Department of Communities for the 388 placement decisions comprising the audit sample.

The 'Recognised Entity/Child Placement Principle' form was provided for a little less than half (173 of 388, or 45%) of all placement decisions comprising the audit sample. This form captures specific information relevant to compliance with section 83 of the *Child Protection Act 1999*.

A supplementary 'Recognised Entity Participation' form was provided for 350 (or 90%) of the 388 placement decisions comprising the audit sample. This form captures the participation of a Recognised Entity relevant to any key decision making, not specifically the placement decision itself. Five (or 1%) of these forms specified that Recognised Entity participation was in regard to the placement decision for the child and were therefore used to inform the audit.[145]

There were 150 Placement Agreements and 330 Case Plans provided. A comprehensive review of these documents revealed that the information in these forms did not systematically capture the necessary information about the placement decision making process. Accordingly, information from the Placement Agreement and Case Plan were not used to directly inform the assessment of compliance with section 83 of the *Child Protection Act 1999*.

Surveys of Recognised Entities and Child Safety Officers

In March 2010, the Commission requested the Advisory Committee's feedback on the proposed content of the surveys. Feedback was incorporated into two electronic versions of the surveys using Microsoft SharePoint Services – one for Child Safety Officers and one for Recognised Entities. Both surveys were modelled on the key requirements of section 83 of the *Child Protection Act 1999* with a workflow to navigate participants through the survey.

The surveys were operational for one month, commencing on 1 June 2010 and closing on 30 June 2010. The Commission was expecting to receive 388 survey responses from Child Safety Officers (one for each placement decision comprising the audit sample) and 366 survey responses from Recognised Entities (slightly less as the Department of Communities advised that Recognised

[145] Of the remaining forms, 204 (53%) forms stated that RE participation was in relation to case planning, 112 (32%) forms did not state what the RE participation was in relation to, 21 (6%) forms stated that RE participation was in relation to an Investigation and Assessment, seven (2%) forms stated that RE participation was in relation to court and one form stated that RE participation was in relation to a Matter of Concern.

Entities were not involved in some placement decisions). To enable increased participation, the surveys were extended three times until the final close date on 13 August 2010.

The Commission received 359 responses from the Department of Communities and 135 responses from Recognised Entities. Preliminary review of the information captured indicated that a significant number of responses for both Child Safety Officers (98) and Recognised Entities (40) required further quality assurance to verify their validity. Specifically, the placement date recorded in the survey did not match the placement decision that a response was required for.

To ensure the final survey sample was as complete as possible, both Recognised Entities and Child Safety Officers were provided an opportunity to quality assure the survey responses in question over a six week timeframe.

A final valid sample of 298 Child Safety Officer survey responses and 99 Recognised Entity survey responses was received.

Part B of this report discusses the findings relevant to the Commission's assessment of the Department of Communities' compliance with section 83 of the *Child Protection Act 1999* using the methodology and information sources outlined.

1.3 Methodology for Part C - Outcomes achieved as a result of the Department of Communities' efforts to comply with section 83 of the Child Protection Act 1999

1.3.1 Established methodology

The methodology established by the Commission for monitoring the outcomes experienced by Aboriginal and Torres Strait Islander children and young people in out-of-home care as a result of the Department of Communities' efforts to comply with section 83 of the *Child Protection Act 1999* entailed:

- Establishing key areas of focus for monitoring the outcomes experienced by Aboriginal and Torres Strait Islander children and young people in out-of-home care, and
- Monitoring the key areas of focus using child focused data captured by the Commission's Community Visitors (CVs) in their visits with Aboriginal and Torres Strait Islander children and young people in out-of-home care.

1.3.2 Process for establishing the key areas of focus

Engagement with Aboriginal and Torres Strait Islander children and young people

The Commission engaged directly with Aboriginal and Torres Strait Islander children and young people in out-of-home care (through CV visits between 11 August 2009 and 11 September 2009) to find out what they think is important in keeping children connected with their family, community and culture (as intended by section 83 of the *Child Protection Act 1999*) by asking:

"What do you think helps kids feel connected to their Mob?"

There were 136 Aboriginal and Torres Strait Islander children and young people in out-of-home care who responded to this question.[146] Thematic analysis of their responses revealed the following as important to keeping kids connected with their Mob:

- Family contact
- Contact with community members
- Participation in cultural activities and events
- Knowledge about family, community and culture.

Literature review

To further inform this process, the Commission conducted a literature review to identify what is important for Aboriginal and Torres Strait Islander children and young people in out-of-home care, with a specific focus on their connection to family, community and culture (as intended by section 83 of the *Child Protection Act 1999*).

The literature review (Appendix 3) further reinforced the key themes identified through engagement with the Aboriginal and Torres Strait Islander children and young people. It also highlighted the importance of strong cultural identity, including the importance of knowledge of Mob, country and language.

Reconciling the findings from the Commission's direct engagement with Aboriginal and Torres Strait Islander children and young people, and the literature review about keeping connected with family, community and culture, the Commission established four key areas of focus for monitoring the outcomes of Aboriginal and Torres Strait Islander children and young people placed in out-of-home care:

- Family contact
- Contact with community/people of significance
- Participation in cultural activities/events, and
- Cultural identity.

1.3.3 Information gathered to inform the assessment of outcomes

Commission Community Visitor reports about children and young people in care

Commission Community Visitors (CVs) regularly visit children and young people in out-of-home care to verify that they are safe, are receiving appropriate care, to advocate on their behalf to help resolve any concerns or grievances and to offer support if required. After each visit CVs prepare a written report about the standard of care experienced by the child. These reports are based on an independent assessment made by the CV. Information and evidence used to formulate the CV's assessment is derived from multiple sources. Depending on the nature of the information these may be engagement and one-on-one discussions with the child during the visit, the CV's observations of the standard of care provided during the visit and/or statements made by the child's carer about the child.

[146] Aged 9 to 17 and on a Child Protection Order who were visited by a CV between 11 August and 11 September 2009.

In 2009-10, an improved CV report framework was introduced within the Commission's information management system, Jigsaw, to enhance data management and reporting and individual and systemic advocacy by the Commission. The implementation involved a change in the way CVs record the information from their visits with children.[147] This enhanced way of reporting enables detailed data capture about care provided to a child, and becomes a particularly powerful tool when that information is analysed across groups of children for trends.

For the purpose of this audit, the Commission collated child focused data captured during their visits with 1109 distinct Aboriginal and Torres Strait Islander children and young people in out-of-home care in July 2010 to monitor outcomes relevant to their connection with family, community and culture. The CVs were asked to ensure they captured all necessary information in their CV reports for July 2010 to inform the Commission's assessment of the outcomes experienced by Aboriginal and Torres Strait Islander children and young people relevant to their connection to family, community and culture.

Part C of this report discusses the findings relevant to the Commission's assessment of outcomes experienced by Aboriginal and Torres Strait Islander children and young people in out-of-home care using the methodology and information sources outlined.

[147] Previously, CVs rated the level of care provided against 17 standards of care on a 1-4 scale, they now provide yes/no responses to over 75 questions, categorise their concerns in additional sub-questions and provide some free text responses.

Appendix 2

Summary of the implementation update provided by the Department of Communities and the Commission's evaluation of implementation of the 28 recommendations made in the inaugural *Indigenous Child Placement Principle Audit Report 2008*

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 1: Identifying an Indigenous child	1	The department develop guidelines for inclusion in/or in support of the Child Safety Practice Manual that assist and support departmental officers in establishing a child's cultural identity, including the criteria for identifying an Aboriginal and/or Torres Strait Islander person.	Information has been included in the Child Safety Practice Manual (CSPM) to ensure that departmental officers identify and record a child's cultural identity. The approved definitions for an Aboriginal person and Torres Strait Islander person have also been included in the Glossary in the CSPM and in the Department of Communities' practice resources, 'The Child Placement Principle', 'Developing a cultural support plan for an Aboriginal and Torres Strait Islander child' and 'Working with Aboriginal and Torres Strait Islander People'.	Implemented. Collectively, the Child Safety Practice Manual (CSPM) and the Practice Resources provide departmental officers adequate guidance to establish a child's cultural identity. In particular, the guidance included in 'The Child Placement Principle' Practice Resource meets the requirement to provide a criteria for identifying an Aboriginal and/or Torres Strait Islander person. The resources also refer to the importance of confirming the child's cultural status in collaboration with the Recognised Entity.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 2: Involvement of Recognised Entities	2	The department develop guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in: – understanding the participation process with a Recognised Entity (including the local nature of relationship development), and – giving the Recognised Entity an opportunity to participate in the placement decision-making process (in accordance with section 83(2) of the *Child Protection Act 1999*). These guidelines should include (but not be limited to) details of how the Recognised Entity's expertise will: – provide cultural information complying with the Child Placement Principle – enhance the department's understanding of the child's family and community structures and relationships – provide support by identifying placement options – provide opinions about the suitability of placement options, and – provide advice on how to: ▪ retain relationships with Indigenous family and community ▪ facilitate contact with Indigenous family and community, and ▪ preserve and enhance the child's sense of Indigenous identity.	Information has been included at multiple points across the CSPM about the Recognised Entity's participation in information gathering, planning and decision-making. The significance of the Recognised Entity's participation is reflected in two overarching policy statements, 'Working with Aboriginal and Torres Strait Islander children, families and communities' and 'The Aboriginal and Torres Strait Islander Child Placement Principle'. Detailed information has also been included in the Department of Communities' practice resources, 'The Child Placement Principle', 'Working with the Recognised Entity' and 'Developing a cultural support plan for an Aboriginal and Torres Strait Islander child', and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Implemented. Collectively, the CSPM and the nominated Practice Resources, in particular the 'Working with Recognised Entity' Practice Resource, comprehensively outline the participation and consultation processes with Recognised Entities in decisions for Aboriginal and Torres Strait Islander children and young people. They also provide detailed guidance on the role of both Recognised Entities and departmental officers in the collaborative decision making process and specify the information that is to be obtained and recorded from the Recognised Entity.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 2: Involvement of Recognised Entities	3	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual to assist and support departmental officers in the consultation process with Recognised Entities that must occur after a placement decision was made without the participation of the Recognised Entity. These guidelines should address: – The local nature of relationship development with Recognised Entities – What is an acceptable time frame for 'as soon as practicable'? – What circumstances can be considered to be 'urgent'? – What information and advice should be sought during consultation with the Recognised Entity? – What are the expected outcomes from the consultation process? – In what circumstances should a decision be reviewed because of the views of the Recognised Entity?	Information has been included in the CSPM about consulting with the Recognised Entity as soon as practicable after a decision was made in relation to an Aboriginal or Torres Strait Islander child where departmental officers were not able to consult prior to or during the decision making process. The CSPM directs departmental officers to record information about circumstances that were deemed to be urgent including how and when the Recognised Entity was consulted, why the matter required urgent action, attempts made to consult with the Recognised Entity, where the child had been placed, information that guided the choice of placement, information about placement options investigated and attempts following an initial placement with a non-Indigenous carer to then locate a placement that complied with section 83 of the *Child Protection Act 1999*. Information about consultation with the Recognised Entity after the placement decision has also been included in the Department of Communities' practice resources, in particular 'The Child Placement Principle' and 'Working with the Recognised Entity'.	Implemented. Collectively, the CSPM and Practice Resources capture the intent of this recommendation. The resources communicate the importance of facilitating a positive relationship with Recognised Entities at the local level. In particular, the 'Working with the Recognised Entity' Practice Resource instructs departmental officers on the need to develop local protocols in partnership with the relevant Recognised Entity. The Practice Resources and CSPM also communicate the importance of consultation with the Recognised Entity as soon as practicable after a placement decision has been made in urgent circumstances and the importance of recording information about why the officer believed urgent action was required, what information guided the decision and how and when the officer consulted with the Recognised Entity about the placement decision. The resources do not provide comprehensive guidance about what constitutes 'as soon as practicable' and 'urgent'. However, based on the Advisory Committee's advice, the Commission

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
				accepts that these words assume their ordinary meaning when being interpreted by departmental officers and that departmental officers now have sufficient policy and procedural guidance to inform their practice.
Step 2: Involvement of Recognised Entities	4	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow recording of whether a placement decision was made because of urgent circumstances.	An enhancement to ICMS, making the question "was this placement due to urgent circumstances?" and the "rationale for placement decision" text box mandatory within the 'Recognised Entity/Child Placement Principle' form, for all placements, is scheduled to enter production in March 2012. Policy and procedures have also been amended and now require that departmental staff record information about circumstances that were deemed to be urgent, including how and when the Recognised Entity was consulted, why the matter required urgent action, attempts made to consult with the Recognised Entity, where the child had been placed, information that guided the choice of placement, information about placement options investigated and attempts following an initial placement with a non-Indigenous carer to then locate a placement that complied with section 83 of the *Child Protection Act 1999*.	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.
Step 3: Hierarchy of placement	5	The department develop guidelines that explain: – the types of relationships that exist in	Guidance is provided to departmental officers in the CSPM about gathering information about the child's family, their relationships, their community	Implemented.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
options		Aboriginal and Torres Strait Islander families and communities – information about Torres Strait Islander child rearing practices or 'traditional adoptions' needs to be included, and – the importance of departmental officers collecting and recording an Indigenous child's family and community structure to ensure appropriate and effective service delivery to Indigenous children.	and traditional practices. The importance of this information is restated in the two overarching policy statements, 'Working with Aboriginal and Torres Strait Islander children, families and communities' and the 'Aboriginal and Torres Strait Islander Child Placement Principle'. Information to this effect has also been included in the Department of Communities' practice resources, 'The Child Placement Principle', 'Working with the Recognised Entity', 'Developing a cultural support plan for an Aboriginal and Torres Strait Islander child', and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Collectively, the CSPM and Practice Resources specify the types of relationships that exist in Aboriginal and Torres Strait Islander families. Specifically, the glossary of terms that is contained in the Practice Resources provide a comprehensive definition of extended family. The overarching policy statement titled 'Aboriginal and Torres Strait Islander Child Placement Principle' also provides an understanding of the family members that are involved in an Aboriginal and/or Torres Strait Islander child's life. The CSPM specifies the consideration that is to be given to the different child rearing practices of Aboriginal and Torres Strait Islander families. It refers to the earlier independence of children, children taking responsibility at an earlier age, cultural authority within kinship/clan groups and cultural responsibility among the extended family and community. In addition, the CSPM and the Practice Resources highlight the importance of departmental officers collecting and recording advice about the child's family, community and relationships. Specifically, 'The Child Placement Principle' Practice Resource specifies that detail about the child's family should be recorded in an ecomap or genogram in ICMS.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 3: Hierarchy of placement options	6	The department develop comprehensive guidelines to support departmental officers in differentiating between family and community members for the purpose of section 83 of the *Child Protection Act 1999.*	Guidance has been included in the CSPM relevant to obtaining information from the child's family and the Recognised Entity about suitable placement options from within the child's family and community. This information can then be used to inform decision making about the child's placement in accordance with section 83 of the *Child Protection Act 1999*. Information to this effect has also been included in the Department of Communities' practice resources, 'The Child Placement Principle' and 'Working with the Recognised Entity', and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Implemented. The CSPM and Practice Resources provide guidance to departmental officers to consult with the Recognised Entity to identify relevant family and community for the purposes of identifying possible placement options. In addition, the glossary included in the Practice Resources provides a comprehensive explanation of key concepts relating to family and community.
Step 3: Hierarchy of placement options	7	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in collecting information about family and community members before an Indigenous child's initial placement (if possible). These guidelines should also address the approach that departmental officers should take if the information required is not available.	Information has been included in the CSPM about consulting with the family and the Recognised Entity to gather information about suitable individuals from within the child's family and community who would be willing and able to provide care. Information has also been included in the practice resources, 'The Child Placement Principle', 'Working with the Recognised Entity', and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Implemented. The CSPM and the Practice Resources refer to gathering information about the child's family, community and culture to inform decision making. They largely focus on the role of the RE in collecting the relevant family, community and cultural information. The CSPM also specifies that where there is insufficient information available to identify a suitable kinship care option for the child (ie. lack of information about family and community), the child will be placed in

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
				another placement in the interim with the decision to be reviewed when an informed decision is possible.
Step 3: Hierarchy of placement options	8	The department enhance the ICMS person record to allow: – the relationship tab to provide drop-down fields that are relevant to Indigenous family and community relationships, and – the mandatory inclusion of the information currently captured in the cultural support plan section in the case plan form.	The Relationships table in ICMS was updated on 27 September 2008 to include Aboriginal and Torres Strait Islander kinship relationships.	Implemented. The relationship tab in ICMS captures fields relevant to Aboriginal and Torres Strait Islander family and community relationships (ie. 1. father – Aboriginal kinship 2. mother – Aboriginal kinship 3. Father -Torres Strait Islander custom 4. Mother Torres Strait Island custom etc). Details about the clan/language/community group for the relevant person are captured in a number of places, including the person record and Carer Agreement.
Step 3: Hierarchy of placement options	9	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in identifying the role that family and community members can play while the child is in out-of-home care – specifically, whether or not family and community members are willing and able to be considered as placement options. Categories similar to those developed by the Victorian Department of Human Services should be considered for	Information has been included in the CSPM relevant to consulting with the family and the Recognised Entity to gather information about individuals who are willing and able to provide a range of support to a child. This information can then be considered during the development of the child's cultural support plan and case plan, including the suitability of individuals to be kinship or respite carers and arrangements for contact. The two policy statements also identify the	Implemented. Collectively, the CSPM and Practice Resources provide guidance that the departmental officer should consult with the Recognised Entity to identify potential suitable family or community members who may be able to provide a placement for the child. In addition, the resources refer to the

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
		classification, including: – care/support not appropriate – willing to provide support when they can – would like to provide support but will experience difficulties – cannot provide support – is prepared to provide support, and – is prepared to be considered as a placement option.	importance of maintaining links with family and community for development of an Aboriginal and Torres Strait Islander child's identity. Information to this effect has been included in the practice resources, 'Working with the Recognised Entity' and 'Developing a cultural support plan for an Aboriginal or Torres Strait Islander child' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	importance of identifying opportunities to maintain the child's contact with family while they are placed in care, including identifying possible respite options where possible.
Step 3: Hierarchy of placement options	10	The department enhance the ICMS recognised entity/Child Placement Principle form to allow for recording of placement options identified from family and community members. The information to be collected in the ICMS could include details of the placement options as well as whether the family and community members are willing and able to be considered.	Enhancements to ICMS, allowing the 'Recognised Entity/Child Placement Principle' form to record all placement options identified, including if these were from family and community members, are scheduled to enter production in March 2012. This will also include details of the placement options as well as whether the family and community members are willing and able to be considered. Current policy and procedures also require that departmental officers record information about placement options investigated and impediments to the use of placement options that complied with the hierarchy of placements outlined in section 83 of the *Child Protection Act 1999*.	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.
Step 3: Hierarchy of	11	The department develop comprehensive guidelines for inclusion in the Child Safety	Information has been included in the CSPM about consulting with the child's family and the	Implemented.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
placement options		Practice Manual that assist and support departmental officers in: – understanding the concept of a compatible Indigenous carer – gathering relevant information to decide if an Indigenous carer is compatible with an Indigenous child, and – making a decision about an Indigenous carer's compatibility with an Indigenous child.	Recognised Entity to gather information about individuals, within the child's family and community, who would be compatible carers. The two policy statements also identify the importance of maintaining links with family and community for development of an Aboriginal and Torres Strait Islander child's identity. Information to this effect has also been included in the practice resources, 'Working with the Recognised Entity' 'Developing a cultural support plan for an Aboriginal or Torres Strait Islander child' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Collectively, the CSPM and the Practice Resources provide comprehensive guidance to departmental officers about understanding and determining compatibility. 'The Child Placement Principle' Practice Resource, 'Working with the Recognised Entity' Practice Resource and the CSPM reinforce the importance of consulting with the Recognised Entity to identify a compatible placement for the child. 'The Child Placement Principle' Practice Resource specifically refers to identifying the factors that would make a potential carer or placement option compatible or incompatible with the child's needs. In addition, the glossary included in the CSPM provides a definition of 'compatible', referring the departmental officer to engage with the Recognised Entity, family, community leaders and elders on a case by case basis to gather information and determine compatibility of a potential carer.
Step 3: Hierarchy of placement options	12	The department enhance the ICMS to allow for recording of Indigenous carers' cultural information.	The person record in ICMS at present allows for such information to be recorded.	Implemented. The person record in ICMS captures the relevant cultural information (ie. Indigenous status, Indigenous community/language

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
				group). In addition, the Carer Assessment (the key document for recording and assessing the carer's suitability) contains comprehensive cultural information about the carer.
Step 3: Hierarchy of placement options	13	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow recording of: – Indigenous placement options identified (outside the family and community) – whether or not the Indigenous carer is compatible for the purpose of section 83 of the *Child Protection Act 1999*, and – how the decision to assess the Indigenous carer as compatible or incompatible was reached.	Enhancements to ICMS, allowing the 'Recognised Entity/Child Placement Principle' form to record all placement options identified are scheduled to enter production in March 2012. Each placement option will identify their relationship priority based on section 83 (4 & 6) of the *Child Protection Act 1999.* This will include if an Aboriginal person or Torres Strait Islander has been identified as "compatible with the child's community or language group" (83 (3)(c)). Within the 'rationale for placement decision' section of the form, users are specifically asked 'where a placement is determined as 'compatible with' the child's community or language group, include information about how this was assessed'. Since the 2008 report, the term 'compatible' has been defined in the CSPM. This is the definition to be used by staff if they identify a person as compatible within this form.	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 3: Hierarchy of placement options	14	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in: – understanding the concept of 'near' for the purpose of section 83 of the *Child Protection Act 1999*, and – making a decision about whether a placement option is 'near' an Indigenous child's family or community. This process should include: – reviewing location details about the child's family and community – reviewing location of placement options with non-Indigenous carers – identifying if the placement option is 'near' the child's family – identifying if the placement option is 'near' the child's community, and – reconciling a placement decision if the location is 'near' one family/community member and not another.	A definition of 'near' has been included in the glossary of terms in the CSPM and in the practice resources. Information has also been included in the CSPM about consulting with the Recognised Entity to ascertain if a placement is 'near' family and/or community. Similar information has also been included in the practice resource, 'The Child Placement Principle' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	Implemented. 'The Child Placement Principle' Practice Resource refers to engaging with the Recognised Entity and Aboriginal and Torres Strait Islander placement service (where relevant) to determine if a placement option is considered 'near' for a particular child. This document also refers to the importance of recording information about 'location'.
Step 3: Hierarchy of placement options	15	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow recording of: – non-Indigenous placement options identified near the child's family and/or community, and – how the decision to assess the non-	Enhancements to ICMS, allowing the 'Recognised Entity/Child Placement Principle' form to record all placement options identified are scheduled to enter production in March 2012. Each placement option will identify their relationship priority based on section 83 (4 & 6)	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
		Indigenous carer as near the family and/or community was reached.	of the *Child Protection Act 1999.* This will include if a person has been identified as "near" the child's family, community or language group. Within the 'rationale for placement decision' section of the form, users are specifically asked 'where a placement is determined as 'near' the child's community or language group, include information about how this was assessed.' Since the 2008 report, the term 'near' has been defined in the CSPM. This is the definition to be used by staff if they identify a person as near within this form.	
Step 3: Hierarchy of placement options	16	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in identifying appropriate placement options for Indigenous children when the options set out in section 83(4) and (6) of the *Child Protection Act 1999* have been exhausted.	Information is included in the CSPM about the departmental officer's roles and responsibilities when an Aboriginal or Torres Strait Islander child has been placed with a non-Indigenous carer. This includes regularly reviewing the placement and continuing to attempt to locate a placement that complies with the hierarchy of placements outlined in section 83 of the *Child Protection Act 1999*. The overarching policy statement also identifies the importance for an Aboriginal and Torres Strait Islander child to be cared for by a member of their own family or community. Information to this effect has also been included	Implemented. Collectively, the CSPM and the nominated Practice Resources communicate the need to consult with the Recognised Entity, family and community members when making placement decisions. They provide clear direction about the need to review placement decisions where the child has not been placed with an Aboriginal and/or Torres Strait Islander carer. The CSPM also refers to placement matching principles to assist the departmental officers in locating a suitable placement for the child. It additionally

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			in the practice resources, 'Working with the Recognised Entity', 'Developing a cultural support plan for an Aboriginal or Torres Strait Islander child' and 'The child placement principle' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	specifies that where a child requires a placement with another entity (section 82(1)(f)) the RE must be involved in the assessment to ensure the placement is able to facilitate family and cultural contact. Additionally, the Placement Services Unit assists departmental officers in locating placement options.
Step 3: Hierarchy of placement options	17	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow recording of placement options identified outside the hierarchy of placement options in section 83(4) and (6) of the *Child Protection Act 1999.*	Enhancements to ICMS, allowing the 'Recognised Entity/Child Placement Principle' form to record all placement options identified are scheduled to enter production in March 2012. Each placement option will identify their relationship priority based on section 83 (4 & 6) of the *Child Protection Act 1999.* Current policy and procedures also require that departmental officers record information about placement options investigated, why a placement option was deemed unsafe or unsuitable and the rationale for placing a child with a non-Indigenous carer.	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.
Step 4: Proper consideration of placement	18	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in collecting information about the relationships between	Procedures outlined in the CSPM require departmental officers to obtain information from family and the Recognised Entity about a child's relationships with their parents, siblings, extended family and significant individuals within	Implemented. Collectively the CSPM and Practice Resources refer to the importance of the

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
options		Indigenous children and their parents, siblings and people of significance.	their community. The overarching policy statements also highlight the importance for an Aboriginal or Torres Strait Islander child to maintain their relationships with family and community. Information to this effect has also been included in the practice resources 'Working with the Recognised Entity', 'Developing a cultural support plan for an Aboriginal or Torres Strait Islander child', 'The child placement principle' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	departmental officer identifying and capturing information about the child's family, community and relationships. The resources instruct the departmental officer to do this in collaboration with the Recognised Entity.
Step 4: Proper consideration of placement options	19	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow for recording of details of the child's relationships with parents, siblings and people of significance.	Relevant information about children used to inform placement decisions is currently recorded within ICMS. A child's relationships with parent's siblings and people of significance are recorded in the Person Profile and key documents including the Child Strength and Needs Assessment and the Case Plan. Recording this information in these locations is considered to be the appropriate record keeping method. Current policy and procedures also require that departmental officers record information about the child's Aboriginal or Torres Strait Islander status and their relationships with family members and other individuals from within their community who are significant in their life.	Implemented. Record keeping in ICMS captures information about the child's relationships with parents, siblings and people of significance.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
Step 4: Proper consideration of placement options	20	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that will assist and support departmental officers in assessing the placement option's ability to retain the child's relationships with parents, siblings and people of significance. The following questions should be addressed by the guidelines: – Will the placement option provide a supportive environment that allows the retention of the child's relationships with parents, siblings and people of significance? – Will the placement option enable contact with parents, siblings and people of significance? – Are there any factors that would prevent/hinder the relationships with parents, siblings and people of significance.	Information has been included in the CSPM about ensuring that the child's case plan and cultural support plan maintain the child's cultural identity and his or her contact with family, community and significant individuals within their network. The two overarching policy statements also identify the importance for an Aboriginal and Torres Strait Islander child to maintain their links with their family and community for the development of their identity. Information to this effect has also been included in the practice resources, 'Working with the Recognised Entity', 'Developing a cultural support plan for an Aboriginal or Torres Strait Islander child' and 'The child placement principle'.	Implemented. Collectively, the CSPM and Practice Resources refer to the importance of ensuring the child's placement maintains their connection to family and community and directs the departmental officers to consult with the Recognised Entity to identify the appropriate family and community structures and placement options to fulfil this. The suite of documents do not contain prescriptive guidance on how the departmental officer should make their assessment about whether the placement will allow for the optimal retention of relationships with key people. Instead, they incorporate the intent of this recommendation by ensuring departmental officers are considering these factors and allowing departmental officers to apply their personal expertise in making the assessment.
Step 4: Proper consideration of placement options	21	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow recording of consideration given to a placement option's ability to retain the child's relationships with parents, siblings and people of significance.	Enhancements to ICMS include amendments to the 'Recognised Entity/Child Placement Principle' form to record the question "Has proper consideration been given to the placements ability to ensure optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.

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			tradition or Island custom? On answering no, reasons why proper consideration was not given must be entered. Within the 'rationale for placement decision' section of the form, users are specifically advised 'You must also discuss how the carer was assessed regarding their ability to help retain the child's family, community and cultural connections.' These enhancements are scheduled to enter production in March 2012. Each placement option will identify their relationship priority based on section 83 (4 & 6) of the *Child Protection Act 1999.*	
Step 4: Proper consideration of placement options	22	The department develop comprehensive guidelines for inclusion in/or support of the Child Safety Practice Manual that assist and support departmental officers in considering the views of the Recognised Entity, including (but not limited to): – involvement in the decision-making process – views expressed during the decision-making process, and – areas of disagreement with the department.	Information has been included at multiple points across the CSPM about the Recognised Entity's participation in information gathering, planning and decision making. The significance of the Recognised Entity's participation is reflected in the two overarching policy statements, 'Working with Aboriginal and Torres Strait Islander children, families and communities' and 'The Aboriginal and Torres Strait Islander Child Placement Principle'. Detailed information has also been included in the practice resources, in particular 'The child	Implemented. The resources duly note the importance of ensuring a Recognised Entity is involved in a placement decision for an Aboriginal or Torres Strait Islander child and note the importance of recording the information and views provided by the Recognised Entity. The 'Working with the Recognised Entity' Practice Resource also provides guidance to departmental officers on what to do when a difference of opinion arises between the Department and the Recognised Entity, instructing them to ensure a senior officer has been consulted and is aware of the

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
			placement principle', 'Working with the Recognised Entity' and 'Developing a cultural support plan for an Aboriginal and Torres Strait Islander child' and the practice paper 'Working with Aboriginal and Torres Strait Islander People'.	decision being made, and ensure the decision, rationale and consultation processes are recorded in ICMS and communicated to the Recognised Entity.
Step 5: Non- Indigenous carers' commitment	23	The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in assessing a non-Indigenous carer's commitment in accordance with the *Child Protection Act 1999*. The assessment process should include (but not be limited to): – the department identifying and recording what its expectation is of the non-Indigenous carer to: – facilitate contact between the child and family members – help maintain contact with the child's community or language group – help maintain a connection with the child's Aboriginal or Torres Strait Islander culture, and – preserve and enhance the child's sense of Aboriginal or Torres Strait Islander identity – the department providing details of its expectations to the non-Indigenous carer – the non-Indigenous carer's response to the department's expectations (including any support that may need to be	Information has been included in the CSPM about the need for Child Safety Services staff to ensure that a carer who is not Aboriginal or Torres Strait Islander is able to demonstrate their commitment to meeting the contact and cultural needs of the Aboriginal or Torres Strait Islander child placed in their care. Departmental procedures also require that this commitment be documented in the Placement Agreement. The overarching policy statement 'The Aboriginal and Torres Strait Islander Child Placement Principle' also outlines requirements when a child is placed with a carer who is not an Aboriginal or Torres Strait Islander person. Information has also been included in the practice resource 'The Child Placement Principle'.	Implemented. The CSPM and Practice Resources refer to the need to consider the non-Indigenous carer's commitment to maintaining the child's connection to family, community in accordance with section 83(7). Specifically, 'The Child Placement Principle' Practice Resource specifies that these commitments must be documented in the Placement Agreement and signed by the carer. The suite of documents do not contain prescriptive guidance on how the departmental officer should make their assessment about the non-Indigenous carer's commitment. Instead, they incorporate the intent of this recommendation by ensuring departmental officers are considering these factors and allowing departmental officers to apply their personal expertise in making the assessment.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
		provided by the department to the non-Indigenous carer), and – a written commitment from the non-Indigenous carer to meet the department's expectations.		
Step 5: Non- Indigenous carers' commitment	24	The department enhance the ICMS Recognised Entity/Child Placement Principle form to allow for recording of the assessment of the non-Indigenous carer's commitment in accordance with section 83(7) of the *Child Protection Act 1999*.	Enhancements to ICMS include amendments to the 'Recognised Entity/Child Placement Principle' form to record if all carers have committed to each section (a to d) of section 83(7) of the *Child Protection Act 1999* and, in making the placement decision, if proper consideration has been given to this. Within the 'rationale for placement decision' section of the form, users are specifically asked to discuss how the carer was assessed regarding section 83(7). Current policy and procedures also require that departmental officers record, in the Placement Agreement, information about the non-Indigenous carer's willingness and ability to comply with the requirements outlined in the legislation, policy and procedures.	Implementation underway. The requisite enhancements to ICMS have been prioritised and are scheduled to enter production in March 2012.
Steps 1-5: General compliance	25	Recommendations 1, 2, 3, 5, 6, 7, 9, 11, 14, 16, 18, 20 and 22 are responded to in a way that results in one comprehensive procedure, to be included in/or in support of the Child Safety Practice Manual. Situations that may require further guidance should be	Departmental officers now have access to a comprehensive suite of policies, procedures and practice resources that guide their intervention with Aboriginal and Torres Strait Islander children, families and communities. These documents include:-	Implemented. Collectively the CSPM and practice papers provide detailed guidance to departmental officers about the application of section 83 of the *Child Protection Act 1999*, including

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		considered for inclusion, such as: – approach to the Child Placement Principle when children have mixed heritage – approach to placing large sibling groups – placement of children long distances away from their communities – contact with family and community – family not wanting contact and child not wanting contact – approach to placement of disabled Indigenous children – parental requests for non-Indigenous placements – emergency placements. As well, all other references to the Child Placement Principle in the Child Safety Practice Manual will need to refer to the specific procedural document.	– Specific provisions within the Act; – Two overarching policy statements; – Four practice resources; and – Extensive references across the majority of chapters in the CSPM.	the additional areas for consideration.
Steps 1-5: General compliance	26	The department develop training for departmental officers about the application of section 83 of the *Child Protection Act 1999*. This training should be rolled out once all procedural recommendations of this report have been implemented.	The Learning Solutions Unit is currently undertaking a continuous improvement process and reviewing the Child Safety Officer (CSO) Entry Level Training Program (ELTP). This review will include the incorporation of all procedural updates implemented in response to the *Indigenous Child Placement Principle Audit Report 2008*. During this process, the Learning Solution Unit will consult with the Child Protection Development and Child Safety Practice Improvement to ensure that the new training package aligns with Departmental policy	Implementation underway. The requisite enhancements to training have been identified and are scheduled for completion in April 2012.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
			and practice requirements. It is expected that this review will be completed by April 2012. ELTP is a structured 72 week program comprising a number of different phases. • Phase 1: Workplace orientation • Phase 2: Face to Face problem solving (including Foundation Studies in Culture) • Phase 3 & 5: Workplace learning activities (Verification of Competence, Workplace Learning Guide) • Phase 4: Face to face consolidation workshops. Working with Aboriginal people and Torres Strait Islander people is integrated throughout the program. Specifically, section 83 of the *Child Protection Act 1999* is covered in the following ways: • During Phase 1 of CSO ELTP, CSOs are required to observe and discuss the work of experienced CSOs in the service centre. In preparation for one of these discussions, new CSOs are required to read sections 6 and 83 of the *Child Protection Act 1999* to explore how these sections impact on the work carried out in the service centre. • During phase 2 of CSO ELTP, all CSOs are required to participate in a 2 day workshop 'Foundation Studies in Culture – Indigenous Engagement.' During this targeted two days of training CSOs are informed and engaged in activities that focus on the sections of the	

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
			Child Protection Act 1999 that apply specifically to Aboriginal and Torres Strait Islander children namely: - Section 6 - Provisions for Indigenous children - Section 83 - Aboriginal and Torres Strait Islander Child Placement Principle - Section 88 - Contact arrangements for Aboriginal and Torres Strait Islander children - Section 246 (I) - Roles and functions of the Recognised Entity. • CSOs work through a number of case scenarios that focus on the application of the *Child Protection Act 1999* and guiding policies and procedures. All case scenarios incorporate Aboriginal and Torres Strait Islander practice topics, including section 83, the Aboriginal and Torres Strait Islander Child Placement Principle. • During phases 3 & 5 of CSO ELTP, CSOs are required to provide evidence of how they have demonstrated competence when working with Aboriginal and Torres Strait Islander people and the Recognised Entities, which covers the requirements of section 83 of the *Child Protection Act 1999*. This evidence is signed off by the CSOs Team Leader and may take the form of: - Direct observation in the workplace - Recent samples of work - Third party verification - Oral questioning.	

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
			CSOs are required to provide evidence that they have demonstrated competence when: • Working with Aboriginal and Torres Strait Islander families (Mandatory) - Explores with the client who they identify as their family and the roles each person adopts within the family to place the child in terms of the Child Placement Principles. • Working with Recognised Entities (Mandatory) - Works collaboratively with the Recognised Entity by including them in the decision making process at all key decision making points and discusses the child protection concerns in the context of culture. - Explores, with the assistance of the Recognised Entity, who the client identifies as their family and the roles each person adopts within the family and records this in case notes.	
Steps 1-5: General compliance	27	The department consider the introduction of specialised positions that case manage only Aboriginal and Torres Strait Islander children. These positions could allow effective engagement with the Recognised Entity and local community members. Expertise in applying the Child Placement Principle would also be developed by the departmental officers.	The department has maintained funded Child Safety Support Officer (CSSO) positions at the AO2, AO3 and AO4 level. This cohort provides a strong resource base to facilitate family contact for Aboriginal and Torres Strait Islander children in contact with the Child Safety service system. The AO4 position is an identified position with a strong focus on supporting the development of key contacts in the Indigenous community, provision of cultural advice, provision	Implemented. The Department of Communities has appropriately considered the possibility of introducing specialised positions to case manage Aboriginal and Torres Strait Islander children and young people.

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
			of advice in relation to the Child Placement Principle, and support to Aboriginal and Torres Strait Islander children and their case managers. The department established Placement Coordination Units in each zone. In Central Zone, consideration is being given to converting a current PO2 position to an identified AO4 position to enable recruitment of an Aboriginal or Torres Strait Islander officer. In Northern Zone, Aboriginal and Torres Strait Islander workers manage placements for all Aboriginal and Torres Strait Islander children, and in Far North Queensland Zone, 3 AO4 identified positions work in the Kinship and Foster Care Team with Aboriginal and Torres Strait Islander carers. In Greater Brisbane Region, 2 project officer positions were established to identify family members for Aboriginal and Torres Strait Islander children, including research and genograms and liaison with Ganyjuu Foster and Kinship Care Service The department has also focussed on recruitment and retention of specified and identified positions, including CSSO positions, and specifically support CSSOs to complete a certificate IV Diploma in Child Protection, and an approved pilot for 20 CSSOs to undertake a Graduate Certificate in Child Protection, making them eligible for employment as a CSO.	
Steps 1-5: General	28	That the ICMS Recognised Entity/Child Placement Principle form is enhanced to	Enhancements to ICMS, relevant to the implementation of recommendations from the	Implementation underway. The requisite enhancements to ICMS have

Compliance Step	Rec #	Recommendation	Summary of action taken by the Department of Communities to implement the recommendation	Commission's evaluation of implementation
compliance		include Recommendations 4, 8, 10, 12, 13, 15, 17, 19, 21 and 24.	*Indigenous Child Placement Principle Audit Report 2008*, are scheduled to enter production in March 2012.	been prioritised and are scheduled to enter production in March 2012.

Appendix 3

Literature review

The Commission conducted a literature review to identify what is important for Aboriginal and Torres Strait Islander children and young people in out-of-home care, with a specific focus on their connection to family, community and culture. This literature review was conducted to complement the views captured during the Commission Community Visitor direct engagement with Aboriginal and Torres Strait Islander children and young people in out-of-home care.

The literature review undertaken reflected the themes identified from the Commission's engagement with Aboriginal and Torres Strait Islander children and young people and highlighted the importance of family contact, contact with community, participation in cultural events, strong cultural identity, knowledge of country, knowledge of language, knowledge of extended family relationships and knowledge of Indigenous codes of conduct.

Literature source (in chronological order)	**Findings**
Bringing Them Home Report - National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, April 1997, Human Rights and Equal Opportunity Commission.	Chapter 10 of the Bringing Them Home Report addresses the consequences of the forcible removal of Indigenous children through the perspectives of the Indigenous people who were removed as children. The accounts provided by the Indigenous people highlights the devastating consequences resulting from being removed and cut-off from their family, community and culture. Witnesses spoke of their loss of cultural identity and their feelings of not belonging either in the Indigenous community or in the non-Indigenous community: *"You spend your whole life wondering where you fit. You're not white enough to be white and your skin isn't black enough to be black either, and it really does come down to that."* (Confidential evidence 210, Victoria). *"We weren't black or white. We were a very lonely, lost and sad displaced group of people. We were taught to think and act like a white person, but we didn't know how to think and act like an Aboriginal. We*

Literature source (in chronological order)	Findings
	didn't know anything about our culture." (Confidential submission 617, New South Wales: woman removed at 8 years with her 3 sisters in the 1940s; placed in Cootamundra Girls' Home). *"I was very fortunate that when I was removed, I was with very loving and caring parents. The love was mutual ... My foster mother used to take me and my sister to town. Mum used to always walk through Victoria Square and say to us, `Let's see if any of these are your uncles'. My sister and I used to get real shamed. I used to go home and cry because I used to get so frightened and could never understand why my mum would do this to us, when it made us upset. Only when I was near 29 did I realise why ... I know my foster parents were the type of people that always understood that I needed to know my roots, who I was, where I was born, who my parents were and my identity ... I remember one day I went home to my foster father and stated that I had heard that my natural father was a drunk. My foster father told me you shouldn't listen to other people: `You judge him for yourself, taking into account the tragedy, that someday you will understand."* (Confidential submission 252, South Australia: woman fostered at 4 years in the 1960s). Witnesses spoke of how they were not able to speak their language and were unable to participate in cultural activities and events: *"My mother and brother could speak our language and my father could speak his. I can't speak my language. Aboriginal people weren't allowed to speak their language while white people were around. They had to go out into the bush or talk their lingoes on their own. Aboriginal customs like initiation were not allowed. We could not leave Cherbourg to go to Aboriginal traditional festivals. We could have a corroboree if the Protector issued a permit. It was completely up to him. I never had a chance to learn about my traditional and customary way of life when I was on the reserves."* (Confidential submission 110, Queensland: woman removed in the 1940s). Witnesses spoke of how there was little if any family contact: *"If we got letters, you'd end up with usually `the weather's fine', `we love you' and `from your loving mother' or whatever. We didn't hear or see what was written in between. And that was one way they kept*

Literature source (in chronological order)	Findings
	us away from our families. They'd turn around and say to you, `See, they don't care about you'. Later on, when I left the home, I asked my mother, `How come you didn't write letters?' She said, 'But we did'. I said, `Well, we never got them'." (Confidential evidence 450, New South Wales: woman removed at 2 years in the 1940s, first to Bomaderry Children's Home, then to Cootamundra Girls' Home; now working to assist former Cootamundra inmates). Additionally, chapter 10 also provides accounts on education, work and wages, and the safety and living conditions of placements.
Having Our Voices Heard, Aboriginal and Torres Strait Islander Youth Perspectives, National Indigenous Youth Leadership Group, 2004-05	The National Indigenous Youth Leadership Group 2004-05, comprised of 15 Aboriginal and Torres Strait Islander young people nationwide aged 18 to 24, provided their thoughts to the Australian Government on important issues affecting Indigenous children and young people in their community. In particular, the young people provided their views regarding what could improve cultural identity. A key theme from the responses was the importance of information and learning about culture, with one young person commenting that their dream for the future was for 'Strong culture and language to hand on to my kids.'
Achieving Stable and Culturally Strong Out of Home Care for Aboriginal and Torres Strait Islander Children, Secretariat of National Aboriginal and Islander Child Care, 2005.	In 2005, the Secretariat of National Aboriginal and Islander Child Care Incorporated (SNAICC) highlighted the importance of national standards being established for Aboriginal and Torres Strait Islander children in out-of-home care to reflect cultural and spiritual needs. Six principles were identified as a guide of necessary considerations in the development of national standards: • Safety is paramount. • Case planning for Aboriginal and Torres Strait Islander children should focus on the maintenance of connections to family and community and the development of cultural and spiritual identity (noting that Indigenous children in care 'must be given opportunities to have a relationship with family, including extended family members, and maintain their place in the interconnected network of people that forms their community'). • Case planning for Aboriginal and Torres Strait Islander children should take a life course approach and focus on the needs of the child, both now and later as an older child, and adolescent and an adult.

Literature source (in chronological order)	Findings
	• Participation of children in decision making. • Plans for the child's cultural and spiritual development should be developed and the implementation of these plans must be adequately resourced (noting the importance of participation in community and cultural events). • Adequate caseworker, medical and educational support for all placements.
Enhancing out-of-home care for Aboriginal and Torres Strait Islander Young People, Australian Institute of Family Studies, October 2005.	Sixteen Aboriginal and Torres Strait Islander children and young people aged 7 to 16 from Queensland and Western Australia participated (in conjunction with a sample of carers and service providers) in a study aimed at enhancing recruitment, retention and support of Indigenous carers and enhancing the cultural connections for Indigenous children in out-of-home care. The young people were asked to present their views on aspects of Indigenous out-of-home care. Responses by young people demonstrated an almost exclusive focus on the importance of family, community and culture, with a strong theme of desired reconnection to family and community expressed. When asked 'If there was one thing in their lives that they could change, what would it be?' children commented 'To be with your family', 'Have family together' and 'We would really want to be with our parents.' The young people also highlighted positive elements of participating in cultural activities, with one young person commenting that 'Cultural activities reminds you of back home. It's cool to do those things.' Responses by carers and service providers were focused on the barriers and promising practices in recruiting and retaining Indigenous carers. One concern raised by carers was the difficulties experienced in managing contact with the child's family owing to the parent's reaction to the placement (as sometimes the families would know each other and this would potentially create hostility). However, in spite of the difficulties experienced, carers acknowledged the importance of maintaining contact with family where possible. Specifically mentioned was the need for contact with siblings where children are placed apart.
Defining Well-being for Indigenous Children in Care, Children Australia, Volume 32, Number 2, 2007.	A study was conducted to define indicators of wellbeing for Aboriginal and Torres Strait Islander children in care, to address the limited work that had been done in this area. The study sought the views of 20 Indigenous carers and child protection workers about what they thought was important for Aboriginal and Torres Strait Islander children in out-of-home care. This information was used to define social, spiritual and cultural wellbeing indicators for Aboriginal and Torres Strait Islander children in out-of-home care, in what the study described as the 'first

Literature source (in chronological order)	Findings
	attempt to define what Indigenous Australians themselves understand as wellbeing indicators for their children in care.' The following indicators were identified: • Social indicators- appropriate social skills and appropriate skills for independent living. • Spiritual indicators- participation in religious ceremonies and active acknowledgement of child's belief system. • Cultural indicators- knowledge of extended family relationships, knowledge of Indigenous codes of conduct, knowledge of country, participation in cultural ceremonies, and knowledge of language. The study identified that feedback should be sought from other Indigenous groups in defining the wellbeing of Indigenous children in care, to be considered in conjunction with findings from this study, and noted the significance of the indicators (in whatever final form they assumed) being operationalised so that outcomes can be evaluated against them.
VIYAC Voices Telling it Like it Is: Young Aboriginal Victorians on Culture, Identity and Racism, Victorian Indigenous Youth Advisory Council and Youth Affairs Council of Victoria.	The Victorian Indigenous Youth Advisory Council (VIYAC), comprised of Aboriginal and Torres Strait Islander young people aged 17 to 24, provided their perspectives on their culture, identity and racism. In particular, the young people provided their views on their connection to culture, how that occurs and how it can be strengthened. Key themes in the young people's responses about connection to culture were the importance of: • Learning about culture. • Participating in cultural activities and events – ie. storytelling, artwork, weaving, spearing, dancing, throwing the boomerang and playing the didgeridoo. • Family connection and contact – ie. 'being in and around my family', 'family ties' and 'listening and learning from my father, family and extended family.' • Connection and contact with community.
Foster their Culture, Caring for Aboriginal and Torres Strait Islander Children in Out-of-Home Care, Secretariat of National Aboriginal and Islander Child Care, 2008.	This report serves as a resource for non-Indigenous carers to assist them in better understanding how to support Indigenous children and young people in out-of-home care to grow up with a 'strong sense and knowledge of their cultural identity.' It highlights the importance of Indigenous children and young people having a clear sense of their cultural identity,

Literature source (in chronological order)	Findings
	'knowing and having access to family and group identity' and having the opportunity to 'learn about and experience their culture.' It specifically acknowledges that placements for Aboriginal and Torres Strait Islander children that 'cut them off from their family, culture and spirituality are at great risk of psychological, health, development and educational disadvantage.
Overcoming Indigenous Disadvantage Key Indicators Report, Steering Committee for the Review of Government Service Provision, Commonwealth of Australia, 2009.	This report serves as a report card for the Council of Australian Governments (COAG) on progress made and areas for further improvement in closing the outcomes gap for Indigenous Australians against broad indicators of Indigenous disadvantage (ie. health, education, employment etc). However, it does discuss the importance of connection to traditional country (ie. recognition of country and access to country) and also contends that 'involvement in art and cultural activities may improve social cohesion and contribute to community wellbeing.'
Measuring the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples, Australian Institute of Health and Welfare, January 2009.	This report discusses findings regrading the social and emotional wellbeing of Indigenous Australians (as sourced in the 2004/05 National Aboriginal and Torres Strait Islander Health Survey) against eight interim social and emotional wellbeing domains – psychological distress, impact of psychological distress, positive wellbeing, anger, life stressors, discrimination, cultural identification and removal from natural family. Of particular relevance: • The 'cultural identification' domain explores the attachment of Indigenous people (in non-remote areas) to their tribe, language group, clan and traditional country. Findings indicate that almost half of Indigenous adults who participated said they identified with a tribe, language group or clan, and 60% identified a specific area as their traditional country. • The 'removal from natural family' domain explores the extent of removal of Indigenous people from their natural families as an important element of social and emotional wellbeing. The report also assesses the utility of the interim domains as the next step in establishing an agreed model for evaluating the social and emotional wellbeing of Indigenous Australians. It identifies areas for improvement across the domains, however notes the importance of retention of both the 'cultural identification' and the 'removal from natural family' domain in measuring social and emotional wellbeing of Indigenous Australians.
Key Directions for a Social, Emotional, Cultural and Spiritual Wellbeing Population Health Framework for	This report discusses social, emotional, cultural and spiritual wellbeing for Indigenous Australians, stating that 'protective factors derive from strong culture, family and community' and identifying the following as 'unique and culturally-specific risk and protective factors' for social, emotional, cultural and spiritual wellbeing:

Literature source (in chronological order)	Findings
Aboriginal and Torres Strait Islander Australians in Queensland, June 2009.	• Kinship. • Family and community. • Spirituality. • Culture and cultural identity.

Appendix 4

Links between recommendations made by the Commission in the inaugural *Indigenous Child Placement Principle Audit Report 2008* and the *Aboriginal and Torres Strait Islander Kinship Reconnection Project* report in 2010

Recommendations made in the Kinship Reconnection project	Alignment with Recommendations made in the inaugural Indigenous Child Placement Principle Audit Report 2008
Summary of findings: The project provided opportunities for improving Aboriginal and Torres Strait Islander children's connections to family, community and culture and therefore has a broader application to other Regions. Recommendation 1: That the Kinship Reconnection project be implemented in other Regions and Child Safety Service Centres taking into account the factors identified as contributing to positive outcomes and those areas identified as requiring improvement.	NA
Summary of findings: Minor issues were identified with the survey tool – tool to be amended in accordance with identified areas for improvement. Recommendation 2: That the survey tool be reviewed and amended in line with the outcomes of this project.	NA

Summary of findings: The cultural background of 10 of the 26 children comprising the sample was unclear and/or in dispute. The process and basis for departmental officers identifying the cultural background of children appears unclear and should be clarified. Recommendation 3: That the process and basis for identifying the cultural background of children be clarified including: • Procedures and practice guidance • Involvement of Recognised Entities • Management of disputes • Documentation of efforts made.	**Inaugural recommendation 1** – The department develop guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in establishing a child's cultural identity, including the criteria for identifying an Aboriginal and/or Torres Strait Islander person. **Inaugural recommendation 2 -** The department develop guidelines for inclusion or in support of the Child Safety Practice Manual that assist and support departmental officers in: • understanding the participation process with a recognised entity (including the local nature of relationship development), and • giving the recognised entity an opportunity to participate in the placement decision-making process (in accordance with section 83(2) of the *Child Protection Act 1999*). These guidelines should include (but not be limited to) details of how the recognised entity's expertise will: • provide cultural information complying with the Child Placement Principle • enhance the department's understanding of the child's family and community structures and relationships • provide support by identifying placement options • provide opinions about the suitability of placement options, and • provide advice on how to: – retain relationships with Indigenous family and community – facilitate contact with Indigenous family and community, and – preserve and enhance the child's sense of Indigenous identity.

Summary of findings: There were significant gaps in identifying and recording immediate and extended family members. Practice guidance is required to support departmental officers in the effective identification and recording of family and cultural information. Recommendation 4: That guidelines and support for identifying and recording family and cultural information be developed.	Inaugural recommendation 5 - The department develop guidelines that explain: • the types of relationships that exist in Aboriginal and Torres Strait Islander families and communities. Information about Torres Strait Islander child rearing practices or 'traditional adoptions' needs to be included, and • the importance of departmental officers collecting and recording an Indigenous child's family and community structure to ensure appropriate and effective service delivery to Indigenous children. Inaugural recommendation 6 – The department develop comprehensive guidelines to support departmental officers in differentiating between family and community members for the purpose of section 83 of the *Child Protection Act 1999*. Inaugural recommendation 7 – The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in collecting information about family and community members before an Indigenous child's initial placement (if possible).These guidelines should also address the approach that departmental officers should take if the information required is not available. Inaugural recommendation 8 – The department enhance the ICMS person record to allow: • the relationship tab to provide drop-down fields that are relevant to Indigenous family and community relationships, and • the mandatory inclusion of the information currently captured in the cultural support plan section in the case plan form.

Summary of findings: The current reform of Aboriginal and Torres Strait Islander child protection service delivery provides an opportunity to review roles and responsibilities for identifying immediate and extended family and community. Recommendation 5: Review the roles and responsibilities of Aboriginal and Torres Strait Islander child protection services and Child Safety Service Centres in identifying, recording, and reviewing relevant family and cultural information.	NA
Summary of findings: There was a lack of involvement of parents and extended family in family group meetings in cases where children are not being cared for in culturally appropriate placements. Family group meetings could be used to review case plans until culturally appropriate placements are achieved in accordance with the Indigenous Child Placement Principle. Recommendation 6: That Family Group Meetings be used to review the case plans of all children who are not being cared for in a culturally appropriate placement until such time that an appropriate placement has been found and the child has been placed.	NA
Summary of findings: Half of the children in the sample did not have a cultural support plan. Cultural support plans are particularly important for children who are not being cared for in culturally appropriate placements. Recommendation 7: That the development of Cultural Support Plans be prioritised of children who are not being cared for in culturally appropriate placements.	NA
Summary of findings: Departmental officers appeared to struggle to identify age appropriate cultural supports (evident	NA

in its absence from cultural support plans). Recommendation 8: That a list of age appropriate cultural supports be developed and provided to Child Safety Service Centres and be incorporated in each child's case plan including the resources section to ensure consideration of funding.	
Summary of findings: New strategies need to be established for developing cultural identity and maintaining connection to culture. In particular, two new strategies were recommended - mentors and local groups (age appropriate groups for Aboriginal and Torres Strait Islander children and young people run locally by Aboriginal and Torres Strait Islander people). Recommendation 9: That strategies for promoting cultural identity and connection for children in care, including the use of cultural mentors and local groups, be further explored.	NA
Summary of findings: Records did not adequately document what is required of carers to provide culturally appropriate care and whether or not this is being achieved. Recommendation 10: That Placement Agreements specify what actions are required of carers to provide cultural support to a child in line with the child's case plan and cultural support plan.	Links in with the concept of making non-Indigenous carers aware of what is expected of them in maintaining the child's connection to family, community and culture. Inaugural recommendation 23 – The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that assist and support departmental officers in assessing a non-Indigenous carer's commitment in accordance with the *Child Protection Act 1999*. The assessment process should include (but not be limited to): • the department identifying and recording what its expectation is of the non-Indigenous carer to: – facilitate contact between the child and family members – help maintain contact with the child's community or language group

	– help maintain a connection with the child's Aboriginal or Torres Strait Islander culture, and – preserve and enhance the child's sense of Aboriginal or Torres Strait Islander identity • the department providing details of its expectations to the non-Indigenous carer • the non-Indigenous carer's response to the department's expectations (including any support that may need to be provided by the department to the non-Indigenous carer), and • a written commitment from the non-Indigenous carer to meet the department's expectations.
Summary of findings: As above. Recommendation 11: That information resource materials be developed for carers about cultural identity, connection and learning, and their role as carers.	As above.
Summary of findings: There was no clear documentation of the steps taken to identify culturally appropriate placements for the children in the sample in line with the Indigenous Child Placement Principle, nor was there adequate records of the outcomes of these steps. Recommendation 12: That steps taken to identify a culturally appropriate placement in line with the Child Placement Principle are clearly documented in the case plan.	Links in with all recommendations targeted at improving record keeping in the ICMS in regards to compliance with section 83 of the *Child Protection Act 1999* (inaugural recommendations 4, 8, 10, 12, 13, 15, 17, 19, 21, 24)
Summary of findings: Practice considerations for each of the placement options in section 83 of the *Child Protection Act 1999* should be clearly identified to support departmental officers and Recognised Entities in decision making. This could be supported by a reporting template to record consideration of	Links in with recommendations targeted at improving policies and guidance provided to departmental officers relevant to placement options prescribed in section 83 of the *Child Protection Act 1999* (inaugural recommendations 5, 6, 7, 9,11, 14, 16)

each step. Recommendation 13. That practice considerations for each of the placement options in the Child Placement Principle be identified to support Child Safety Service Centre and Recognised Entities in decision making.	
Summary of findings: Recognised Entity involvement was not always clear from the records. Recommendation 14: That the recording of Recognised Entity involvement in placement decisions be reviewed and amended including consideration of: • tagging the Recognised Entity pop-up to the creation of the location specific to each carer for the child • confirming Recognised Entity participation by email sent to the Child Safety Officer, who should enter the email into case notes and refer to it in the Recognised Entity participation form. •	NA. The *Indigenous Child Placement Principle Audit Report 2008* found that the main gap in record keeping about RE involvement was whether the placement decision had been made in urgent circumstances (and made inaugural recommendation 4 accordingly).
Summary of findings: The placement of children with non-Indigenous carers has implications for maintaining connection to family, community and culture. The impact is exacerbated the longer the placement continues and is compounded by factors such as attachment to the carer. Recommendation 15: That the purpose of interim placements with non-Indigenous carers or other non-Indigenous placements is made explicit in the Placement Agreement and clearly communicated to all stakeholders.	NA
Recommendation 16: That the steps to be taken to locate and assess extended family members or locate another culturally appropriate placement are clearly identified and subject to three monthly reviews.	NA

Recommendation 17: That practice guidance on emotional and cultural attachment be developed and disseminated.	NA
Summary of findings: There were significant gaps in information about family contact and reasons inhibiting contact. The gaps included information not being recorded, contact not having been explored, and family members not being known to Child Safety. Recommendation 18: That the case plan clearly identify: • parents, siblings and extended family • strategies for maintaining or establishing contact with parents, siblings and extended family • arrangements for contact including necessary supports.	Inaugural recommendation 20 – The department develop comprehensive guidelines for inclusion in the Child Safety Practice Manual that will assist and support departmental officers in assessing the placement option's ability to retain the child's relationships with parents, siblings and people of significance. The following questions should be addressed by the guidelines: • Will the placement option provide a supportive environment that allows the retention of the child's relationships with parents, siblings and people of significance? • Will the placement option enable contact with parents, siblings and people of significance? • Are there any factors that would prevent/hinder the child's relationships with parents, siblings and people of significance? Inaugural recommendation 21 – The department enhance the ICMS recognised entity/Child Placement Principle form to allow recording of consideration given to a placement option's ability to retain the child's relationships with parents, siblings and people of significance.
Summary of findings: There is need to clarify the roles and responsibilities of Recognised Entities, Family Support Services and Foster Care and Kinship Care Services in identifying and confirming cultural background, identifying family and community and providing advice about relationships between family members and community members to Child Safety. Recommendation 19: That the Recognised Entities have primary responsibility for coordinating the collection of information and provision of advice to Child Safety Service Centres in relation to identifying and	**Inaugural recommendation 2 -** The department develop guidelines for inclusion or in support of the Child Safety Practice Manual that assist and support departmental officers in: • understanding the participation process with a recognised entity (including the local nature of relationship development), and • giving the recognised entity an opportunity to participate in the placement decision-making process (in accordance with section 83(2) of the *Child Protection Act 1999*). These guidelines should include (but not be limited to) details of how

confirming cultural background, identifying family and community and providing advice about relationships between family members and community members.	the recognised entity's expertise will: • provide cultural information complying with the Child Placement Principle • enhance the department's understanding of the child's family and community structures and relationships • provide support by identifying placement options • provide opinions about the suitability of placement options, and • provide advice on how to: – retain relationships with Indigenous family and community – facilitate contact with Indigenous family and community, and – preserve and enhance the child's sense of Indigenous identity.
Summary of findings: The potential of specified Child Safety Support Officers to contribute to culturally appropriate support and care for children and families was not being realised. Recommendation 20: That the role of specified Child Safety Support Officers be reviewed and their contribution to culturally appropriate support and care being provided to children and families be promoted.	No direct relationship with inaugural recommendations but aligns conceptually with the notion that having specialised officers will assist in ensuring maintained connection to family, community and culture. Inaugural recommendation 27- The department consider the introduction of specialised positions that case manage only Indigenous children. These positions could allow effective engagement with the recognised entity and local community members. Expertise in applying the Child Placement Principle would also be developed by departmental officers.
Summary of findings: Significant case management issues were identified in relation to all children included in the sample. Recommendation 21: That the training of departmental staff be reviewed and updated to develop their cultural capability.	Inaugural recommendation 26 – The department develop training for departmental officers about the application of section 83 of the *Child Protection Act 1999*. This training should be rolled out once all procedural recommendations of this report have been implemented.
Recommendation 22: That the Child Safety Practice Manual be reviewed and updated to provide additional guidance for staff, at all points of the child protection process, in culturally responsive practice.	Links in with all recommendations targeted at improving guidance provided to departmental officers (inaugural recommendations 1, 2, 3, 5, 6, 7, 9, 11, 14, 16, 18, 20, 22, 23, 25).

Recommendation 23: That the roles and responsibilities of the Department of Community Services (Child Safety Services) and Aboriginal and Torres Strait Islander child protection services in relation to case management be reviewed in the broader context of the Aboriginal and Torres Strait Islander Child Safety Taskforce and the development and implementation of a comprehensive plan for reducing over-representation in the child protection system.	NA
Summary of findings: The existing service system has limited capacity to identify, assess and support family members who are willing to provide kinship care. Neither Child Safety Service Centres or Aboriginal and Torres Strait Islander child protection services are resourced to undertake this work. Recommendation 24: That the role of the Aboriginal and Torres Strait Islander Foster and Kinship Care services be reviewed and consideration be given to focusing their resources on finding, assessing and supporting kinship carers.	NA
Summary of findings: There are currently only nine funded Aboriginal and Torres Strait Islander Foster and Kinship Care services across Queensland. Recommendation 25: That the level of need for kinship care and resources required to meet that need be identified.	NA
Summary of findings: Kinship care is more akin to 'in-family care' than to foster care – therefore a Kinship Care program would need to be developed. Recommendation 26: That an Aboriginal and Torres Strait Islander Kinship Care Program be developed with reference to:	NA

• finding kin • assessing and approving kin (including the use of provisional approval and obtaining the required 'suitability clearances') • planning placements with kin including resource requirements • supporting and training kin in relation to the demands and requirements of their role • providing casework support to children placed with kin • linking placement planning with case planning and the allocation of resources required to support culturally appropriate care and achieving the desired outcomes identified for the child and their family.	
Summary of findings: The time it takes to find kinship carers and the lack of availability of other culturally appropriate options contributes to the placement of Aboriginal and Torres Strait Islander children with non-Indigenous carers and their disconnection from family, community and culture. Recommendation 27: That culturally appropriate short term placement and support options be developed and funded for Aboriginal and Torres Strait Islander children.	NA
Summary of findings: If family or community members cannot be found for children, other culturally appropriate placement and support services to which children can transition from short term placement and support options to longer term care and support will need to be available. Recommendation 28: That other strategies to increase the availability of culturally appropriate placement and support options for Aboriginal and Torres Strait Islander children be established and funded.	NA

Appendix 5

Counting rules for assessing compliance using the three sources of data that informed the audit

Step 1 – Identify the child is Indigenous (s83(1))

Yes	Child is Aboriginal, Torres Strait Islander or both.
No	Child is not Aboriginal, Torres Strait Islander or both.
NVR	No valid survey response.
NA	• NA[3] - RE did not have records or knowledge about the placement decision that would allow them to complete the survey. • NA[4] - RE was not involved in the placement decision or was not consulted after the placement was made in urgent circumstances. • NA[6] - RE did not participate in the placement decision once provided the opportunity (or it was unknown).

Step 2 – Involvement of a Recognised Entity (RE) – (s83(2) and (3))

Yes	RE was provided the opportunity to participate in the placement decision or was consulted after the placement was made in urgent circumstances.
No	RE was not provided the opportunity to participate in the placement decision or was not consulted after the placement was made in urgent circumstances.
NVR	No valid survey response.
NA	• NA[1] - Child is not Indigenous. • NA[2] - No known RE to consult with. • NA[4] - RE was not involved in the placement decision or was not consulted after the placement was made in urgent circumstances. (This category would normally be a 'no' for this section, however 'NA' was assigned in some cases where the RE responded that it was unknown if their RE service had been provided the opportunity to participate to prevent a false assessment). • NA[11] - RE participation not supported by family.
NFP	No ICMS form provided (ie. no valid response).
NI	ICMS form provided but no information contained (ie. no valid response).

Step 3 – Hierarchy of placement options – (s83(4) and (6))

Yes	Evidence that each level of the hierarchy was considered until the placement was made.
No	Lack of evidence to determine compliance.
NVR	No valid survey response.
NA	• NA[1] - Child is not Indigenous. • NA[3] - RE does not have records or information to allow them to complete the survey. • NA[4] - RE was not known to be given the opportunity to participate in the placement decision before the placement was made, nor consulted after the placement was made in urgent circumstances. • NA[5] - RE was consulted after the placement decision, therefore the RE was not involved in the decision making process itself. • NA[6] - Unknown if RE participated in the placement decision once provided the opportunity. • NA[7] - This relates to information captured in ICMS – it means that an assessment could not occur as there was only a record of the outcome of the decision making process.

Step 4 – Part A – Proper consideration of REs views – (s83(5))

Yes	Evidence that there was proper consideration of the REs views. This means that there was agreement between the RE and the CSO, or where there was not agreement there was evidence that the CSO had discussed the placement with the RE and identified/considered their views.
No	• No evidence that the CSO gave consideration to the REs views • Urgent circumstances could not be established as a reason for failure to provide the RE the opportunity to participate in the placement decision, therefore proper consideration of the REs views cannot be determined to have occurred as intended by section 83.
NA	• NA[1] - Child is not Indigenous. • NA[2] - No known RE to consult with. • NA[3] - RE does not have records or information to allow them to complete the survey. • NA[4] - RE was not involved in the placement decision or consulted after the placement was made in urgent circumstances. • NA[6] - Unknown if RE participated once they were given the opportunity. • NA[10] - The participant inaccurately entered an earlier response therefore the necessary information was not subsequently captured by the survey workflow. • NA[11] - RE participation not supported by family. • NA[12] - Evidence that the RE was initially consulted about the suitability of the respite placement to occur on an ongoing basis, therefore there was no record of the RE's views provided in the immediate instance.
NVR	No valid survey response.
NFP	No ICMS form provided (ie. no valid response).

NI	ICMS form provided but no information contained (ie. no valid response).

Step 4 – Part B – Retention of relationships – (s83(5))

Yes	Consideration of ALL relevant relationships (ie. if a key person is deceased or the child does not have any siblings etc they are deemed not relevant for consideration).
No	• Partial consideration of relevant relationships. • No evidence of consideration of any relevant relationships. • It is unknown to the CSO where the child was placed therefore this question could not be validly answered.
NA	• NA[1] - Child is not Indigenous. • NA[3] - RE does not have records or information to allow them to complete the survey. • NA[4] - RE was not involved in the placement decision or was not consulted after the placement was made in urgent circumstances. (This category would normally be a 'no' for this section, however NA was assigned in some cases where the RE responded that it was unknown if their RE service had been provided the opportunity to participate to prevent a false assessment). • NA[5] - RE was consulted after the placement decision, therefore the RE was not involved in the decision making process itself. • NA[6] - Unknown if RE participated in the placement decision once provided the opportunity. • NA[7] - This relates to ICMS – it means that there was incomplete information to adequately assess whether retention of the child's relationships was considered. The inaugural recommendations have not yet been implemented, therefore the forms do not contain specific fields that ask the CSO to identify and provide details of the child's relationship with key people in their lives, provide an assessment of whether the placement will ensure optimal retention of the relationship and provide details of how it will do this. Currently, the Case Plan and the Placement Agreement contain general information about contact arrangements with key people. Based on the information provided, the Commission has insufficient evidence to determine whether proper consideration has been given to ALL key people, which was established as the threshold for compliance for assessing the CSO and RE surveys. For example, it is possible that the Case Plan or Placement Agreement might contain some information about contact arrangements with the child's mother, however it is not possible to determine whether this is the only family member or person of significance that needs to be considered when making an assessment about the retention of the child's relationships. It is possible that the child may have a father, siblings, extended family or community members that are absent from consideration. The inverse is also true. It is not possible to determine that there is non-compliance (ie failure to consider the retention of all relationships with all key people) based on the absence of information. For this reason, the assessment of compliance will be based on CSO and RE survey responses where participants have been asked specific questions about the retention of relationships based on their knowledge and records as relevant to the placement decision.
NVR	No valid survey response.

Step 5 – Assessment of non-Indigenous carer commitment – s83(7))

Yes	Consideration of ALL elements of non-Indigenous carer commitment. This means that there was evidence of an assessment of commitment, regardless of whether the non-Indigenous carer was or was not committed.
No	• Partial consideration of elements of non-Indigenous carer commitment • No evidence of consideration of non-Indigenous carer commitment • It is unknown to the CSO where the child was placed therefore this question could not be validly answered.
NA	• NA[1] - Child is not Indigenous. • NA[3] - RE did not have records or knowledge about the placement decision that would allow them to complete the survey. • NA[4] - RE was not involved in the placement decision or consulted after the placement was made in urgent circumstances. • NA[5] - RE was consulted after the placement decision, therefore the RE was not involved in the decision making process itself. • NA[6] - Unknown if RE participated in the placement decision once provided the opportunity. • NA[8] - It is unknown to the RE where the child was placed therefore this question could not be validly answered. • NA[9] - Child was not placed with a non-Indigenous carer.
NVR	No valid survey response.
NFP	No ICMS form provided (ie. no valid response).
NI	ICMS form provided but no information contained (ie. no valid response).

Summary of NA breakdown for compliance table

NA[1]	Child is not Indigenous.
NA[2]	No known RE to consult with.
NA[3]	RE did not have records or knowledge about the placement decision that would allow them to complete the survey.
NA[4]	RE was not involved in the placement decision or was not consulted after the placement had been made in urgent circumstances.
NA[5]	RE was consulted after the placement decision, therefore the RE was not involved in the placement decision itself.
NA[6]	RE did not participate in the placement decision once provided the opportunity (or it was unknown if they participated).
NA[7]	There was insufficient evidence to adequately assess.

NA[8]	The RE did not know where the child was placed therefore could not validly respond.
NA[9]	Child was not placed with a non-Indigenous carer.
NA[10]	The participant inaccurately entered an earlier response therefore the necessary information was not subsequently captured by the survey workflow.
NA[11]	RE participation not supported by family.
NA[12]	Evidence that the RE was initially consulted about the suitability of the respite placement to occur on an ongoing basis, therefore there was no record of the REs views provided in the immediate instance.

Appendix 6

Counting rules for assessing overall compliance with each step of the Compliance Assessment Tool

This document outlines the counting rules that were used to assess overall compliance with each step of the Compliance Assessment Tool when reconciling the three unique assessments that were made from each of the three data sources used to inform the audit (CSO surveys, RE surveys and ICMS forms).

Yes, evidence of compliance	• All yes responses. • One or more yes responses accompanied only by a No Valid Response (NVR) or No Form Provided (NFP) (assessment based on valid information available ie. no evidence to discredit). • Where the RE response is a yes and one of the Department of Communities' information sources (CSO survey or ICMS) is a yes. • Where there is a discrepancy between the Department of Communities information sources (ICMS record and/or CSO survey) and the RE survey and at least one information source indicates compliance (benefit of the doubt based on Advisory Committee's advice). • Where there is only the Department of Communities' information sources available (ICMS record and the CSO survey) and there is a discrepancy, however ICMS indicates a yes response (ICMS record used as point of truth based on the Department of Communities' advice).
No evidence of compliance	• All no responses. • One or more no responses accompanied only by a NVR or NFP (assessment based on valid information available ie. no evidence to discredit).
No valid response (NVR)	• Where there is insufficient evidence to make an assessment of compliance.
Not applicable (NA)	• Not applicable for one of the reasons noted in Appendix 5.

Appendix 7

Assessment of compliance across the five steps of the Compliance Assessment Tool by information source

Assessments with an * represent the placement decisions where there was a discrepancy between the Department of Communities' data sources and the Recognised Entities survey response. However, compliance was assessed to have occurred where at least one source evidenced compliance.

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[5]	NA[7]	No	Yes	Yes	Yes	Yes	Yes	NA[5]	NA[7]	Yes	NA[9]	NA[5]	Yes	Yes	No
2	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
3	Yes	NVR	Yes	Yes	Yes	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NA[2]	NA[2]	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
4	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
5	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
6	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
7	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	Yes	NA[5]	NA[7]	Yes	No	Yes	NVR	Yes*	No	NA[5]	NA[7]	No	NA[9]	NA[5]	NVR	NA[9]	No
8	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[6]	NA[6]	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
9	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
10	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
11	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
12	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	NVR	Yes	Yes	No	NA[7]	Yes*	Yes	No	NVR	Yes*	Yes
13	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	NA[9]	NA[9]	NA[9]	NA[9]	Yes
14	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
15	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
16	No	NVR	Yes	Yes	NA[1]	NVR	NVR	NA[1]	NA[1]	NVR	NA[7]	NA[1]	NA[1]	NVR	NVR	NA[1]	NA[1]	NVR	NA[7]	NA[1]	NA[1]	NVR	NVR	NA[1]	NVR
17	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
18	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
19	NVR	NA[4]	Yes	Yes	NVR	No	NVR	No	NVR	NA[4]	NA[7]	NVR	NVR	No	NVR	No	NVR	NA[4]	NA[7]	NVR	NVR	NA[4]	NVR	NVR	No
20	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	NVR	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	NVR	Yes	Yes
21	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
22	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
23	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
24	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	NA[5]	NA[7]	No	Yes	Yes	NVR	Yes	Yes	NA[5]	NA[7]	Yes	Yes	NA[5]	NVR	Yes	No
25	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[5]	NA[7]	NVR	NVR	Yes	Yes	Yes	NVR	NA[5]	NA[7]	NVR	NVR	NA[5]	NA[9]	NA[9]	NVR
26	NVR	NVR	Yes	Yes	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	No
27	Yes	NA[6]	Yes	Yes	No	Yes	NVR	Yes*	No	NA[6]	NA[7]	No	No	NA[6]	NVR	No	No	NA[6]	NA[7]	No	No	NA[6]	NVR	No	No
28	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
29	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	No	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	NA[9]	Yes	NVR	Yes*	No
30	Yes	Yes	Yes	Yes	No	Yes	NVR	Yes*	No	No	NA[7]	No	No	Yes	NVR	Yes*	Yes	No	NA[7]	Yes*	NA[9]	NA[9]	NVR	NA[9]	No
31	Yes	NVR	Yes	Yes	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NA[2]	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
32	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
33	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
34	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
35	No	Yes	Yes	Yes	NA[1]	Yes	Yes	Yes	NA[1]	No	NA[7]	No*	NA[1]	Yes	Yes	Yes	NA[1]	No	NA[7]	No*	NA[1]	NA[9]	NA[9]	NA[9]	No
36	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes
37	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[5]	NA[7]	NVR	NVR	No	Yes	Yes*	NVR	NA[5]	NA[7]	NVR	NVR	NA[5]	Yes	Yes	NVR
38	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	Yes	Yes	NVR	Yes	No	Yes	NA[7]	Yes*	No	Yes	NVR	Yes*	No
39	Yes	NA[3]	Yes	Yes	Yes	Yes	NVR	Yes	No	NA[3]	NA[7]	No	Yes	NA[3]	NVR	Yes	Yes	NA[3]	NA[7]	Yes	Yes	NA[3]	NVR	Yes	No
40	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[12]	NVR	NVR	NA[12]	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
41	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
42	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
43	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
44	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
45	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
46	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
47	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
48	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
49	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
50	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No
51	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
52	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
53	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
54	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NA[9]	NA[9]	No
55	Yes	NVR	Yes	Yes	Yes	NVR	No	No	Yes	NVR	NA[7]	Yes	Yes	NVR	No	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
56	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	Yes	Yes	Yes
57	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
58	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[5]	NA[7]	No	No	Yes	Yes	Yes	No	NA[5]	NA[7]	No	No	NA[5]	Yes	Yes	No
59	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes
60	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
61	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
62	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
63	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
64	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
65	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
66	Yes	NA[4]	Yes	Yes	Yes	NA[4]	Yes	Yes*	Yes	NA[4]	NA[7]	Yes	Yes	NA[4]	Yes	Yes	Yes	NA[4]	NA[7]	Yes	NA[9]	NA[4]	NA[9]	NA[9]	Yes
67	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
68	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[6]	NA[6]	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
69	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
70	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
71	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	No	NA[4]	NA[7]	No	NA[9]	NA[4]	NVR	NA[9]	No
72	Yes	Yes	Yes	Yes	NA[2]	Yes	Yes	Yes	No	No	NA[7]	No	NA[2]	Yes	Yes	Yes	No	No	NA[7]	No	No	Yes	Yes	Yes	No
73	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
74	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	Yes	Yes	No
75	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
76	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
77	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
78	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	NA[9]	NA[4]	NVR	NA[9]	No
79	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	NA[9]	NA[4]	NVR	NA[9]	No
80	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
81	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No
82	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
83	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
84	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
85	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
86	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
87	Yes	No	Yes	Yes*	Yes	Yes	Yes	Yes	Yes	NA[1]	NA[7]	Yes*	Yes	NA[1]	Yes	Yes*	Yes	NA[1]	NA[7]	Yes*	NA[9]	NA[1]	NA[9]	NA[9*]	Yes
88	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
89	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
90	Yes	Yes	Yes	Yes	No	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	No	Yes	NVR	Yes*	No	No	NA[7]	No	NA[9]	NA[9]	NVR	NA[9]	No
91	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
92	NVR	NVR	Yes	Yes	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	No
93	Yes	Yes	Yes	Yes	NA[2]	Yes	NVR	Yes*	No	NA[5]	NA[7]	No	NA[2]	Yes	NVR	Yes*	Yes	NA[5]	NA[7]	Yes	NA[9]	NA[5]	NVR	NA[9]	No
94	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
95	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
96	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	Yes	Yes	No
97	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
98	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	NA[6]	NA[6]	No	NVR	NA[7]	No	Yes	NVR	NA[9]	NA[9]	No
99	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
100	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	NA[9]	No	Yes	Yes*	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
101	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
102	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
103	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
104	Yes	Yes	Yes	Yes	NA[2]	Yes	NVR	Yes*	Yes	Yes	NA[7]	Yes	NA[2]	Yes	NVR	Yes*	No	No	NA[7]	No	NA[9]	NA[9]	NVR	NA[9]	No
105	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
106	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	Yes
107	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
108	Yes	NA[4]	Yes	Yes	No	No	NVR	No	No	NA[4]	NA[7]	No	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	NA[9]	NA[4]	NVR	NA[9]	No
109	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
110	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	Yes
111	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	NA[9]	NA[9]	NA[9]	NA[9]	Yes
112	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
113	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
114	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
115	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
116	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	NVR	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NVR	No*	No
117	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
118	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	NA[5]	NA[7]	No	Yes	Yes	NVR	Yes	Yes	NA[5]	NA[7]	Yes	NA[9]	NA[5]	NVR	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
119	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
120	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
121	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[12]	NVR	NVR	NA[12]	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
122	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	No
123	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
124	Yes	Yes	Yes	Yes	No	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	No	Yes	NVR	Yes*	Yes	Yes	NA[7]	Yes	No	NA[9]	NVR	No	No
125	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
126	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
127	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
128	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
129	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
130	NVR	NA[4]	Yes	Yes	NVR	No	NVR	No	NVR	NA[4]	NA[7]	NVR	NVR	No	NVR	No	NVR	NA[4]	NA[7]	NVR	NVR	NA[4]	NVR	NVR	No
131	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
132	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
133	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	Yes	Yes	No
134	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
135	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[5]	NA[7]	No	Yes	Yes	Yes	Yes	Yes	NA[5]	NA[7]	Yes	NA[9]	NA[5]	NA[9]	NA[9]	No
136	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	Yes	Yes	NVR	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	NVR	Yes	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
137	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
138	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
139	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	No	Yes	Yes*	No
140	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
141	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
142	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
143	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
144	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
145	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
146	Yes	NA[4]	Yes	Yes	No	No	Yes	No	No	NA[4]	NA[7]	No	No	No	Yes	No	No	NA[4]	NA[7]	No	No	NA[4]	Yes	Yes	No
147	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
148	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
149	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
150	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
151	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
152	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
153	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	NA[9]	NA[9]	NA[9]	NA[9]	Yes
154	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
155	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
156	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes
157	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
158	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
159	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
160	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
161	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
162	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
163	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
164	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
165	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes
166	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
167	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
168	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
169	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	NA[6]	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	NA[9]	NA[9]	NA[9]	NA[9]	Yes
170	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
171	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
172	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
173	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
174	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
175	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
176	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
177	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No
178	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
179	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
180	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
181	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
182	Yes	NVR	Yes	Yes	NA[2]	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[2]	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
183	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
184	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
185	NVR	NA[3]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[3]	NA[7]	NVR	NVR	NA[3]	Yes	Yes	NVR	NA[3]	NA[7]	NVR	NVR	NA[3]	Yes	Yes	NVR
186	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
187	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	Yes	Yes	No
188	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
189	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
190	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
191	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
192	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
193	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
194	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
195	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[5]	NA[7]	No	No	Yes	Yes	Yes	No	NA[5]	NA[7]	No	No	NA[5]	Yes	Yes	No
196	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
197	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
198	Yes	NVR	Yes	Yes	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NA[2]	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
199	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	Yes	Yes	No
200	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
201	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[6]	NA[6]	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
202	NVR	NVR	Yes	Yes	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	No
203	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	NA[9]	NA[9]	NA[9]	NA[9]	Yes
204	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	No
205	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
206	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	Yes
207	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
208	Yes	NA[4]	Yes	Yes	Yes	NA[4]	Yes	Yes	Yes	NA[4]	NA[7]	Yes	Yes	NA[4]	Yes	Yes	Yes	NA[4]	NA[7]	Yes	NA[9]	NA[4]	NA[9]	NA[9]	Yes

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
209	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	NA[5]	NA[7]	No	No	Yes	Yes	Yes	Yes	NA[5]	NA[7]	Yes	No	NA[5]	Yes	Yes	No
210	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
211	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
212	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	Yes	NA[8]	NA[7]	Yes	Yes	NA[8]	Yes	Yes	No
213	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	Yes	NA[9]	No
214	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
215	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
216	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
217	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
218	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
219	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	Yes	Yes	No
220	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
221	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
222	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
223	Yes	Yes	Yes	Yes	No	Yes	NVR	Yes*	No	NA[5]	NA[7]	No	No	No	NVR	No	Yes	NA[5]	NA[7]	Yes	No	NA[5]	NVR	No	No
224	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
225	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
226	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
227	Yes	NVR	Yes	Yes	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NA[2]	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NA[9]	NA[9]	No
228	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
229	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	No	NA[4]	NA[7]	No	NA[9]	NA[4]	NVR	NA[9]	No
230	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
231	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[6]	NA[6]	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
232	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
233	Yes	NA[4]	Yes	Yes	Yes	NA[4]	Yes	Yes	No	NA[4]	NA[7]	No	Yes	NA[4]	Yes	Yes	Yes	NA[4]	NA[7]	Yes	Yes	NA[4]	Yes	Yes	No
234	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[12]	NVR	NVR	NA[12]	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
235	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
236	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
237	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
238	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
239	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	No	NA[7]	No	NVR	Yes	NVR	Yes	NVR	No	NA[7]	No	NVR	Yes	NVR	Yes	No
240	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	No	NA[7]	No	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	NVR	Yes	No
241	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
242	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
243	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
244	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
245	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	NVR	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
246	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
247	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	No	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	No	Yes	Yes*	No
248	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
249	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	Yes	Yes	NVR	Yes	NA[7]	Yes	NVR	No	Yes	Yes*	Yes
250	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
251	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
252	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	Yes
253	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
254	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
255	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
256	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
257	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	No	NA[4]	NA[7]	No	NA[9]	NA[4]	NVR	NA[9]	No
258	Yes	NA[4]	Yes	Yes	No	No	NVR	No	Yes	NA[4]	NA[7]	Yes	No	No	NVR	No	No	NA[4]	NA[7]	No	NA[9]	NA[4]	NVR	NA[9]	No
259	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
260	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
261	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	NA[9]	NA[9]	NA[9]	NA[9]	Yes
262	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
263	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
264	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
265	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
266	Yes	NA[4]	Yes	Yes	Yes	NA[4]	NVR	Yes	No	NA[4]	NA[7]	No	Yes	NA[4]	NVR	Yes	Yes	NA[4]	NA[7]	Yes	No	NA[4]	NVR	No	No
267	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
268	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
269	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	Yes	Yes	No
270	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	Yes	Yes	No
271	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	NA[9]	NA[9]	NA[9]	Yes
272	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
273	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	No	NA[7]	No	NVR	Yes	Yes	Yes	NVR	NA[8]	NA[7]	NVR	NVR	NA[8]	Yes	Yes	No
274	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
275	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	NVR	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	Yes	Yes	No
276	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
277	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
278	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
279	NVR	NVR	Yes	Yes	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	No
280	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
281	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
282	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	No	Yes	Yes*	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	No
283	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
284	Yes	Yes	Yes	Yes	No	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	No	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	NA[9]	NA[9]	NVR	NA[9]	Yes
285	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No
286	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
287	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	Yes	Yes	No
288	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	NA[9]	NA[9]	Yes	NA[9]	Yes
289	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
290	Yes	NVR	Yes	Yes	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NA[2]	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
291	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
292	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes
293	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
294	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	No	No	NA[7]	No	Yes	NA[9]	Yes	Yes*	No
295	NVR	NA[4]	Yes	Yes	NVR	NA[4]	NVR	NVR	NVR	NA[4]	NA[7]	NVR	NVR	NA[4]	NVR	NVR	NVR	NA[4]	NA[7]	NVR	NVR	NA[4]	NVR	NVR	NVR
296	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
297	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
298	Yes	Yes	Yes	Yes	NA[2]	Yes	Yes	Yes	No	No	NA[7]	No	NA[2]	Yes	NA[6]	Yes*	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
299	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	No	Yes	Yes	Yes	Yes
300	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	No
301	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
302	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
303	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	NA[6]	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	Yes
304	Yes	NA[3]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[3]	NA[7]	Yes	No	NA[3]	Yes	Yes	Yes	NA[3]	NA[7]	Yes	NA[9]	NA[3]	NA[9]	NA[9]	Yes
305	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NA[7]	Yes	No	Yes	NVR	Yes	Yes	No	NA[7]	Yes*	NA[9]	Yes	NVR	Yes*	Yes
306	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
307	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	No	NA[7]	No	NVR	Yes	Yes	Yes	NVR	Yes	NA[7]	Yes	NVR	NA[9]	Yes	Yes*	No
308	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
309	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
310	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
311	Yes	NVR	Yes	Yes	NA[2]	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[2]	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
312	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
313	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
314	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
315	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
316	Yes	NVR	Yes	Yes	Yes	NVR	No	No	Yes	NVR	NA[7]	Yes	Yes	NVR	No	No	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
317	Yes	Yes	Yes	Yes	NA[2]	Yes	NVR	Yes*	No	No	NA[7]	No	NA[2]	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	No	NA[9]	NVR	No*	No
318	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
319	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
320	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
321	Yes	NVR	Yes	Yes	NA[11]	NVR	NVR	NA[11]	No	NVR	NA[7]	No	NA[11]	NVR	NVR	NA[11]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
322	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	No	Yes	NVR	Yes*	No	No	NA[7]	No	No	No	NVR	No	No
323	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
324	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	Yes	NA[7]	Yes*	NA[12]	Yes	NVR	Yes	Yes	No	NA[7]	Yes	NA[9]	NA[9]	NVR	NA[9]	Yes
325	Yes	NVR	Yes	Yes	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NA[2]	NA[2]	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
326	Yes	Yes	Yes	Yes	NA[2]	Yes	NVR	Yes*	Yes	Yes	NA[7]	Yes	NA[2]	Yes	NVR	Yes*	No	Yes	NA[7]	Yes*	NA[9]	NA[9]	NVR	NA[9]	Yes
327	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
328	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
329	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
330	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No
331	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	No
332	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
333	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	Yes	Yes	NVR	Yes	NA[7]	Yes	NVR	NA[9]	NA[9]	NA[9]	Yes
334	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	NA[9]	NVR	NA[9]	Yes

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
335	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	NVR	Yes	Yes	NA[8]	NA[7]	Yes	Yes	NA[8]	NVR	Yes	Yes
336	Yes	Yes	Yes	Yes	NA[2]	Yes	No	Yes*	No	NA[5]	NA[7]	No	NA[2]	Yes	No	Yes*	Yes	NA[5]	NA[7]	Yes	No	NA[5]	Yes	Yes	No
337	NVR	NVR	Yes	Yes	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	No	No	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	No
338	No	NVR	Yes	Yes	NA[1]	NVR	NVR	NA[1]	NA[1]	NVR	NA[7]	NA[1]	NA[1]	NVR	NVR	NA[1]	NA[1]	NVR	NA[7]	NA[1]	NA[1]	NVR	NVR	NA[1]	NVR
339	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	No	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	No	Yes	Yes*	No
340	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	NA[9]	NVR	NA[9]	Yes
341	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No
342	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NA[9]	NA[9]	No
343	Yes	NVR	Yes	Yes	Yes	NVR	No	No	No	NVR	NA[7]	No	No	NVR	No	No	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No
344	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
345	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
346	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	Yes	NA[7]	Yes*	Yes	Yes	NVR	Yes	No	No	NA[7]	No	No	NA[9]	NVR	No*	No
347	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
348	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
349	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
350	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	NA[9]	NA[9]	No
351	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No
352	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
353	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	No	NVR	NVR	No	No
354	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	No	NVR	No	No
355	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	NA[9]	NA[9]	NVR
356	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No
357	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
358	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
359	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NA[9]	NA[9]	Yes
360	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	NA[9]	NA[9]	No
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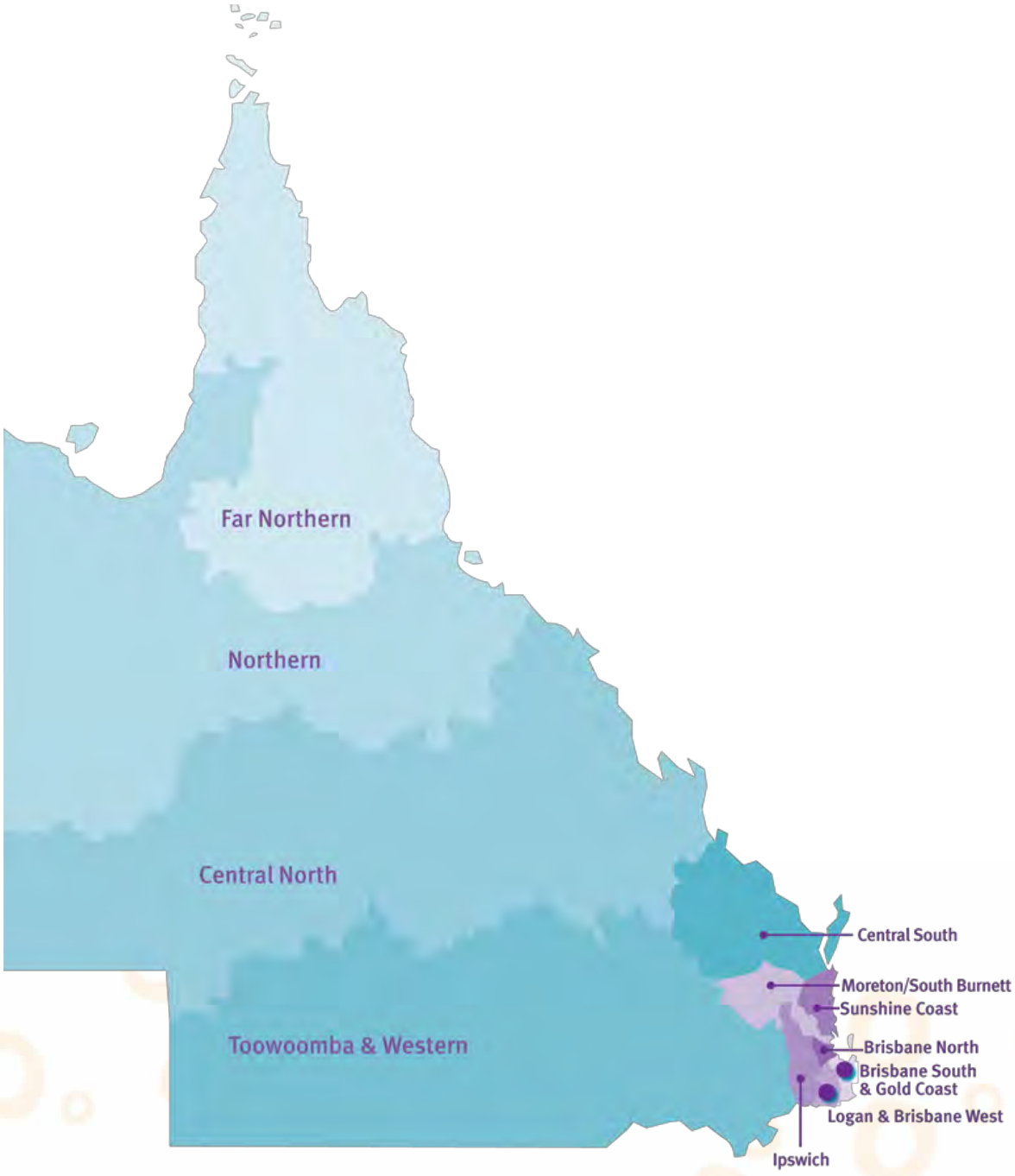
362	Yes	NVR	Yes	Yes	No	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
363	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
364	Yes	NVR	Yes	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
365	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	NA[9]	NVR	NVR	NA[9]	No
366	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	Yes	Yes	NVR	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NVR	NA[9]	No
367	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
368	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	NA[7]	Yes*	Yes	Yes	Yes	Yes	No	No	NA[7]	No	NA[9]	NA[9]	NA[9]	NA[9]	No
369	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
370	Yes	Yes	Yes	Yes	Yes	Yes	NVR	Yes	No	No	NA[7]	No	NA[6]	Yes	NVR	Yes*	Yes	No	NA[7]	Yes*	NA[9]	NA[9]	NVR	NA[9]	No

ID	CSO - Step 1	RE - Step 1	ICMS - Step 1	Overall Step 1	CSO - Step 2	RE - Step 2	ICMS - Step 2	Overall Step 2	CSO - Step 3	RE - Step 3	ICMS - Step 3	Overall Step 3	CSO - Step 4 - Part A -	RE - Step 4 - Part A	ICMS - Step 4 - Part A	Overall Step 4 – Part A	CSO - Step 4 - Part B	RE - Step 4 - Part B	ICMS - Step 4 - Part B	Overall Step 4 – Part B	CSO - Step 5	RE – Step 5	ICMS - Step 5	Overall Step 5	Compliance summary
371	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	Yes	NA[9]	Yes	Yes*	No
372	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
373	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
374	NVR	Yes	Yes	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	Yes	NVR	Yes	NVR	Yes	NA[7]	Yes	NVR	NA[9]	NVR	NA[9]	Yes
375	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	Yes	Yes	Yes	Yes	No	No	NA[7]	No	Yes	NA[9]	Yes	Yes*	No
376	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No
377	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	Yes	NVR	NVR	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
378	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NVR	NA[9]	Yes
379	NVR	NVR	Yes	Yes	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR	NVR	NA[7]	NVR	NVR	NVR	Yes	Yes	NVR
380	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
381	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	Yes	NVR	Yes	Yes	Yes	NVR	NA[7]	Yes	NA[9]	NVR	NA[9]	NA[9]	Yes
382	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	No	Yes	Yes	Yes	Yes	Yes	NA[7]	Yes	NA[9]	NA[9]	NA[9]	NA[9]	Yes
383	NVR	NVR	Yes	Yes	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR	NVR	NA[7]	NVR	NVR	NVR	NVR	NVR	NVR
384	Yes	NVR	Yes	Yes	NA[2]	NVR	NVR	NA[2]	No	NVR	NA[7]	No	NA[2]	NVR	NVR	NA[2]	Yes	NVR	NA[7]	Yes	No	NVR	NVR	No	No
385	Yes	NVR	Yes	Yes	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No	NVR	NA[7]	No	No	NVR	NVR	No	No
386	Yes	NVR	Yes	Yes	Yes	NVR	NVR	Yes	No	NVR	NA[7]	No	No	NVR	NVR	No	Yes	NVR	NA[7]	Yes	Yes	NVR	NVR	Yes	No
387	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No	NVR	NA[7]	No	NA[9]	NVR	Yes	Yes	No
388	Yes	NVR	Yes	Yes	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	Yes	NVR	Yes	Yes	No	NVR	NA[7]	No	No	NVR	Yes	Yes	No

Compliance summary	58
Overall Step 5	148
ICMS - Step 5	91
RE – Step 5	12
CSO - Step 5	89
Overall Step 4 – Part B	180
ICMS - Step 4 - Part B	NA[7]
RE - Step 4 - Part B	34
CSO - Step 4 - Part B	155
Overall Step 4 – Part A	224
ICMS - Step 4 - Part A	151
RE - Step 4 - Part A	76
CSO - Step 4 - Part A -	140
Overall Step 3	99
ICMS - Step 3	NA[7]
RE - Step 3	34
CSO - Step 3	77
Overall Step 2	242
ICMS - Step 2	160
RE - Step 2	84
CSO - Step 2	171
Overall Step 1	388
ICMS - Step 1	388
RE - Step 1	79
CSO - Step 1	295
ID	Total yes

Appendix 8

The Commission for Children and Young People and Child Guardian Community Visitor Zones



Appendix 9

Dictionary and Abbreviations

Administrative compliance

A report of the number of Aboriginal and Torres Strait Islander children and young people placed with Indigenous or kinship carers (an outcome of the decision making process) rather than a report of the number of placement decisions that complied with each requirement of the decision making process prescribed in section 83 of the *Child Protection Act 1999* when making a placement decision for an Aboriginal and/or Torres Strait Islander child or young person.

Case plan

A written document identifying the goals of the ongoing child protection intervention with a child and the outcomes and actions required to achieve the goals. The *Child Protection Act 1999* states that every child who is in need of protection and requires ongoing help (such as those in out-of-home care) must have a case plan[148] that is reviewed regularly.[149] At a minimum, case plans must be reviewed every six months.[150] The plan should be focused on meeting the child's protection and care needs, and is developed in a participative process between Department of Communities, the child, the child's family and other significant people.[151]

Children (when used within the context of the Commission Views of Young People Queensland Reports)

Persons aged 5 to 8 years.

Children and young people or children

Persons aged 0 to 18 years.

Child protection order

Under section 54 of the *Child Protection Act 1999* an authorised officer may apply to the Childrens Court for a child protection order for a child. Section 59 of the *Child Protection Act 1999* specifies that a court may make a child protection order only if it is satisfied the child is in need of protection and the order is appropriate and desirable for the child's protection.

Child Safety Officer or CSO

Child Safety Officers provide statutory child protection services to children and families through:

- undertaking the roles of an authorised officer under the *Child Protection Act 1999*
- the application of relevant legislation, delegations, policies, procedures and quality standards

[148] Section 51C of the *Child Protection Act 1999*.

[149] Section 51A of the *Child Protection Act 1999*.

[150] Section 51V of the *Child Protection Act 1999*.

[151] Section 51L of the *Child Protection Act 1999*.

- working collaboratively with approved carers, the community, government and non-government service providers.[152]

Child protection system or child safety system

The child protection system includes the services collectively delivered by the Department of Communities (as lead agency) and relevant government service providers, including Queensland Health and the Department of Education and Training as well as non-government service providers. The system also includes children and young people of whom the Department becomes aware because of allegations of harm or risk of harm, regardless of whether these children enter out-of-home care.

Child Safety Service Centre or CSSC and Child Safety Region

Regional offices of the Department of Communities (see regions).

Commission Community Visitors or CVs

Employees of the Commission who monitor the safety and wellbeing of children and young people in out-of-home care by conducting regular and frequent visits and advocating on behalf of children and young people to resolve any issues.[153]

CVs regularly visit children and young people in out-of-home care and, after each visit, prepare a written report relating to the outcomes of their discussions with the child or young person and their observations of the standard of care provided. In 2009-10, a new report framework and information management system (called Jigsaw) was introduced to enhance CV reporting and individual and systemic advocacy.

The Department of Communities

The Department of Communities is responsible for the following areas of service delivery in Queensland:

- Aboriginal and Torres Strait Islander services
- Child Safety
- Community
- Disability and Community Care
- Housing and Homelessness
- Multicultural
- Sport and Recreation
- Women

In the majority, this report refers to the services provided by the child safety service delivery areas.

Harm

Under section 9 of the *Child Protection Act 1999*, harm to a child is defined as any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.

[152] Accessed at http://www.childsafety.qld.gov.au/practice-manual/introduction/cssc.html.
[153] Chapter 5 of the *Commission for Children and Young People and Child Guardian Act 2000*.

Integrated Client Management System or ICMS

ICMS is a statewide information system designed to enable staff to view comprehensive client histories, facilitate informed decision making and the enhance the effectiveness of interventions.[154] The system is intended to provide frontline staff with comprehensive information about children and young people at risk, their families and their carers. ICMS replaced the existing Child Protection System (CPS) and Families Information System (FAMJY) in 2007.[155]

Indigenous Child Placement Principle

A decision-making process that must be observed when placing Aboriginal and Torres Strait Islander children and young people in out-of-home care, as described in section 83 of the *Child Protection Act 1999.*

Out-of-home care (and the reporting on services provided to children and young people in out-of-home care)

Out-of-home care refers to placements of children, subject to statutory child protection intervention, with individuals and services approved or licensed under the *Child Protection Act 1999*. Out-of-home care includes placements with:

- a licensed care service, or
- an approved carer.

The Department of Communities reports on this group of children and young people as follows:

1. Subject to protective orders:
   This measure includes all children and young people subject to short and long-term child protection orders and court assessment orders.

2. In out-of-home care:
   This measure is reported in accordance with the nationally agreed reporting definitions. It includes care provided to all children and young people in out-of-home care (including foster care, kinship care, provisionally approved care and residential services).

3. Living away from home:
   Data reported under this category includes all children and young people who have been removed from their home, regardless of whether the placement is departmentally funded or unfunded. It is important to note that not all of these children and young people are subject to a protective order, but are subject to some form of intervention by the Department.

The reporting on the services provided to children and young people in out-of-home care is also impacted by their custody and guardianship arrangements. The child protection system is required to provide more services to children and young people in the custody or guardianship of the chief executive, for example Education Support Plans and Child Health Passports.

For children and young people in out-of-home care, the Commission's Community Visitor Program is legislatively obligated to visit children and young people who are in the custody or guardianship of the chief executive.

[154] Accessed at page 16 http://www.childsafety.qld.gov.au/department/annual-report/documents/dchs-annual-report-2006-full.pdf.
[155] Accessed at page 47 http://www.childsafety.qld.gov.au/department/annual-report/documents/dchs-annual-report-2006-full.pdf.

This means that the reporting on services provided to children and young people in out-of-home care is a complex matter. Care has been taken throughout the report to clearly identify the population to whom is being referred.

Recognised Entity or RE

An entity (an individual or organisation) with whom the Department must either provide the opportunity to participate in decision-making processes for significant decisions or consult with for all other decisions relating to the protection and care of Aboriginal and Torres Strait Islander children, as outlined in sections 6 and 83 of the *Child Protection Act 1999*.

Regions

The Child Safety Service Centre regions are as follows:

- Brisbane region
- Central Queensland region
- Far North Queensland region
- North Coast region
- North Queensland region
- South East region
- South West region

Residential care

Non-family based accommodation for children and young people in out-of-home care. A licensed residential care service include rostered staff models and group homes, and may provide up to 24 hours a day care for children between the ages of 12-17 years. A younger child may also be placed in a licensed care residential care service where they are part of a larger sibling group, to keep siblings together. These placement types occur in a group setting of up to six young people.[156]

Systemic issues

Includes issues relating to children and young people in the child safety system which have affected, or will potentially affect, more than one child in a way detrimental to their rights, interests and wellbeing.

Young people (when used within the context of the Commission Views survey)

Persons aged 9 to 18 years.[157]

[156] Page 12, chapter 5, *Child Safety Practice Manual*.
[157] Page 3 of *Commission Views of Children and Young People in Foster Care, Queensland,* 2008.

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This document has been security classified using the Queensland Government Information Security Classification (QGISCF) as PUBLIC and will be managed according to the requirements of the QGISCF.

commission for
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A better life for Queensland children

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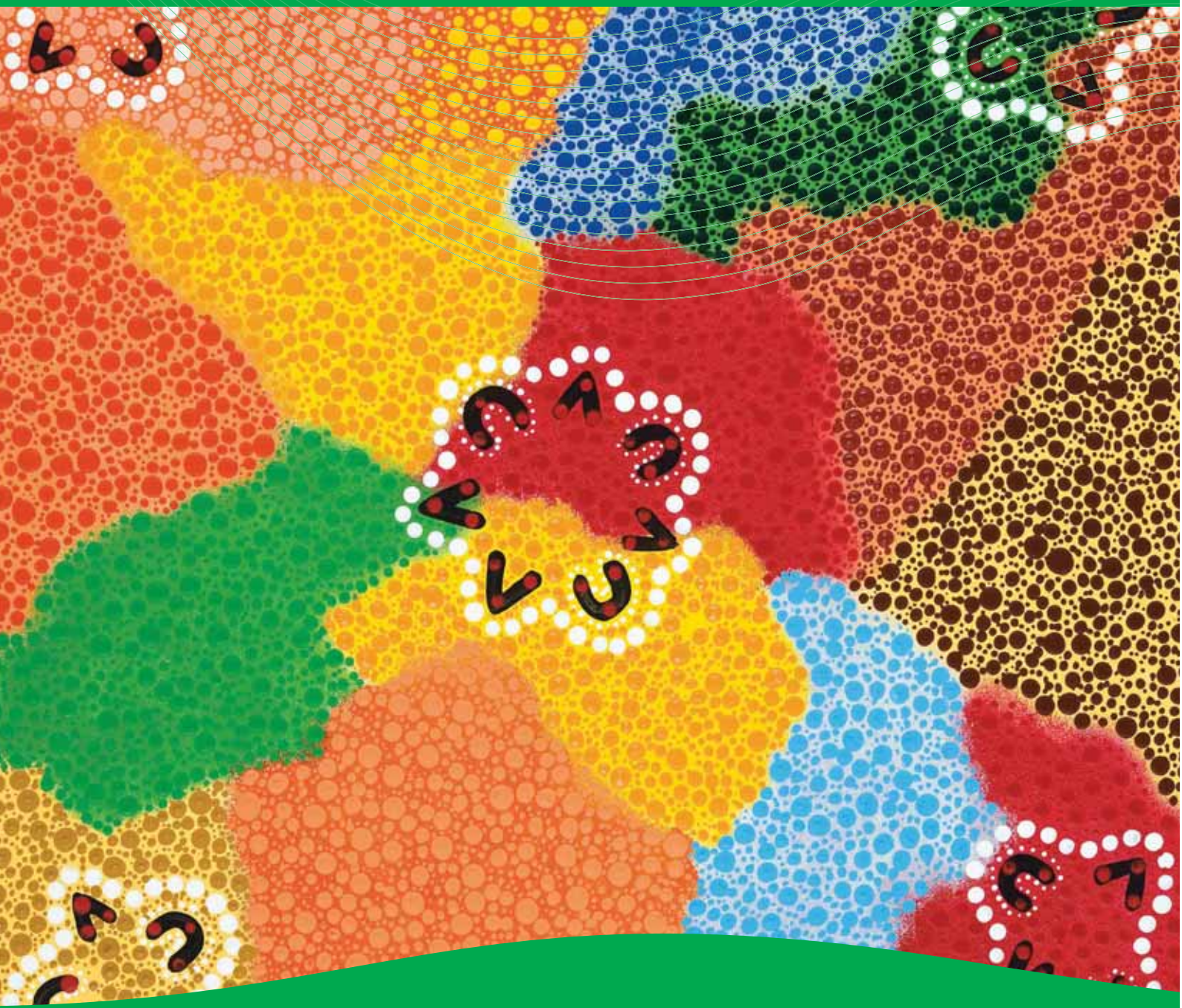
Views of Children and Young People in Foster Care

Queensland 2010



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commission for children and young people and child guardian

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- officers of the Commission's Strategic Marketing and Communication team for assistance with the publishing process.

Abbreviations

ADHD	attention-deficit hyperactivity disorder
CMC	Crime and Misconduct Commission
CSO	Child Safety Officer
CV	Community Visitor
ESP	Education Support Plan
SD	standard deviation

Cover artworks courtesy of *Youth Works* art program

Front cover: *Dots*, 2008
Back cover: *Behind the Purple Door*, 2008

- The *Youth Works* art program assists young people in the Brisbane and Townsville (Cleveland) youth detention centres to "create a brighter future through art".
- *Youth Works* is one of a range of programs offered to help these young people develop job and life skills and divert them from the youth justice system once they return to the community.
- The culmination of the art program is an annual art exhibition held in Brisbane and Townsville.
- The art program and exhibitions are a collaborative effort between the Department of Communities and Education Queensland.
- The exhibitions provide an opportunity for the community to recognise the young people's artistic talent.
- All proceeds from the sale of the artworks are paid into the trust account for each young person.

September 2010

Dear Minister

I am pleased to present you with the Commission's report *Views of Children and Young People in Foster Care, Queensland, 2010*. This report details the Commission for Children and Young People and Child Guardian's third survey of the views and experiences of children and young people in foster care in Queensland.

The survey recognises that children and young people in state care have important views which are valid and can be used by decision-makers, practitioners and researchers to improve the interventions and support provided to children and young people in the child protection system.

Yours sincerely

Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

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Foreword

It is my pleasure to present the *Views of Children and Young People in Foster Care, Queensland, 2010*. This report details the findings of the Commission's third survey of children and young people in foster care.

The *Views* research comprises the largest repeated cross-sectional longitudinal study of its kind involving the direct participation of children and young people in state care. The research explores the perceptions and experiences of children and young people in foster and kinship care, residential care and youth detention and monitors changes in these over time. Alongside other monitoring and performance data, the Commission believes that the views of children and young people, as expressed through these surveys, provide a critical perspective on the effectiveness of Queensland's child protection, residential care and youth justice systems.

The survey findings presented in this report point to strengths of the child protection system as well as to areas where improvements need to be made. The report reveals, for instance, that the vast majority of children and young people in care feel safe, loved and cared for and treated well. They are also very satisfied with the support and advocacy provided by their Community Visitors. These findings are particularly heartening given the substantial changes made to the child protection system in the decade since the Forde and CMC inquiries. Also encouraging are findings which point to notable improvements over the years, for instance, in relation to the support provided by Child Safety Officers and in the number of children and young people who report having case plans and education support plans.

The report also reveals that a considerable number of children and young people continue to experience numerous placement changes, have a variety of unmet health and education support needs, do not feel involved in decisions that affect them, and are worried about further placement changes. Many young people also indicated that they were prefer not to leave their foster care family once they turn 18.

The Commission will continue to work closely with the Department of Communities and other government and non-government agencies responsible for administering child protection so that children and young people in these systems can enjoy the kinds of positive life circumstances that other children experience.

I would like to thank sincerely those who participated in the survey for their trust and courage in sharing with us their experiences and perceptions of life in care. I also appreciate the role that carers played in making the survey possible by accommodating longer than usual visits and helping children and young people complete and return the questionnaires about Community Visitors.

I encourage you to read this report and be open to what young people have to tell us about their lives in care and their views about what we can do better for them.

Elizabeth Fraser
Commissioner for Children and Young People
and Child Guardian

Summary of findings

The study

- This report presents the findings of the third Views of Children and Young People in Foster Care survey. The survey captures the views and experiences of children and young people living in foster care, kinship care and specialist foster care in Queensland.
- The foster care survey comprises several self-report questionnaires that feature closed and select responses questions. Two questionnaires (one for young people and one for children) focus on satisfaction with foster care and two questionnaires (one for young people and one for children) focus on satisfaction with Community Visitors (CVs). Another questionnaire (for carers to complete on behalf of young children or those who, because of a disability, are unable to express an opinion) includes questions on satisfaction with both foster care and CVs. CVs assist children and young people to complete the foster care survey, while carers assist the children and young people to complete the survey on CVs.

Satisfaction with care survey

In total, 2727 young people, children and carers on behalf of young children responded to this survey. Respondents have a mean age of 8 years 9 months and come from all geographical regions of Queensland. Slightly more females than males responded. Around two thirds are in foster care and 29% in kinship care. Around two thirds are of Caucasian Australian background and around 28% of Aboriginal background. Approximately 80% report having a carer of the same cultural background.

Wellbeing and health

- It is pleasing that the vast majority of children and young people report feeling happy, healthy, loved and cared for by someone. Of concern, however, is the substantial proportion who report that they often worry about things.
- A considerable number of respondents also appear to experience health problems although the proportion reporting to have received help for these problems has increased significantly since 2007. Reports of having a child health passport have more than doubled from 7.0% in 2007 to the current rate of 15.5%. According to 43.1% of carers responding on behalf of young children, the child in their care has a child health passport.
- Respiratory, dental and mental health problems continue to be some of the most common problems experienced by respondents.
- Around 18% of young people, 17% of children and 23% of young children report having some kind of disability. The nature of disabilities mentioned varies considerably but includes cognitive/learning disorders, autistic spectrum disorder, Aspergers syndrome, foetal alcohol syndrome, and Down syndrome.
- Some of the ‘disabilities’ identified by respondents are disorders that might more commonly be perceived as health problems (for example, attention deficit hyperactivity disorder (ADHD) and epilepsy). Given this perception, the reported rates of disability are likely to be somewhat inflated.
- Reported rates of taking medication for ADHD remain persistently high among the children (15.2%) and young people (16.4%). Although not medically recommended for under 6 year-olds, responses from carers indicated that many children under the age of 6 are being medicated for ADHD.

Education

- Reports from young people and children indicate that many experience difficulties at school.
- More than one quarter of young people and around 16% of children report having been kept back a year at school on at least one occasion.
- More than four in ten young people report having been suspended from school at some time and almost one in ten have been formally excluded (expelled).
- Around one third of children and young people report experiencing one or more problems at school. For both children and young people, the most commonly reported problem is school work, followed by bullying.
- More than half the young people report having an Education Support Plan. Of this group more than three quarters consider their plan to be helpful. These proportions have increased significantly over the years.

- Also encouraging is the finding that, of the small proportion of young people who are not attending school, most are participating in other training or education or are working.

Placement histories

There have been some marked changes over the years in some aspects of respondents' placement histories.

- The mean age at which the current cohort first came into care was 4 years 9 months, compared with 4 years and 7 months in 2006 and 4 years 5 months in 2007.
- The mean number of placement changes has increased significantly from 2.6 in 2007 to 2.8 for the current cohort. More than 60% of the cohort reported experiencing more than one placement, 534 of whom reported experiencing 4 or more placements.
- Of concern are the numbers of respondents reporting to have experienced numerous placement changes. In 2009, 77 respondents reported having 10 or more placements. In 2007, this number was 32.

Other aspects of placement histories have remained stable.

- The mean length of time that respondents have been in their current placement is 3 years and 2 months while the total length of time in care averages 4 years and 7 months.
- The mean number of times that respondents have been returned home to their birth family is 0.33. Although this indicates that the majority of respondents have not experienced a failed reunification, 71 respondents reported having been returned home 3 or more times.

Current placement

Consistent with 2006 and 2007 findings, almost all the young people and children report feeling safe and happy in their current placement.

- The vast majority also report that: their carer listens to them and treats them well; they are treated the same as other children and young people in the household; the rules and discipline are reasonable; and their possessions are treated with respect.
- For most children and young people, the best things about their placement are lifestyle factors and the relationship they have with their carer.
- Suggestions for improvements include the need for changes to the household membership or management, more material goods and services, alterations to the premises, more contact with birth family, and greater access to opportunities and activities.
- Household sizes vary considerably with numbers of other children and young people in the household ranging from 0 to 20 with an average of 2.9.

Having a say

There have been positive changes in relation to case plans and young people's perceptions that they are listened to and have decisions explained to them.

- Almost two thirds of young people report having a case plan – a significant increase on the proportions in 2006 and 2007. Furthermore, responses from carers reveal that more than 80% of young children have a case plan.
- There have also been significant increases over the years in the proportion of young people reporting that they are listened to all or most of the time. A similar proportion of children also report that they are listened to.
- Young people's reports of having decisions explained have also increased significantly since 2006 and 2007 although almost one third continue to feel that decisions are not explained to them.

In contrast to these improvements, having a say in matters that affect them appears to be a growing source of discontent for many young people.

- Almost half (47.3%) indicated that they rarely or never have a say in what happens to them, significantly more than the 2007 proportion of 40.6%.
- Almost one fifth of young people continue to report being worried that they will have to change placements in the coming months.
- In addition, only one third of young people reported having been told what to expect about being in care.
- Around one third of young people and almost half of the children reported that no one had explained to them why they came into care. It was evident from their comments, however, that many already knew the reason or felt they would have been too young at the time to understand.

Impacts of being in care

Children's and young people's views about the daily impacts of being in care were varied.

- Most report that they do not miss out on things, have to do things that they don't want to do, or are made to feel different because they are in care.
- According to many young people, however, obtaining permission to do things is a problem. For almost one third (30.8%) permission is not often or never given in time to do things and for 46.8% the types of things that permission is required for are not reasonable.
- Permissions are also an issue for carers responding on behalf of young children with around 30% reporting that the types of things that they need permission for in relation to the child in their care are not reasonable. Many carers commented on difficulties obtaining permission and the need for more autonomy when it comes to making decisions about medical interventions, hair cuts, holidays, and outings.
- Confidence in the department's assurances is another issue for young people. Less than half (48.6%) reported feeling confident that when the department says they can do, or have, something it will happen.

Contact with family and community

Contact with family continues to be a source of discontent for many children and young people although there have been some notable improvements over the years.

- More than 40% of children and young people would like to see their family more often. For children, however, this figure represents a significant improvement since 2007 when almost 70% reported wanting to see their family more.
- In contrast, only 16% of carers feel that the child should see their family more often. Nevertheless, this is significantly more than the 11% of carers in 2007.
- Children and young people are more likely to be satisfied with how often they get to speak to their family. More than two thirds of the young people and just over half of the children indicated being happy with how often they talk with their family. It is noteworthy that the proportion of children reporting to be satisfied with how often they see and speak to their family has increased significantly since 2006 and 2007.
- Of those with Aboriginal and Torres Strait Islander backgrounds, more than 70% report being in touch with their community. This represents a statistically significant increase on the 2007 figure of 63%. Those with a carer of the same cultural background were significantly more likely than those with a carer of a different background to report being in touch with their community.

Support and advocacy

- It is encouraging that the majority of children and young people appear to know who they can contact if they need help. That said, less than half the young people are aware that they can contact the Children Services Tribunal (now the Queensland Civil and Administrative Tribunal (QCAT) if they are unhappy with a departmental decision.
- Around 9% of young people reported having contacted the Commission about a concern or complaint.
- Only 17% of young people whose case went to court reported having their own lawyer.

Areas for improvement

Findings indicate that the vast majority of young people feel that their lives have improved since coming into care. Notwithstanding, comments from young people, children and carers of young children pointed to how the current placement or the system in general might be changed or improved.

- Although 88.1% of young people acknowledged that they are better off since coming into care, this figure represents a significant decline since 2007 when 92.6% reported feeling better off.
- Related to this, a substantial proportion of young people (27.1%) and children (29.3%) indicated that there is something that they would like to have happen that no one is listening to them about. The issues most commonly raised are more contact with family and friends, more material assistance or improved access to services, changes to care arrangements such as a placement change or guardianship of carer, and more participation in activities.
- More than one third of the carers would like things to be done differently for the child in their care. Their comments focused on better case planning and management by the department, greater support and understanding, and changes to family arrangements.

- Numerous young people and carers offered suggestions for how the system could be improved for those in care. Young people's suggestions included improved departmental communication and decision-making, greater support and understanding, more contact with birth family and Child Safety Officers (CSOs), and more and better foster carers.
- Improvements noted by carers included greater involvement on their part in decision-making, more experienced CSOs and more frequent visits from CSOs, prioritising permanency planning, improved communication processes, and greater focus on the best interests of the child.

Child Safety Officers

Overall, there appears to be widespread and growing satisfaction with the nature of contact that respondents have with CSOs although many would still like to see their CSO more often.

- The vast majority of children and young people also feel that their CSO is nice to them, listens to them and cares about what is best for them. Likewise, most carers report that the CSO cares about the interests of the child in their care. Analyses also reveal significant improvements in these responses over the years.
- Most young people and carers consider their CSO to be helpful with ratings of helpfulness increasing significantly since 2006 and 2007.The majority of children also reported that their CSO has helped them with something.
- Things that respondents mentioned CSOs had helped with include help at school and help with finding family members.
- More than half (51.3%) the young people and 45.8% of carers of young children reported seeing their CSO around once per month. When asked if they see their CSO 'much' more than half (51.6%) of the children reported that they do.
- Although reports from young people and children point to a significant increase over the years in the frequency with which CSOs visit, a substantial proportion of young people (32.3%), children (45.3%) and carers (29.1%) would like to see their CSO more often.

Leaving care

Many young people aged 16-18 years appear to feel prepared for life after their foster care placement.

- Around 70% indicated that someone has spoken to them about what will happen to their care situation when they turn 18 and more than three quarters (79.7%) reported feeling confident that they will be able to manage independent living.
- Despite this, more than half (54.2%) expressed a preference to stay with their foster care family beyond 18 years of age.
- The vast majority (87.7%) also anticipate needing help once they leave care, particularly help with finding accommodation and gaining financial assistance, while around 86% acknowledge that a range of supports will assist their transition from care. The type of support most often identified was staying in contact with the foster care family.
- Only 37.2% reported having a leaving care plan. The vast majority of these young people reported being involved in the development of their plan.

Satisfaction with Community Visitors survey

In total, 2227 young people, children and carers on behalf of young children responded to this survey. The overall mean age for the three groups combined is 8 years 5 months. Slightly more females than males responded. Around two thirds of the group is in foster care and 28% in kinship care. Almost two thirds are of Caucasian Australian background and around 28% of Aboriginal background.

Community Visitors

Reports from young people, children and carers indicate that CVs continue to perform an important and valued role in the lives of those in care.

- Most respondents report that the CV listens to them and cares about their best interests. They are able to contact their CV if needed and appear satisfied with the frequency of CV visits. Satisfaction with the frequency of CV visits has increased significantly since 2007.
- Ratings of CV helpfulness remain consistently high. Comments from respondents highlight the numerous ways in which CVs have been able help children and young people in care. Commonly listed were listening to problems and liaising with the department about medical appointments, care arrangements, contact with family, transition from care plans and assisting with school issues and homework.

Introduction

This report presents the findings of the Commission's third survey of children and young people in foster and kinship care in Queensland. The survey is part of the Commission's *Views of Children and Young People* survey series (the *Views* surveys) – an ongoing body of research that gathers the views and experiences of young people in foster and kinship care, residential care and youth detention. The Commission conducts the *Views* surveys because it strongly believes that the views and experiences of children and young people in state care and youth detention must be heard and seriously considered in order to continuously improve the effectiveness of Queensland's child protection and youth justice systems.

Purpose of the *Views* surveys

The *Views* surveys serve at least three important functions. Firstly, they are a means of engaging a particularly vulnerable group of children and young people – those in state care and youth detention. The United Nations Convention on the Rights of the Child, ratified by the Australian Government in 1989, declares that children and young people have the right to be consulted and their views taken into consideration, to have access to information, to freedom of speech and opinion, and to challenge decisions made on their behalf (United Nations, 1991). This right has been codified in Australian legislation, including the *Queensland Child Protection Act 1999*. The principle is also embedded in the legislation that frames the operation of the Commission. In performing its functions, the Commission is required to consult with, listen to, and seriously consider, the concerns, views and wishes of children, particularly those most vulnerable. The *Views* research upholds this position by providing children and young people with an opportunity to express their opinions on the child protection and youth justice systems.

Secondly, the *Views* surveys contribute to knowledge about the needs and circumstances of children and young people in state care and youth detention and the extent to which their needs are being met. Such an evidence base is essential for addressing the personal and social disadvantages that often underpin children's and young people's entry into these systems. Through the *Views* surveys, children and young people in state care or detention are able to provide information about their individual circumstances including the nature and extent of problems they are experiencing and the helpfulness of initiatives developed to meet their needs.

And, finally, the *Views* surveys serve as a mechanism for monitoring the safety and wellbeing of children and young people in state care and youth detention. Recent public inquiries in Queensland[1] have highlighted the considerable vulnerability of children and young people in the care of the state to abuse and/or neglect. These inquiries underscore the importance of having effective mechanisms for children and young people to communicate their needs and concerns and voice complaints about the services provided to them. Through the *Views* surveys, children and young people can raise issues of concern that they feel no one is listening to them about.

The *Views of Children and Young People in Foster Care* surveys

The *Views of Children and Young People in Foster Care* survey provides an opportunity for children and young people in foster care to share their views and experiences of state care. The Commission's first survey of children and young people in foster care in Queensland was conducted in 2006. At this time, a total of 1703 children and young people participated. The second survey, conducted in 2007, attracted 1767 respondents. Findings from these surveys have consistently shown that respondents have been generally happy with many aspects of their care situation. Respondents have generally reported, for instance:

- feeling safe in their current placement
- being treated well by their carer, and
- being understood by their carer.

[1] The 1999 Commission of Inquiry into the Abuse of Children in Queensland Institutions and the 2003 Crime and Misconduct Commission Inquiry into Abuse of Children in Foster Care.

On the other hand, areas of concern that have emerged from the findings include:

- a high proportion of children and young people who think their views are not seriously considered
- large numbers experiencing many different care placements
- the number of attempts at family reunification for some children
- the length of time in care without permanency planning
- a lack of confidence that when the department approves something it will actually happen
- the high proportion of young people who do not know if they have a Case Plan
- the high proportion of children and young people wanting more contact with their family and their CSO, and
- difficulties associated with obtaining permission to do things.

Implications to date of the *Views* foster care findings

Insights gained through the survey provide an invaluable perspective on the effectiveness of Queensland's child protection system. They help the Commission to identify individual and systemic risks to children's and young people's safety, wellbeing and rights as well as providing first hand information on the availability and responsiveness of programs and services. The survey findings also help inform child protection policy and practice decisions and contribute to a range of departmental performance indicators.

Report structure

The report is divided into four main sections:

Context of the research outlines the context of the research, in particular the child protection system and the role that foster care plays within it.

Research design describes the respondents, instruments, procedure and data analyses involved in the study, along with the strengths and limitations of the research design.

Findings is divided into two main sections: Satisfaction with care and Satisfaction with Community Visitors. These sections are further divided into sub sections according to the focus of the survey questions. Each sub section commences with an introduction and concludes with a summary of the key findings. For the most part, findings are presented in the form of frequencies and percentages. Comments from children and young people are also included to further highlight or exemplify responses to particular items. A more complete list of comments in response to selected questions can be found in the appendix.

Discussion and future directions discusses the findings in light of other research in the area and relevant policy initiatives or directions. It also highlights implications for policy and describes the future directions for the Commission's work relating to children and young people in care.

Context of the research

The child protection system

Foster care sits within a larger child protection system designed to investigate and intervene where children and young people do not have a parent able and willing to care for them adequately. In Queensland, there is a whole-of-government approach to child protection, although the Department of Communities, which administers the *Child Protection Act 1999*, is primarily responsible. Until March 2009 the Act was administered by a dedicated Department of Child Safety. At this time, this department was subsumed by the Department of Communities in machinery-of-government changes.

Although the number of children in out-of-home care continues to grow, reaching 7093 children and young people at 30 June 2009 (Australian Institute of Health and Welfare, 2010), it is still a relatively small proportion of cases where contact with the child protection system results in out-of-home care. In the year ending 30 June 2009, 44,589 children were the subject of a child concern report and 20,959 children were the subject of a notification. In the vast majority of cases no further departmental action is required but in a minority of cases a child is assessed to be in need of protection, in which case the department has an obligation to intervene.

There are a number of intervention options and priority is given to options that allow children and young people to remain with their families while support is provided to address child protection concerns. Where parents are not able or willing to work with the department to address immediate concerns, children and young people are placed away from home. Preference is given to placing children and young people with parents' consent but a court order transferring custody or guardianship to the chief executive of the department can be sought where consent is not forthcoming.

Care agreements made with parental consent and the majority of court orders transfer custody to the chief executive while guardianship remains with parents. In a smaller number of cases guardianship is also transferred by court order. In cases where only custody is transferred, day to day decisions about the child or young person are made by the carer under the authority of the department but long term decisions, for example relating to health and education, continue to be made by parents. Under a guardianship order both short and long term decisions are transferred to the chief executive. Day-to-day decisions are delegated to carers and departmental staff are responsible for long term decisions on behalf of the chief executive.

When children and young people are placed in out-of-home care reunification with family is the initial goal. In some cases, reunification will not be possible so a permanent out-of-home care solution is planned in parallel. If it becomes clear that reunification will not be possible, long term orders that remain in effect until the child turns 18 may be sought from the court. In some cases guardianship may be retained by the chief executive and in others guardianship is transferred to a suitable carer. This is usually a family member, although guardianship can be transferred to a biologically unrelated carer with the support of the department.

Children's and young people's rights

Children and young people in the care of the state are afforded a special set of rights under the *Child Protection Act 1999*. For these children, the state's obligation goes beyond protecting them from abuse and neglect and extends to providing for their overall health and wellbeing. Where guardianship has been transferred to a carer as described above, these rights do not apply, although the department retains an oversight role and is still required to intervene where children may be at risk of harm.

Under s122 of the Act the department must meet the following standards of care for children and young people in the custody or guardianship of the chief executive. The standards are to be applied taking into account the length of time the child or young person has been in care and their age and development.

a) the child's dignity and rights will be respected at all times
b) the child's needs for physical care will be met, including adequate food, clothing and shelter

c) the child will receive emotional care that allows him or her to experience being cared about and valued and that contributes to the child's positive self-regard
d) the child's needs relating to his or her culture and ethnic grouping will be met
e) the child's material needs relating to his or her schooling, physical and mental stimulation, recreation and general living will be met
f) the child will receive education, training or employment opportunities relevant to the child's age and ability
g) the child will receive positive guidance when necessary to help him or her to change inappropriate behaviour (techniques for managing the child's behaviour must not include corporal punishment or punishment that humiliates, frightens or threatens the child in a way that is likely to cause emotional harm)
h) the child will receive dental, medical and therapeutic services necessary to meet his or her needs
i) the child will be given the opportunity to participate in positive social and recreational activities appropriate to his or her developmental level and age
j) the child will be encouraged to maintain family and other significant personal relationships (if the chief executive has custody or guardianship of the child, the child's carer must act in accordance with the chief executive's reasonable directions), and
k) if the child has a disability – the child will receive care and help appropriate to the child's special needs.

Further to this, s74 outlines a charter of rights for children and young people under the custody or guardianship of the chief executive.

a) to be provided with a safe and stable living environment
b) to be placed in care that best meets the child's needs and is most culturally appropriate
c) to maintain relationships with the child's family and community
d) to be consulted about, and to take part in making, decisions affecting the child's life (having regard to the child's age or ability to understand) particularly decisions about where the child is living, contact with the child's family and the child's health and schooling
e) to be given information about decisions and plans concerning the child's future and personal history, having regard to the child's age or ability to understand
f) to privacy, including, for example, in relation to the child's personal information
g) if the child is under the long-term guardianship of the chief executive, to regular review of the child's care arrangements
h) to have access to dental, medical and therapeutic services, necessary to meet the child's needs
i) to have access to education appropriate to the child's age and development
j) to have access to job training opportunities and help in finding appropriate employment, and
k) to receive appropriate help with the transition from being a child in care to independence, including, for example, help about housing, access to income support and training and education.

Both the department and the Commission monitor children and young people in out-of-home care to ensure these standards and rights are appropriately implemented. Where these standards are breached or rights violated the department has an obligation to rectify the situation and this may include providing assistance to carers or moving children and young people to placements more suited to their needs. Both the Commission and the department monitor out-of-home care at a systemic level to ensure policies and processes support children's and young people's rights.

Foster care

There are a variety of out-of-home care placement options including foster care, kinship care, residential care and independent living. A small number of children and young people in the custody or guardianship of the chief executive reside in other facilities including hospitals and juvenile detention and the department may also place children and young people with parents as part of the reunification process, although custody or guardianship may continue to be held by the chief executive.

Home-based foster care placements, including kinship care placements, are the preferred option for children and young people in the care of the state. In general, residential care is only used where children's and young people's needs cannot be provided for in home-based foster care and is considered suitable only for young people aged 12 or older. Independent living is only considered suitable for young people aged 15 or older. As such, the vast majority of children and young people in out-of-home care live in foster care placements. At 30 June 2009, there were 6649 children and young

people in home-based foster or kinship care in Queensland (Australian Institute of Health and Welfare, 2010), accounting for 87.6% of all children and young people in out-of-home care.

As far as possible, foster care provides children and young people with a normal family environment. A major advantage of foster care is that children and young people are given an opportunity to form relationships with carers and other family members. These caring relationships are extremely important for children's and young people's sense of wellbeing and development. At the same time, wherever possible, children and young people are encouraged to maintain relationships with their family of origin to maintain a sense of attachment to family and personal and cultural identity. Foster carers are required to facilitate these relationships.

Foster carers, including kinship carers, are screened by the department for suitability and all adult household members, including carers, are required to hold a Blue Card, which is issued by the Commission. Training in providing quality care is provided to all foster carers, although it is encouraged but not mandatory for kinship carers to participate. All carers including relatives receive ongoing support from the department to contribute to the costs of caring for the child in the form of regular fortnightly payments and payments for individual expenses as they arise, providing they are required under a case plan and approved by the department.

The Commission's role

The Commission for Children and Young People and Child Guardian promotes and protects the rights, interests and wellbeing of children and young people in Queensland. This includes a special responsibility for children and young people in the child protection system. In exercising this responsibility, the Commission undertakes a number of functions including the Community Visitor Program. Community Visitors (CVs) regularly visit and listen to children and young people in state care to see that they are safe and receiving appropriate care, to advocate on their behalf to help resolve any concerns or grievances and to offer support if required. Serious issues that cannot be resolved locally are escalated to the Commissioner for further action.

In addition, the Commission has a dedicated complaints resolution function that is able to address any complaint that relates to a child or young person in the child protection system who is not receiving adequate services. Children and young people or people making complaints on their behalf can contact the Commission's complaints team through their CVs or directly by telephone, email or SMS.

The Commission also takes a broader role of monitoring child protection at a systemic level. Information is gathered from a variety of sources including from CVs and complaints but also through reviews, audits, ongoing provision of administrative and performance data from the department and through research initiatives such as the *Views*. The Commission uses this information to work with the key stakeholders, including the department, to improve the way the child protection system operates, to advocate for changes to policies and legislation and to monitor and report on outcomes for children and young people in the child protection system.

Research design

A self-report survey is used to capture the views and experiences of children and young people in foster care. For the purposes of the report the term foster care generally refers to foster care, kinship care and specialist home-based foster care. The survey is repeated at regular intervals with cross-sections of children and young people in foster and kinship care using a common set of survey questions. This repeated cross-sectional longitudinal design allows changes in survey responses to be monitored over time.

Respondents

Children and young people who were living in foster and kinship care at the time of the survey period of 1 April to 26 June 2009 and who were visited by the Commission's Community Visitors (CVs) were invited to participate in the survey. In addition, questionnaires were distributed to carers to complete on behalf of young children or those who, because of a disability, were unable to express an opinion. Participation is voluntary and respondents remain anonymous. CVs are on hand to assist each child and young person to complete their survey. For the purposes of the study, foster care placement options consisted of short- and long-term foster care, kinship care and specialist foster care.

A total of 2727 respondents completed the survey. This number comprises 1180 questionnaires from young people, 769 questionnaires from children and 778 questionnaires from carers of young children. This represents 960 more surveys than was received in 2007 and 1024 more than in 2006.

In addition, 922 young people, 527 children and the same 778 carers of young children completed a questionnaire on the Commission's CVs.

Instruments

The survey instruments are based on those originally developed using focus group discussions with groups of children and young people living in state care across Queensland. The instruments were also informed by existing research in the field, particularly the seminal work by Cashmore and Paxman (1996), Delfabbro, Barber and Bentham (2002), and Barber and Delfabbro (2005) that explored the views of children in out-of-home care in South Australia.

Several government agencies were also consulted about the survey content. These agencies included the former Departments of Child Safety, Communities, Education, Training and the Arts, Housing, Justice and Attorney-General, and Disability Services Queensland. The core human services agencies continue to play a role in the ongoing development of the instruments.

To accommodate the different comprehension and literacy levels of the respondents, several questionnaires were developed. Two questionnaires focus on foster care and two on CVs. A questionnaire for carers of young children incorporates questions on both foster care and the Community Visitor Program. The focus of the questionnaires, their particular target group and administration methods as described below, have remained largely consistent over the years.

The survey sought information on respondents' background characteristics, health and wellbeing, education, placement histories and perceptions of current placement, as well as perceptions of Child Safety Officers (CSOs), the child protection system in general, and their CV. Select response, rating scale and open-ended questions were used to collect data. To ensure the comparability of data, the 2009 questionnaires remained largely consistent with those used in 2006 and 2007. That said, a number of new questions were added to the 2009 survey, namely those on wellbeing and transitions from care. In addition, the wording of some questions was refined to improve clarity and a number of prompts were introduced throughout the questionnaires to direct respondents to questions that were relevant to them.

- Questionnaire 1 focuses on foster care and comprises 79 items. It is designed for young people aged 9 to 18 years. Depending on their abilities, young people may complete the questionnaire independently or with the assistance of their CV.
- Questionnaire 2 focuses on foster care and comprises 50 items. It is targeted at children aged 5 to 8 years. CVs are required to complete the questionnaire with the child.

- Questionnaire 3 focuses on both foster care and the CVs and comprises 45 items. It is designed for children less than 5 years of age or for children and young people with a disability who are unable to express an opinion. Carers complete the questionnaire on behalf of these respondents.
- Questionnaire 4 focuses on CVs and comprises 15 items. Like questionnaire 1, it is designed for young people aged 9 to 18 years. Young people can complete the questionnaire independently or with the assistance of their carer.
- Questionnaire 5 focuses on the CVs, comprises 13 items and is designed for children aged 5 to 8 years. Carers complete this questionnaire with the child.

Procedure

Questionnaires for each young child, child and young person in care were distributed to all CVs. CVs administered questionnaires about foster care during their scheduled visits. In order to ensure impartiality, the CV questionnaires were not administered by CVs. Instead these questionnaires were given to carers to complete with the children and young people. In some cases, young people chose to complete the survey independently once the CVs had assisted with the completion of the demographic component of the survey. Surveys that were completed during a scheduled visit were returned to the Commission by CVs. Surveys completed after the visit were returned to the Commission in the reply-paid envelopes provided.

To ensure comparability of 2006, 2007 and 2009 data, processes for the distribution and administration of the questionnaires, along with the coding and interrogation of data, were largely replicated. The primary exception was that the survey administration period was extended from 2 months to 3 months allowing extra time for CVs to administer the survey.

Analysis of data

Before the data analyses, quantitative data from questionnaires were screened for accuracy of data entry and missing values. These data were then coded and analysed using *SPSS (Statistical Package for the Social Sciences) for Windows*. Frequency and descriptive statistics were employed to identify patterns or trends among responses.

Depending on the nature of the variables, inferential statistics using chi-square analyses and Kruskal–Wallace or Mann–Whitney tests of significance were employed to identify significant differences in responses across the 2006, 2007 and 2009 datasets. An alpha level of 0.05 was used as the level for significance.

Qualitative comments underwent thematic analyses that involved organising the various responses into topics or themes. As themes emerged during analysis, the data were organised categorically. These categories were reviewed repeatedly and reduced by grouping topics or themes that related to each other.

Strengths and limitations

One of the greatest strengths of the *Views* surveys is the sheer number of children and young people able to be included. The *Views* is the largest study in the world to directly involve the participation of children and young people in care. The size of the sample strengthens the statistical significance of the findings and coupled with the repeated cross-sectional longitudinal design allows trends to be identified and changes to be tracked over time.

The major advantage of involving children and young people directly is that it enables the researcher to tap directly into the subjective experiences of participants in a way that administrative data cannot. The *Views* surveys shed light on children's and young people's feelings of safety and happiness and their perceptions of being cared for and supported, which are integral to their overall experiences of wellbeing. To ensure foster care is a suitable environment for children and young people in the care of the state it is necessary to seek their views systematically and regularly and the *Views* surveys are the best mechanism for achieving this goal.

Apart from the subjective experiences of children and young people, the data generated by the *Views* surveys fill critical gaps in official departmental data. For example, the department is unable to calculate the number of reunifications, successful or otherwise, that children and young people experience. While a self-report survey is not the ideal avenue for collecting these factual data, in the absence of more appropriate departmental figures, it is the best available source of information.

As with any methodology, the *Views* surveys have some distinct limitations and it is important to acknowledge these. A concern for self-report surveys is the reliability of the respondents in recalling facts accurately. This is particularly relevant for children and young people who may have been in care for an extended period or who have had numerous placements. To maximise reliability of factual information, CVs assisted children and young people to complete demographic questions and encouraged and assisted them to seek external assistance to recall information. In some cases, CVs were able to provide reliable information from Commission records. While the assistance provided by CVs is likely to enhance the quality of factual information, it may bias other responses. To ensure this bias was minimised, CVs were provided with a detailed guide for administering the survey and participants were given verbal and written assurance that the survey would be private and anonymous except in circumstances where a child's or young person's safety or well being may have been at risk.

Finally, it is important to consider the representativeness of the sample and the generalisability of the findings. Data on the 6649 children and young people who were in foster care in Queensland at 30 June 2009 (Australian Institute of Health and Welfare, 2010), reveal similarities in terms of particular demographic characteristics (namely placement type, sex and cultural background) with the 2727 participants at the time that the survey was administered. Also similar are the proportions of children and young people within certain age groups. The exception here are children aged less than 1 year of age who comprised only 1.8% of survey participants compared to 3.8% of the general population in foster care.

It is also important to recognise that by using a three month timeframe for data collection, the *Views* surveys are more likely to capture the views of children and young people in care for extended periods. According to departmental figures, in approximately 35% of cases, children and young people exit care within 6 months of entering out-of-home care[2]. The majority of these children and young people will enter and leave care in between *Views* surveys without ever completing a survey while those who spend many years in care would have several opportunities to respond. Indeed, many children and young people participating in the 2009 survey will be the same children and young people who responded in 2006 and 2007.

As a result, the sample includes a relatively small number of children and young people who have been in care for less than six months (4% in the sample compared to approximately 35% of children and young people who go through the out-of-home care system) and a relatively large number of children and young people who have been in care for 5 or more years (39% compared to 11%[3]). This needs to be considered when making more general statements about the care population based upon the findings.

[2] Based on figures relating to children exiting out-of-home care by length of time in out-of-home care. In 2008-09, 34.5% of children and young people exited care within six months of entering out-of-home care.

[3] In 2008-09, 10.6% of children and young people exited care after being in care for more than five years

Findings

Satisfaction with care

Questionnaires were offered to all young people and children in foster care visited by the Commission's Community Visitors (CVs) during the survey period of 2 April to 26 June 2009. In addition, questionnaires were distributed to carers to complete on behalf of young children or those who, because of a disability, were unable to express an opinion.

A total of 2727 respondents completed the Commission's three questionnaires related to satisfaction with care. This number comprises 1180 questionnaires from young people, 769 questionnaires from children and 778 questionnaires from carers of young children. This represents 960 more surveys than was received in 2007 and 1024 more than in 2006.

Throughout the report, findings from the 2009 survey are compared with those from the 2007 and 2006 survey in order to identify any changes that have occurred during this time.

Respondents' characteristics

Introduction

The number of children living in foster care in Queensland has expanded rapidly over the last five years. As at 30 June 2009 there were 6649 children living in home-based foster care compared to 4366 at 30 June 2004. This represents an increase of 52.3% in five years.

A feature of this population is the strong over representation of Aboriginal and Torres Strait Islander children. As the foster care population has expanded, this over representation has become more pronounced. By 30 June 2009 35.3% of children and young people in foster care identified as Aboriginal and/or Torres Strait Islander, up from 22.7% in June 2005. In the general population, it is estimated that 6.5% of children and young people are of Aboriginal and/or Torres Strait Islander background (Australian Bureau of Statistics, 2009). The proportion of children and young people in foster care of other cultural backgrounds is unknown.

While the majority of children and young people live with unrelated foster carers the proportion living in kinship care has increased in recent years. At 30 June 2005 27.0% of children and young people in home based foster care were placed with a kinship carer. The relative proportion of kinship care peaked in 2007 at 37.0% dipping slightly to 35.8% at 30 June 2009. This general increase relates to increases in kinship placements for non-Indigenous children, 35.4% of whom were placed in kinship care at 30 June 2009 compared to 24.3% at 30 June 2005. By contrast, 36.1% of Aboriginal and Torres Strait Islander children and young people were placed with kin in 2005 compared to 36.4% at 30 June 2009.

Figures relating to the age and gender profile of all children in out-of-home care have been reasonably consistent over the last four years. At 30 June 2009 there were slightly more males in out-of-home care than females (50.9% compared to 49.1%).

Demographic profile

The first section of each questionnaire asked respondents general profile and background questions such as their age, their sex, their Child Safety Service Centre, the type of care in which they are living, and if their carer is living in community housing. Respondents were also asked about their cultural background. Community Visitors were asked to complete this section of the questionnaire with the child or young person.

Table 1 presents these data and shows that the average age of young people is 12 years and 11 months. Children average 7 years and 7 months of age and young children, 3 years and 11 months of age. Figure 1 presents the distribution of the ages for the three groups of respondents combined. As can be seen in Table 1, females slightly outnumber males among the young people and children, whereas there are marginally more males than females among the group of young children. A high

proportion of respondents are from some of the most densely populated zones of the state including Ipswich, Brisbane West, the Gold Coast, and Toowoomba.

The table also shows that two thirds (66.6%) of young people and children and 70.6% of young children are living in foster care. A further 28.5% of young people, 32.2% of children and 26.4% of young children are living in kinship care, while the remainder live in specialist foster care. The proportion of young people living in kinship has increased significantly from 22.9% in 2007 and 19.5% in 2006.

Around 15% of young people, 17% of children and 16% of young children live with a carer in community housing.

With the exception of the greater proportion of young people residing in kinship care, the demographic profile for the cohorts remains largely consistent with that of previous years.

Table 1.
Profile – young people, children, young children, and total group (2009)

Characteristic	Young people (9–18 years) *n* = 1180	Children (5–8 years) *n* = 769	Young children (0–4 years) *n* = 778	Total group *N = 2727*
Age in years and months				
Mean	12yrs 11mths	7yrs 7mths	3yrs 11mths	8yrs 9mths
SD	2yrs 6mths	2yrs 0mths	3yrs 0mths	4yrs 7mths
Median	12yrs	7yrs	3yrs	8yrs
Sex				
Male	46.1%	46.1%	53.1%	48.1%
Female	53.9%	53.9%	46.9%	51.9%
Zone				
Far Northern	8.4%	8.1%	7.1%	7.9%
Northern	4.2%	3.1%	2.9%	3.5%
Central North	8.3%	8.9%	6.4%	7.9%
Central South	7.8%	7.8%	11.0%	8.7%
Ipswich	9.2%	13.7%	11.5%	11.1%
Toowoomba & Western	14.3%	10.1%	14.0%	13.0%
Brisbane North	6.0%	7.4%	7.3%	6.8%
Sunshine Coast	3.8%	6.0%	6.5%	5.2%
Brisbane South	4.3%	6.0%	7.5%	5.6%
Gold Coast	9.3%	7.6%	9.9%	9.0%
Moreton & South Burnett	7.7%	8.0%	4.7%	6.9%
Logan	6.3%	6.2%	5.4%	6.0%
Brisbane West	10.6%	7.2%	5.9%	8.3%
Type of care				
Foster care	66.6%	66.6%	70.6%	67.7%
Kinship care	28.5%	32.2%	26.4%	29.0%
Specialist foster care	4.9%	1.2%	3.0%	3.3%
Live with a carer in community housing	15.0%	17.1%	15.9%	15.3%

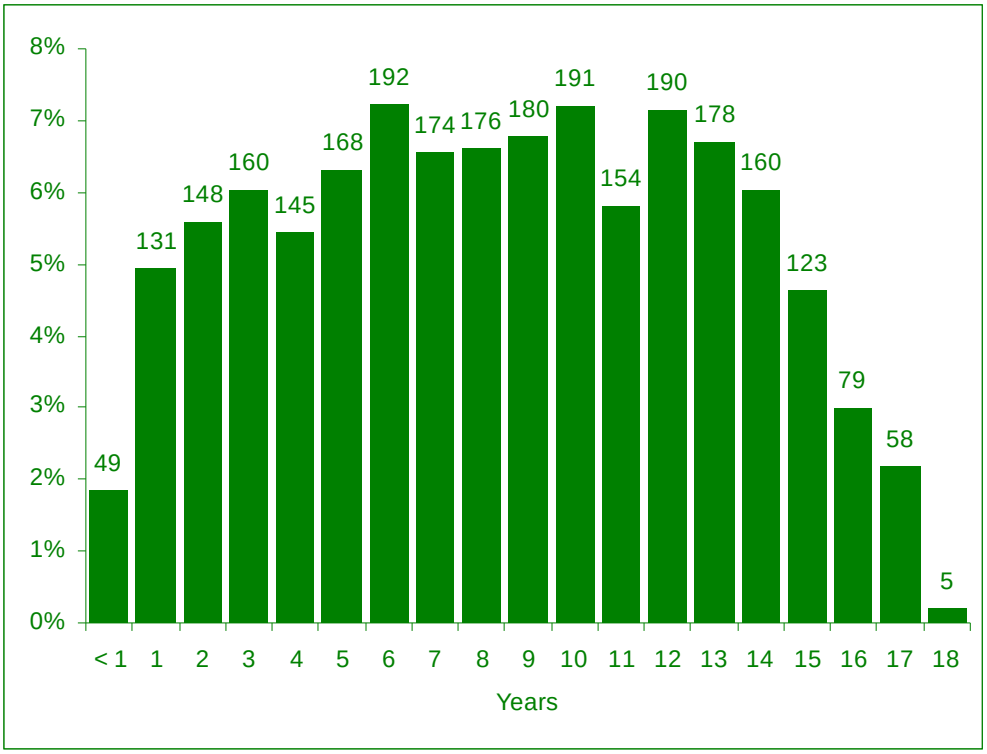

Figure 1. Age in years – total group (2009) (*n* = 2727)

Cultural background

Table 2 shows almost two thirds (65.1%) of the total group identified as Caucasian Australian. Around 28% of the total group are of Aboriginal background and around 4% are of Torres Strait Islander background. In total, 30.2% of respondents identified as Indigenous (Aboriginal, Torres Strait Islander or both). Respondents from 'Other' backgrounds comprise 7.8% of the total group. Comments from these respondents indicate that they are from countries such as New Zealand, Samoa, Vietnam, Papua New Guinea, Fiji, and Sudan. As some respondents selected more than one option (for instance, Caucasian Australian and Aboriginal or Caucasian Australian and Other), the percentages exceed 100.

Respondents were also asked about the language spoken in their birth home and whether or not at least one of their carers shares their cultural background. Overall, more than 95% reported speaking English at home and around 80% indicated that at least one of their carers is of the same cultural background.

Table 2.
Cultural background – young people, children, young children, and total group (2009)

Characteristic	Young people (9–18 years) *n* = 1180	Children (5–8 years) *n* = 769	Young children (0–4 years) *n* = 778	Total group *N = 2727*
Cultural background*				
Caucasian Australian	65.8%	63.7%	65.3%	65.1%
Aboriginal	27.5%	28.7%	28.7%	28.2%
Torres Strait Islander	3.8%	4.2%	3.9%	3.9%
Both Aboriginal and Torres Strait Islander	2.2%	0.9%	2.3%	1.8%
Other	8.7%	6.5%	7.6%	7.8%
Language at home				
English	95.0%	96.8%	96.0%	95.8%
Other	3.6%	1.9%	1.4%	2.5%
Don't know	1.4%	1.3%	2.6%	1.7%
Carer cultural background is the same				
Yes	78.9%	81.3%	79.3%	79.7%
No	16.0%	16.0%	20.2%	17.2%
Don't know	5.1%	2.7%	0.5%	3.1%

*As some respondents selected more than one option, the total exceeds 100%.

When compared with 2007 findings, the only notable differences between the groups according to cultural profile are an increase in numbers of young people of Aboriginal background (up from 20.2% in 2007 and 19.1% in 2006) and a marginal increase across the three groups in the proportion reporting 'other' cultural backgrounds.

Summary of findings

- 2727 young people, children and carers on behalf of young children participated in the survey.
- The overall mean age for the three groups combined is 8 years 9 months.
- Slightly more females than males participated.
- Around two thirds of the group is in foster care and 29% in kinship care.
- Around two thirds are of Caucasian Australian background and around 30% are of Indigenous background.
- Approximately 80% report having a carer of the same cultural background.

Health and wellbeing

Introduction

The health and wellbeing of children and young people in foster care presents a major challenge to child protection systems worldwide. Research shows that a significant number of children and young people have physical and intellectual disabilities and they are considerably more likely than the general population to experience a range of physical and mental health problems.

A recent study in NSW, for instance, found a range of unidentified health needs among children and young people in care. Of the 122 participants, 30% had dental problems, 26% had hearing loss, 24% had incomplete immunisations, and 20% had problems with their eyesight. In addition, of those younger than 5 years of age, 60% had failed to reach developmental milestones, 45% had delayed speech and 54% had significant behavioral and emotional problems (Tzioumi & Nathansen, 2008). CREATE's research with 10 to 17 year olds living in care in Australia also revealed high rates of self-reported health problems. Of the 281 participants, 83% reported having dental problems, 24% eyesight problems and 15% hearing problems (CREATE, 2006).

International and Australian research confirms the consistently higher rates of mental health problems among children and young people in care. Bruskas (2008) notes that in the United States, studies estimate the incidence of significant mental health disorders at around 50% of the foster care population, with these children experiencing problems such as depression, anxiety, post-traumatic stress disorder and social problems (Casey Family Programs, 2005; cited in Bruskas, 2008; Burns, Philips, Wagner, Barth, Kolko, & Campbell, 2004). In one study, 84% with the most extreme symptoms had not received any mental health assistance (Burns et al., 2004). In a South Australian study, the rate of mental health problems among those in care was estimated at 61%, 6 to 7 times that of the general population (Sawyer, Carbone, Searle, & Robinson, 2007). The researchers add that these children and young people are more likely to exhibit both internalising behaviours (withdrawal, anxiety and depression) and externalising behaviours (attention problems, delinquency, aggression and social problems) and to have attempted suicide. Despite this, only 27% had received professional help for their problems during the past 6 months. Research in Australia by Osborn and Delfabbro (2006) also revealed high rates of both physical and mental health problems among children in care. Their study identified the four most common problems experienced by children in care with high support needs. In order of prevalence these problems were diagnosed conduct disorder, intellectual disorder, personality disorder/mental illness, and physical disability.

Given the prevalence of attention and conduct disorders among children and young people in care, it is not surprising that they are frequently diagnosed as having attention deficit hyperactivity disorder (ADHD). Children exposed to domestic violence, child abuse or other trauma can indeed develop behaviours symptomatic of ADHD (Royal Australasian College of Physicians, 2009) and an emerging body of research points to ADHD medication being prescribed to those in statutory care at rates well above those in the general community (CCYPCG, 2006a, 2006b, 2008, and 2009b; Simmel, Brookes, Bath & Hinshaw, 2001). However, as the latest guidelines from the Royal Australasian College of Physicians (2009) caution, ADHD medication should only be prescribed after a comprehensive medical, developmental and psychosocial assessment, preferably by a suitably trained paediatrician or child and adolescent psychiatrist, and only to those aged 6 years and older.

Numerous explanations exist for the high rate of developmental, behavioural and mental health problems among children and young people in care. Tzioumi and Nathansen (2008) suggest that exposure to abuse and neglect coupled with a history of social disadvantage are significant risk factors. Other researchers cite insecure attachments and the cumulative effects of child maltreatment (RANZCP, 2008), complex trauma (Jee, Tonniges & Szilagyi, 2008), the interaction of pre-care adversities and negative in-care experiences (Fernandez, 2008), and what Lee and Whiting (2007) refer to as ‘ambiguous loss’. Studies suggest that these existing problems are compounded when children experience placement instability (Strijker, North & Knot-Dickscheit, 2008; Fernandez, 2008; Osborn & Delfabbro, 2006), do not feel secure, loved and cared for whilst in care (Cashmore & Paxman, 2006) and are not referred to, or receive, the necessary health care services (Ellerman, 2008).

The United Nations Committee for the Rights of the Child has highlighted the inadequate health care services provided to children and young people in care in Australia (RANZCP, 2008). Yet, as acknowledged by Nathanson and Tzioumi (2007), there are significant barriers to children in care receiving effective health treatment. These barriers include problems in recording and transferring children’s health information especially when there is limited medical history available and a tendency to rely on carers who may not be fully informed, particularly when there have been frequent changes in placements and in case workers.

Queensland context

In order to identify and address the complex health needs of those in care, all children and young people coming into care in Queensland since 2007 are required to have a comprehensive health assessment and an individual child health passport. A child health passport records a child's or young person's health details and provides carers with the information they need to meet day-to-day health needs. The passport should be continually updated throughout a child's or young person's time in care and move with them if their care arrangement is changed.

This section of the survey focused on general wellbeing and health. Respondents were asked if they feel loved and cared for by someone (as an indicator of their felt security). They were also asked about their health and happiness and the extent to which they worry about things (as an indicator of wellbeing). Further questions asked respondents about their health concerns, if they have a child health passport, if they have a disability, and if they are currently prescribed medication for ADHD.

Do you feel loved and cared for by someone?

An overwhelming proportion of young people reported feeling loved and cared for by someone. Figure 2 reveals that around three quarters (74.8%) feel loved and cared for by someone all of the time and more than one fifth (22.0%) feel loved and cared for most of the time. A very small proportion reported that they do not feel loved and cared for very often, while less than 1% reported never feeling loved and cared for.

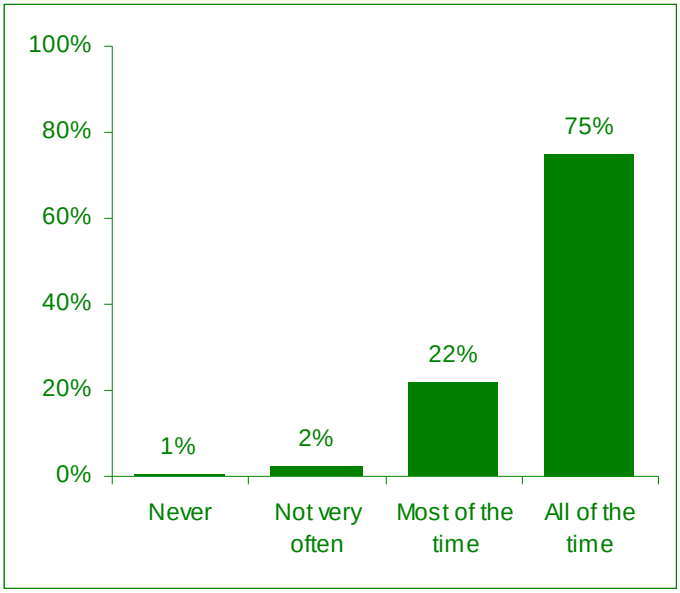

Figure 2. Feel loved and cared for – young people (2009)

Children were also asked to indicate whether or not they feel loved and cared for by someone. As Figure 6 shows, nearly all the children (97.5%) reported that they do.

How happy would you say you are?

The vast majority of young people reported feeling happy. As Figure 3 shows, more than half (57.6%) indicated they are very happy and more than a third (36.2%) indicated feeling pretty happy. Around 5% reported they are not very happy while the remaining 1.2% indicated that they are not at all happy.

More than three-quarters of carers (77.1%) consider the young children in their care to be very happy and a further 21.8% reasonably happy. Only 1.0% of the carers reported that the child in their care was not at all happy and none reported that the child was not at all happy.

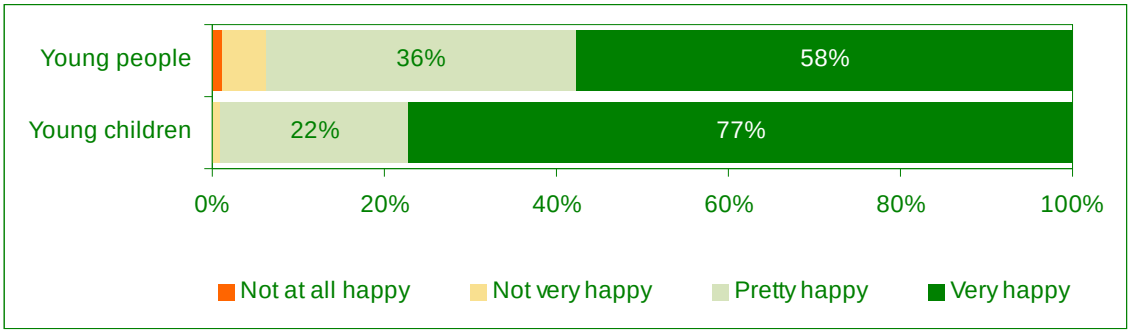

Figure 3. Feel happy – young people and young children (2009)

Children were also asked to indicate whether or not they are happy most of the time. Figure 6 shows that the vast majority (93.7%) reported that they are.

How often do you worry about things?

Responses from young people indicated that many spend a lot of time worrying about things. Although 63.4% indicated that they don't very often (51.0%) or never (12.4%) worry about things, more than one third (36.6%) report that they are often worried. Figure 4 shows that of this group, 25.6% report worrying about things most of the time, while 11.0% reported that they worry all the time.

Compared with young people, responses from carers suggested that young children were far less prone to worry about things. As Figure 4 shows, 44.8% of carers reported that their child never worried, while 46.2% reported that their child did not worry very often. Only 9% reported that their child worried most of the time (7.6%) or all of the time (1.4%).

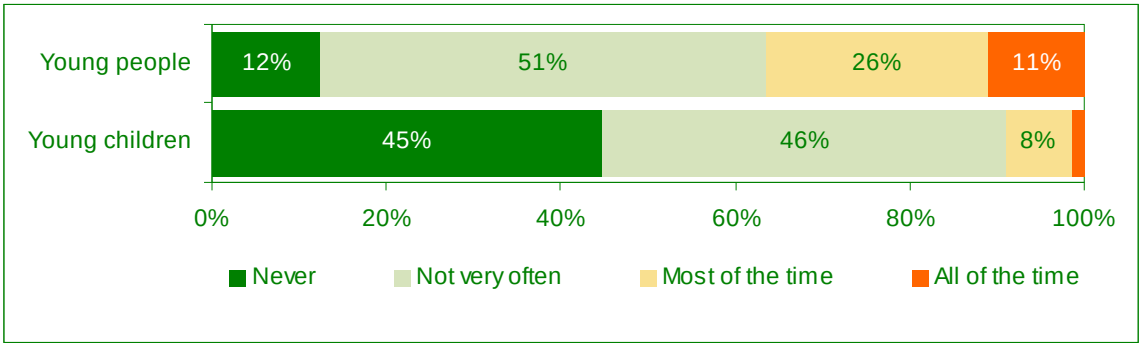

Figure 4. Worry about things – young people and young children (2009)

As can be seen in Figure 6, when children were asked if they worry about things a lot, almost half (44.5%) responded that they do.

How healthy would you say you are?

Reports from young people indicate that the vast majority feel healthy. As can be seen in Figure 5, more than half (58.5%) the young people reported feeling very healthy and more than one third (38.4%) pretty healthy. Around 2% indicated they are not very healthy while less than 1% indicated that they are not at all healthy.

Figure 5 shows that almost two thirds of carers (64.8%) consider the child in their care to be very healthy and a further third (33.1%) reasonably healthy. Only 2.1% considered their child to be not very healthy (1.7%) or not at all healthy (0.4%).

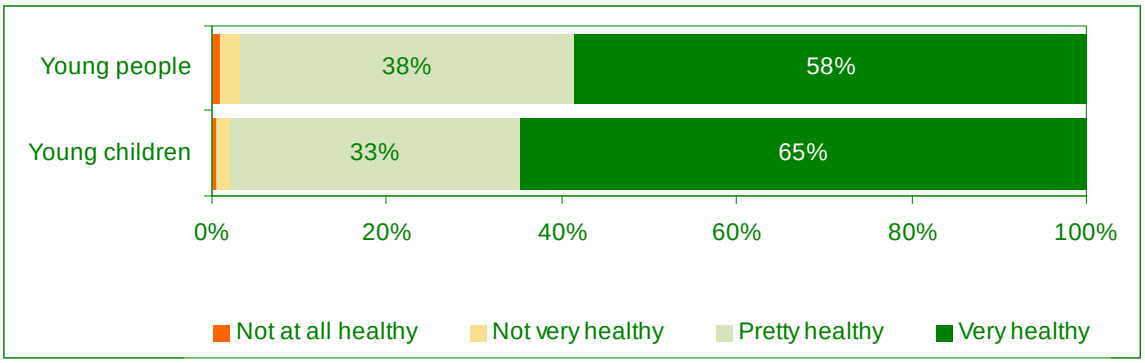

Figure 5. Feel healthy – young people and young children (2009)

Almost all the children (96.3%) responded 'yes' to the question "are you healthy most of the time?" (see Figure 6).

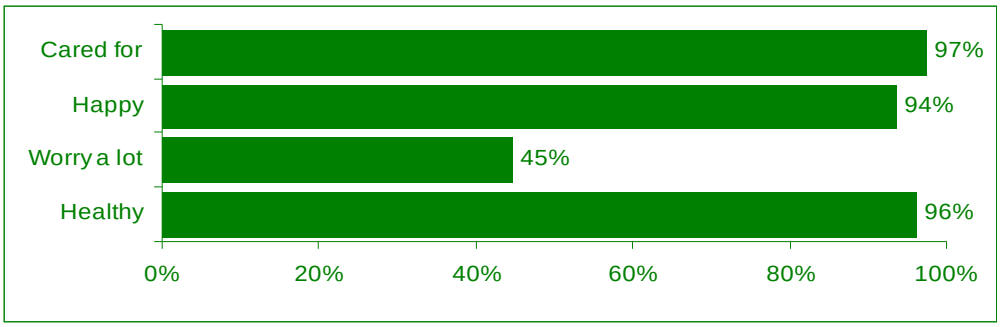

Figure 6. Indicators of felt security and wellbeing – children (2009)

Do you have any health problems that you are concerned about? If yes, what sort of problems?

As Figure 7 shows, 12.3% (or 140) of young people reported having a health problem that they are concerned about. Two hundred and six or 26.7% of carers reported that the child in their care has a health problem. This higher prevalence of health-related problems was not unexpected given that carers also completed surveys for those children or young people in their care who, due to a cognitive or physical impairment, are unable to express an opinion. Rates of reported health problems remain largely consistent with those of 2007.

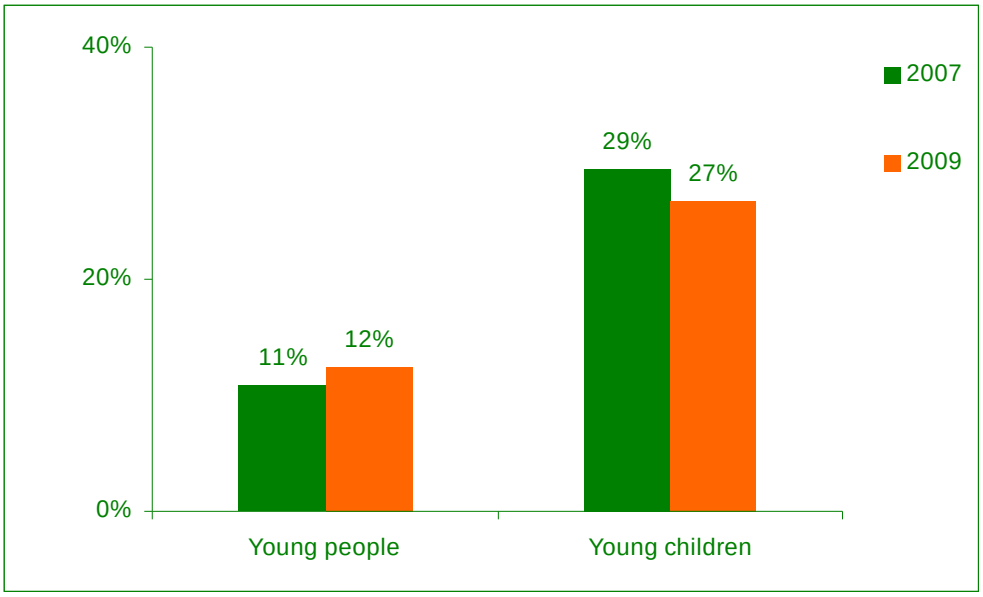

Figure 7. Have a health problem – young people and young children (2007, 2009)

Respondents were asked to identify the nature of their health problem. A very broad range of problems was reported with the most common being dental problems, motor/skeletal problems, infections, mental health issues, allergies, and respiratory conditions such as asthma. Other problems experienced include headaches or migraines, skin complaints and eating disorders.

Have you been able to see someone about these problems?

Figure 8 shows that, of the young people who reported having a problem, around two thirds (67.2%) reported having seen someone about it. This represents a significant increase since 2007 when half (50.0%) reported having seen someone about their problem. Around 90% of carers indicated that their child has seen someone about their problem.

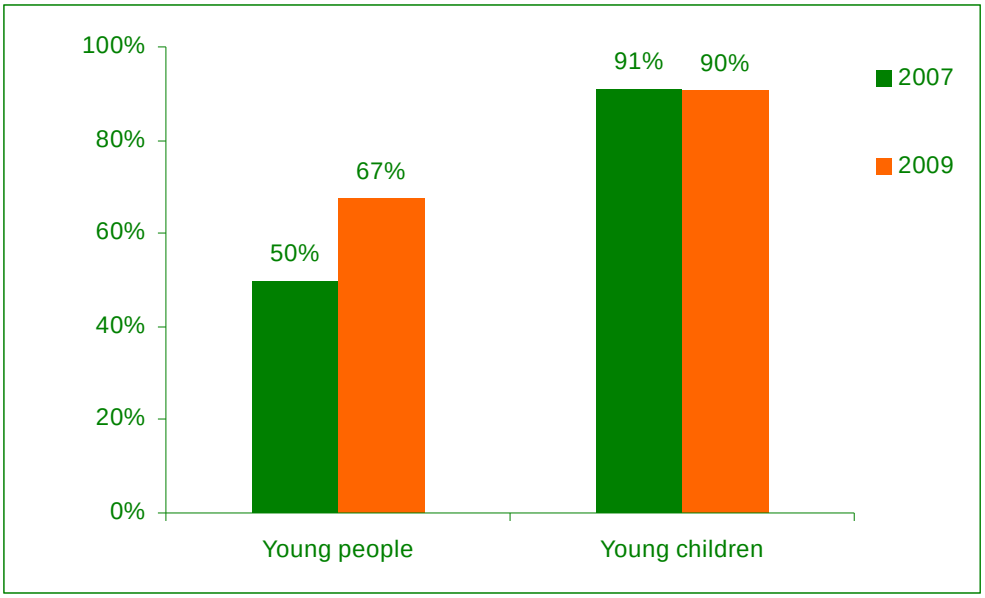

Figure 8. **Have a health problem and have seen someone about it – young people and young children (2007, 2009)**

Do you have a child health passport?

Of the young people who responded to the survey, 15.6% reported that they have a child health passport. Of the remainder, 45.8% reported being unsure if they have a passport and 38.6% reported not having a passport. Figure 9 shows that the proportion of young people reporting to have a passport has increased from 7% in 2007. This increase is statistically significant.

In the 2009 survey, carers were also asked if the child in their care has a child health passport. Around 43% reported that their child does have a passport and more than half (56.9%) reported that they do not.

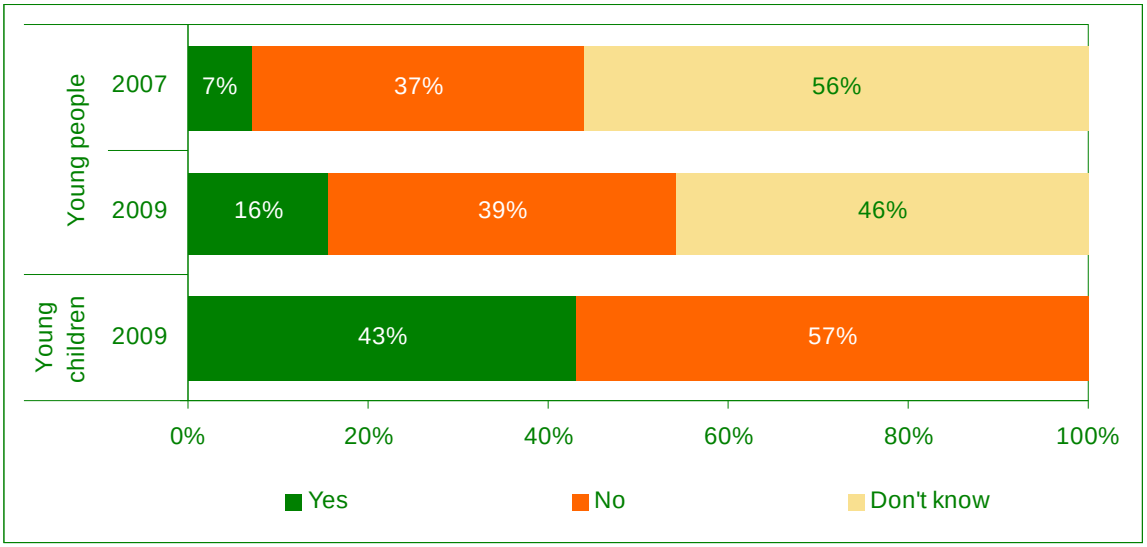

Figure 9. **Have a health passport – young people (2007, 2009) and young children (2009)**

Disability

Information was obtained from participants to establish the prevalence of disabilities among those in care. Around 18% of young people and 17% of children reported having a disability. Responses from carers indicate that the disability rate among young children is higher at 22.6%. Given that this cohort includes those who are unable to express an opinion, this finding is not unexpected. Rates of

disability among children and young children have remained largely consistent with those reported in previous years.

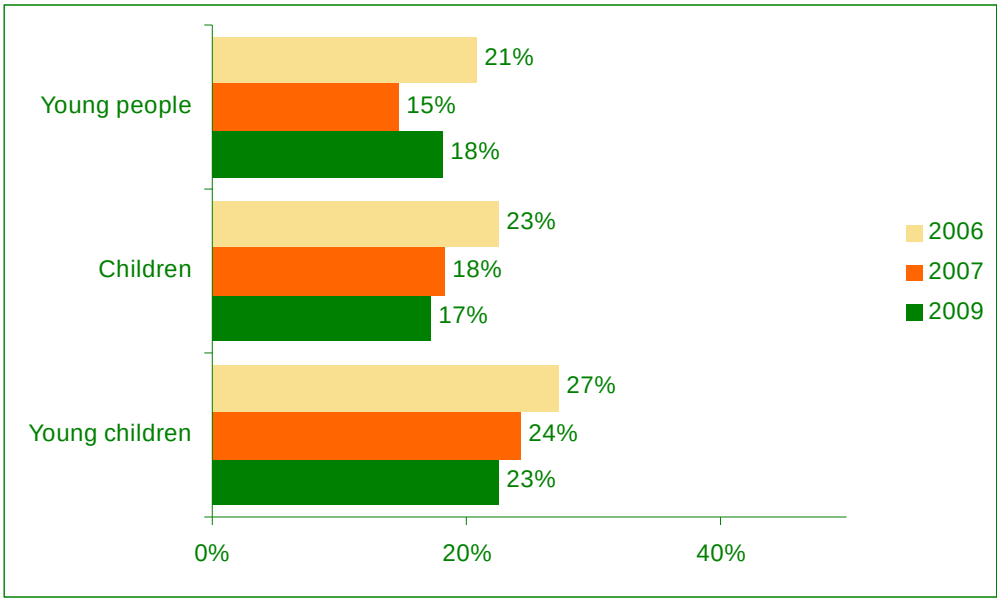

Figure 10. Have a disability – young people, children, young children (2006, 2007, 2009)

Respondents were asked to identify the nature of their disability. A broad range of disabilities was reported along with disorders that may more typically be classified as health problems. The most common disabilities and disorders noted include cognitive/learning disorders, attention-deficit hyperactivity disorder (ADHD), autistic spectrum disorder, and Aspergers syndrome. Visual, hearing and speech problems, foetal alcohol syndrome, Down syndrome, cerebral palsy, and epilepsy were also reported, particularly by carers.

Do you take any medication (tablets or capsules) for ADHD (hyperactivity)?

Figure 11 shows that 16.4% of young people and 15.2% of children reported taking medication for ADHD. These figures remain largely consistent with those of previous years and are well above the rate of 6.7% for the general population of children and young people in Australia (RANZCP, 2009).

Of the carers, 7.0% reported that the child in their care is currently taking ADHD medication. While this is similar to the rate for the general Australian population, further analyses of survey data reveal that around 30% of these children are less than 6 years of age.

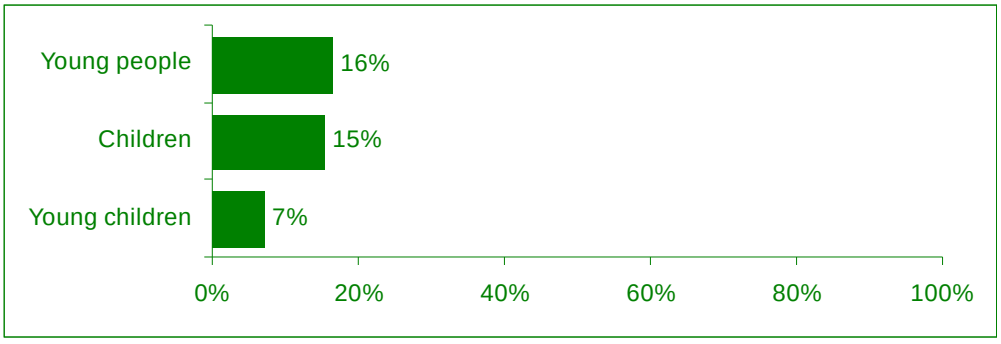

Figure 11. Take medication for ADHD – young people, children, young children (2009)

Summary of findings

- It is pleasing that the vast majority of children and young people report feeling happy, healthy and loved and cared for by someone. Of concern however, is the substantial proportion (36.6%) who report that they often worry about things.
- A considerable number of respondents also appear to experience health problems although

the proportion reporting to have received help for these problems has increased significantly since 2007. Reports of having a child health passport have more than doubled from 7.0% in 2007 to the current rate of 15.5%. According to 43.1% of carers, the child in their care has a child health passport.

- Respiratory, dental and mental health problems continue to be some of the most common problems experienced by respondents.
- Around 18% of young people, 17% of children and 23% of young children (as responded to by carers) report having some kind of disability. The nature of disabilities mentioned varies considerably but include cognitive/learning disorders, autistic spectrum disorder, Aspergers syndrome, foetal alcohol syndrome, and Down syndrome.
- Some of the 'disabilities' identified by respondents are disorders that might more commonly be perceived as health problems (for example, ADHD and epilepsy). Given this perception, the reported rates of disability are likely to be somewhat inflated.
- Reported rates of taking medication for ADHD remain persistently high among the children (15.2%) and young people (16.4%). Reports from carers revealed that many children under the age of 6 are being medicated for ADHD.

Education

Introduction

Children and young people in foster care are often the most vulnerable students in the school system. Many are struggling with personal, familial and educational problems (Fram & Altshuler, 2009) associated with maltreatment or neglect, lack of support from family members and caseworkers, as well as frequent school disruptions (Havalchak, White, O'Brien, Pecora, & Sepulveda, 2009).

Not surprisingly, a growing body of literature confirms that compared with their peers, children and young people in care often fare poorly when it comes to educational outcomes. Worldwide, numerous studies have revealed that students living in care are at greater risk of poor academic performance, grade retention and the need for special education services (Fram & Altshuler, 2009; Havalchak et al., 2009).

In Australia, recent research has found that children in foster care are more likely to experience significant difficulties at school in relation to attention, social interactions, anxiety, and aggression (Fernandez, 2008). School absenteeism has also found to be a major problem among those in care. In the UK, a recent report revealed that 0.9% of children in care were permanently excluded from school compared to 0.1% of all children (DfES, 2007). In one study in Scotland, almost three quarters of care leavers reported having been temporarily or permanently excluded from school during their time in care. Truancy was also common with 83% claiming to have stayed away from school at some point and 51% claiming to have stayed away 'often' (Stein & Dixon, 2006). An Australian study of children in care with high needs found similar rates of school absenteeism with three quarters reporting having been suspended from school in the previous 6 months and 13% reporting having been permanently excluded (Osborn & Delfabbro, 2006). Adding to absenteeism resulting from formal exclusions and truancies, Bruskas (2008) points out that many school days are lost when a child has to transition from one placement to another.

Given these obstacles it is hardly surprising that rates of school completion and participation in further education are considerably lower among those who are, or have been, in care. In one United States study, only 1.8% of care leavers continued to post secondary education compared to 24% of the general population (Children's Administration Research, 2004; cited in Bruskas).

Queensland context

In Queensland, the Department of Education and Training (DET) has a range of plans within the school setting to cater for the individual educational needs of students. These include Individual Education Plans for students with disabilities, Individual Behaviour Plans for students requiring individualised behaviour support, Senior Education and Training plans for students in Years 10, 11 and 12. In addition, every child in state care is entitled to an Education Support Plan (ESP). An ESP is a formal written document that identifies the educational goals of the child or young person in care. It includes the strategies needed to achieve these goals, the required and available resources, who is responsible for implementing the strategies, and processes for

monitoring and reviewing the plan. According to DET, an ESP may not necessarily be written as a discrete plan but is more likely to be incorporated into one of the student's other educational plans.

Figures available from DET indicate that in August 2009 81% of the 4201 children in the care of the state enrolled in Queensland schools, had an ESP. An additional 14% had ESPs under development while the remaining 5% did not have an ESP.

Analysis of other recent departmental data confirm that compared with the general Queensland student population, children and young people in care are less likely to meet national benchmarks for literacy and numeracy and have higher rates of school suspensions and exclusions (CCYPCG, 2009a). Furthermore, in 2007 none of the 369 young people aged 17 to 18 years who were in the custody or guardianship of the Chief Executive of the then Department of Child Safety and living in care received or were eligible for an OP[4] (CCYPCG, 2009a).

Questions asked in this section focused primarily on respondents' school experiences. They sought information from children and young people on the number of schools attended, rates of repeating a year at school, rates of formal exclusion from school, problems experienced at school, and ESPs. Those who were not attending school at the time of the survey were asked about their involvement in other education or training.

How many primary schools have you attended?

Of the 1949 children and young people responding to the survey, all but six (0.3%) reported having commenced school. Taken together, the average number of primary schools that both groups report having attended is 2.9. Figure 12 presents the distribution for the number of primary schools attended. It shows that 597 (32.2%) children and young people reported having attended only one primary school. A further 472 (25.5%) reported having attended two primary schools, while 572 (30.8%) had attended between three and five schools. Of the remainder, 175 (9.4%) reported having attended between 6 and 9 schools, and 38 (2.3%) 10 or more schools.

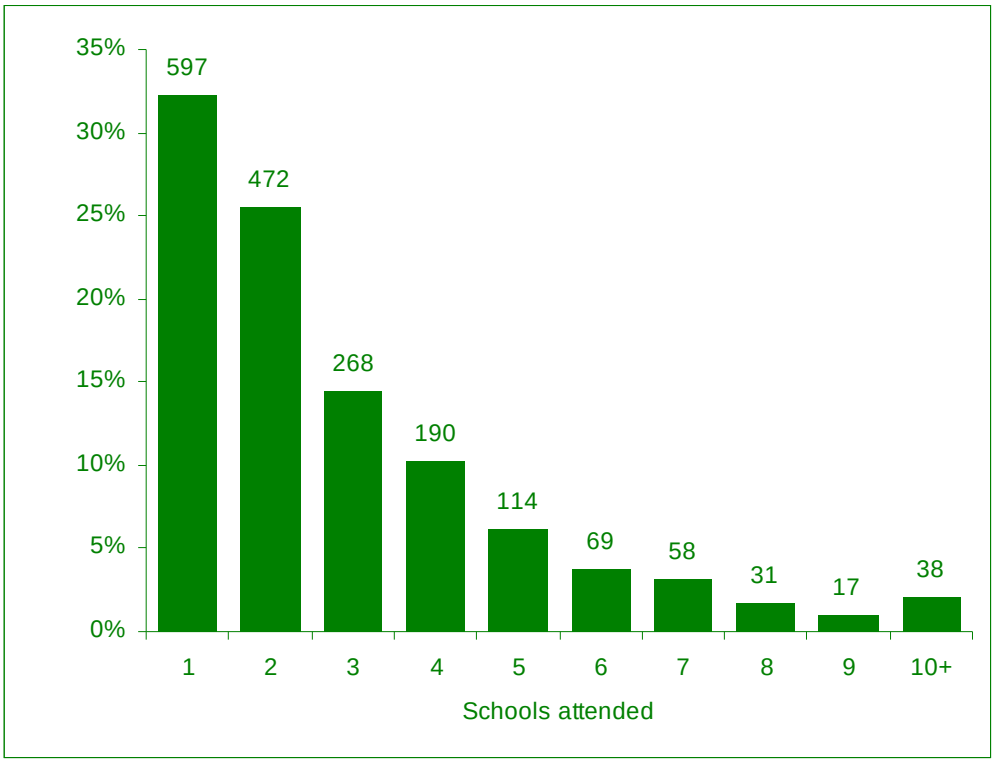

Figure 12. Number of primary schools attended – young people and children combined (2009) (*n* = 1854)

[4] Due to limitations with the data collection and matching processes, the Commission for Children and Young People and Child Guardian was unable to identify the specific young people who were enrolled in Year 12 in 2007. Therefore, it is possible that not all of the 369 young people were enrolled at school.

How many secondary schools have you attended?

Reports from the 571 respondents who were enrolled in Year 8 or above indicated that the average number of secondary schools they had attended is 1.5. Figure 13 presents the distribution for the number of secondary schools attended. It shows that the majority (70.5%) had attended only one school, while almost one fifth (19.5%) had attended two secondary schools. A further 10.1%, accounting for 53 respondents, had attended between three and nine schools.

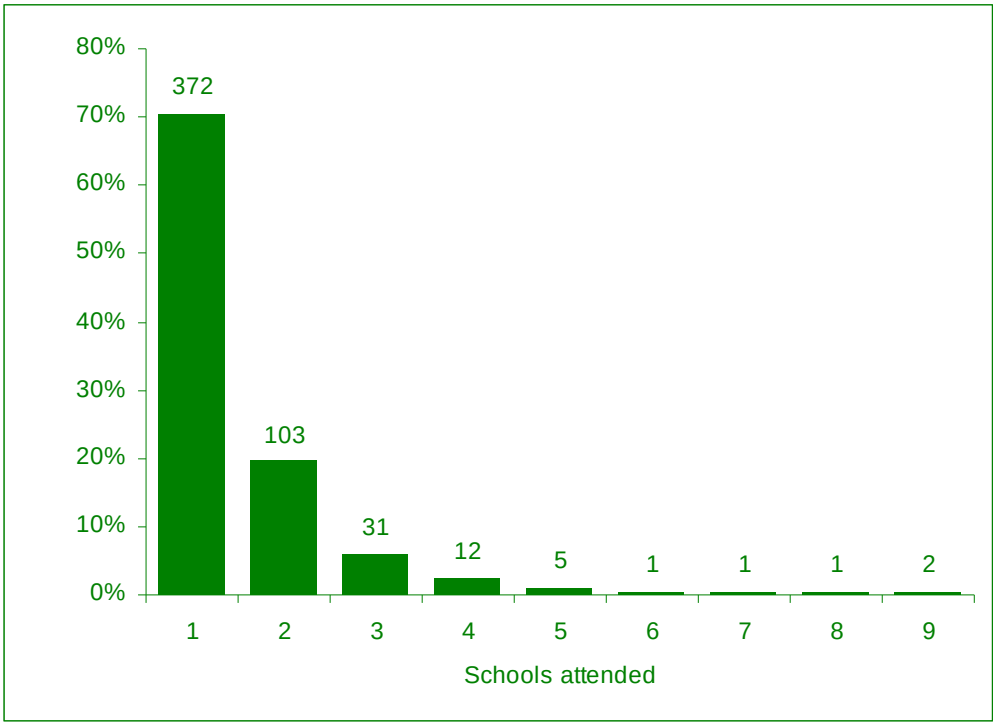

Figure 13. Number of secondary schools attended – Year 8+ (2009) (*n* = 571)

Have you ever been kept back at school? If so, how many times?

More than one quarter (28.1%) of young people and 15.8% of children reported having been kept back a year at school. While the number of young people reporting having repeated school is consistent with that of previous years, there has been a statistically significant decrease since 2006 in the proportion of children reporting that they have been kept back at school. In 2006, this proportion was 24.9%.

Of the young people who reported having been kept back a year, 91.6% reported having been kept back only once. A further 5.2% reported repeating a year twice and 3.1% reported repeating between 3 and 11 times. Like the young people, the vast majority (90.5%) of the children reported having been kept back only once. A further 8.6% had been kept back twice and one child (1.0%) reported being kept back 4 times. Table 3 shows that the mean number of times young people report having repeated school is 1.2 with a range of 1 to 11. For children this figure is 1.1 with a range of 1 to 4.

Table 3.
Kept back at school – young people and children (2009)

	Mean (SD)	Median	Min – Max
Young people	1.2 (.87)	1	1 – 11
Children	1.1 (.40)	1	1 – 4

Have you ever been suspended from a school?

To gauge the rate of school suspensions, young people were asked to select one of the three options, 'have never been suspended', 'have been suspended in the past', or, 'are currently suspended'. Responses from young people indicated that more than half (57.8%) have never been suspended,

40.7% have been suspended in the past, and 1.5% were currently suspended. Taken together then, reports from 42.2% of young people indicated that they have been previously, or were currently, suspended from school (see Figure 14).

Have you ever been formally excluded (expelled) from a school?

Compared with rates of suspension, rates of formal exclusion (expulsion) from school were considerably lower. Responses from young people indicated that 90.7% had never been formally excluded, 8.8% had been formally excluded in the past and 0.5% were currently excluded. In total then, 9.3% of young people reported that they had been, or were currently, formally excluded from school. While these percentages may appear minimal, they still account for 107 young people.

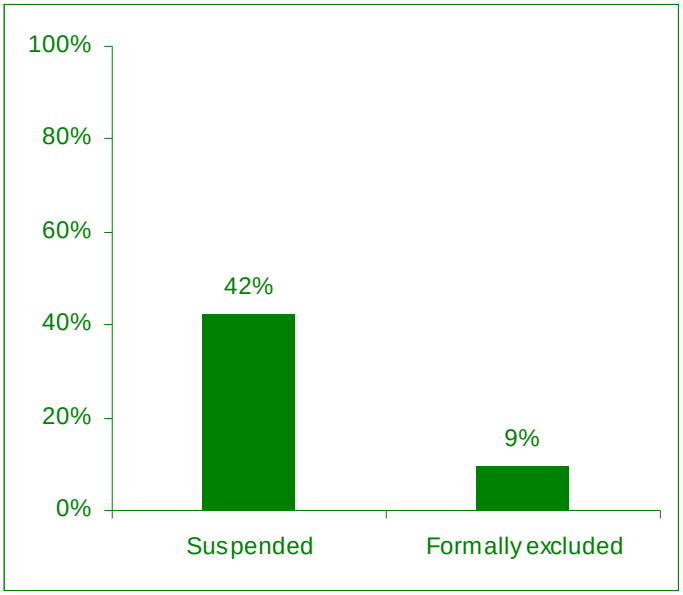

Figure 14. Suspended or formally excluded from school at some time – young people (2009)

Do you currently go to school? If yes, what year level?

The vast majority of young people (94.8%) and children (97.8%) reported that they attend school. Five (0.3%) of these are participating in Special Education programs. Figure 15 presents the frequency distribution for year enrolled at school for both groups combined. As can be seen, the largest single group of respondents, accounting for 183 or 10.4% of the group was enrolled in Year 4 although almost as many were enrolled in Year 5 (10.0%), Year 7 (9.7%) and Year 8 (9.8%).

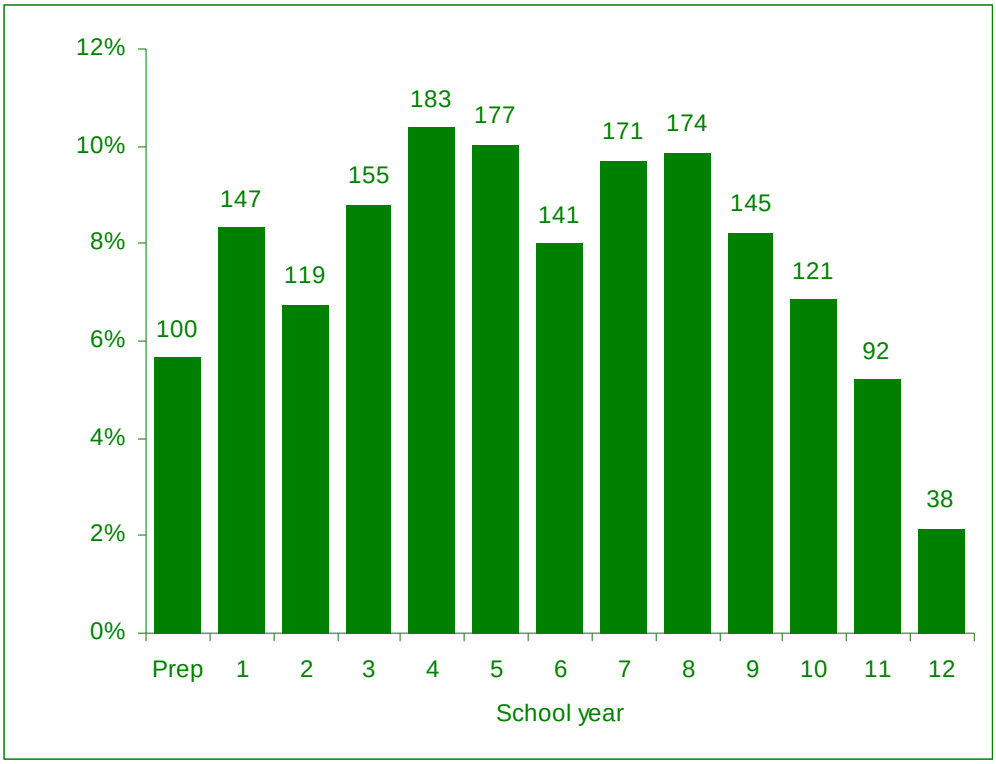

Figure 15. School year level – young people and children combined (2009) (*n* = 1756)

Do you have any problems at school that you haven't been able to get help with? If yes, what sort of problems?

Of the young people surveyed who attend school, 29.3% indicated that they a problem at school that they have not received help with. This represents a statistically significant increase since 2007 and 2006 when the proportions of young people reporting unresolved problems at school were 17.9% and 14.9% respectively. This increase may be partly due to the addition of select response options that immediately follow the question. These options identify several types of typical school problems and it is possible that they served as prompts for young people who might otherwise have indicated that they do not have a problem.

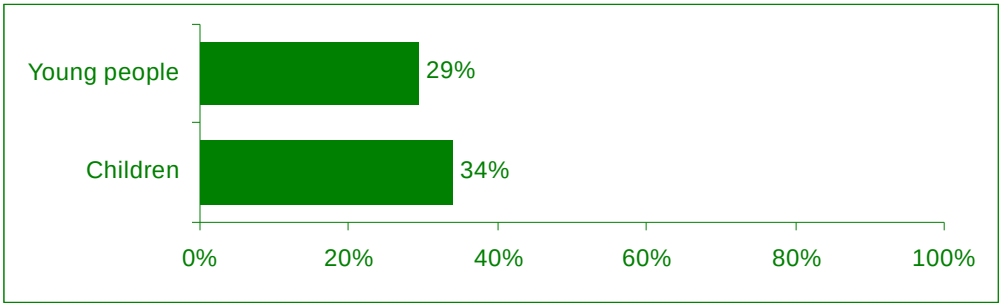

Figure 16. Experiencing unresolved problems at school – young people and children (2009)

As noted, those who reported having a problem were asked to indicate from a range of select response options the type of problem they were experiencing. These options were derived from analyses of young people's comments in the 2007 survey regarding the nature of problems they experienced at school. As some respondents were likely to report experiencing multiple problems, the survey explained that they could select as many problems as considered relevant. In addition, young people could select 'other' and provide a description of their problem. Figure 17 shows the types of problems reported and their prevalence.

As can be seen, the most commonly selected problem (59.5%) was school work. According to more than one third (36.5%), bullying was a problem, while more than one quarter (28.5%) indicated that they had problems with their behaviour. Around one in five young people (21.4%) experienced problems with teachers, while a small proportion (6.4%) reported not having the sorts of things they need for school such as a computer, uniform, books or money for excursions. A small number of respondents also identified 'other' problems. These included:

- ***Want to get out of boarding.***
- ***Hate school want to get a job.***
- ***Hearing.***
- ***Messy writing.***
- ***I can't keep my big mouth shut.***

The 2009 survey also asked children for the first time if they had any problems at school for which they had been unable to get help with. Two hundred and forty seven children, or more than one third (33.8%), reported that they do. Figure 17 illustrates the nature and frequency of problems that children reported experiencing. Like young people, the most commonly reported problem was school work (48.2%), followed closely by bullying (42.1%). Almost one third (30.4%) of children also indicated that their behaviour was a problem while a further 18.6% felt that teachers didn't listen or understand them. Around 5% indicated that they did not have all the things they needed for school.

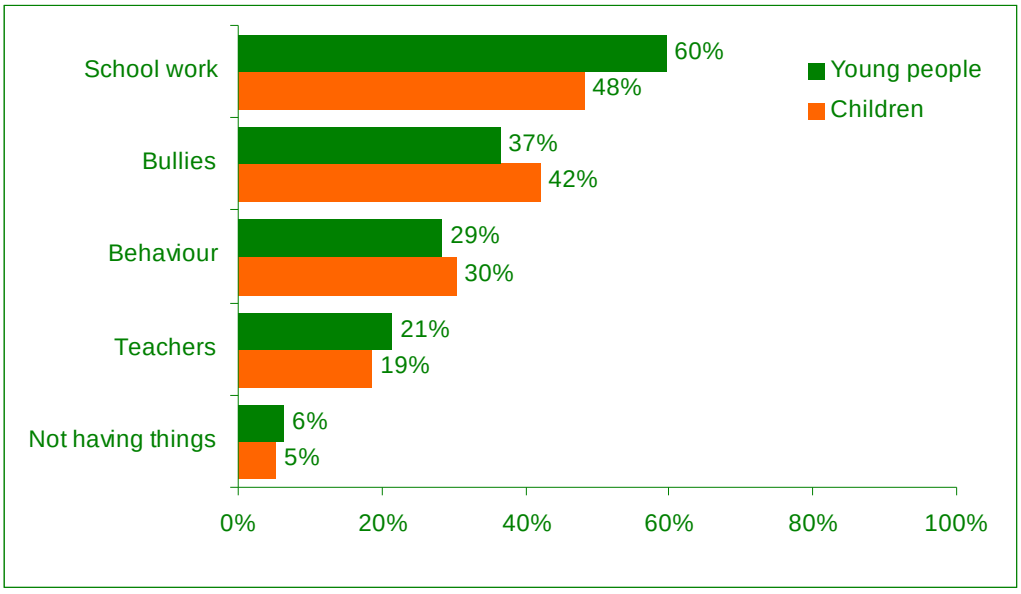

Figure 17. Types of problems at school – young people and children (2009)

Figure 18 shows that although the majority of children and young people reported experiencing only one problem at school, a considerable proportion reported experiencing multiple problems. Reports from 20.3% of young people and 25.8% of children indicated they were experiencing two problems, while a further 13.4% of young people and 10.7% of children were experiencing three problems at school. The figure also reveals that around 5% of children and young people reported experiencing four or more types of problems at school.

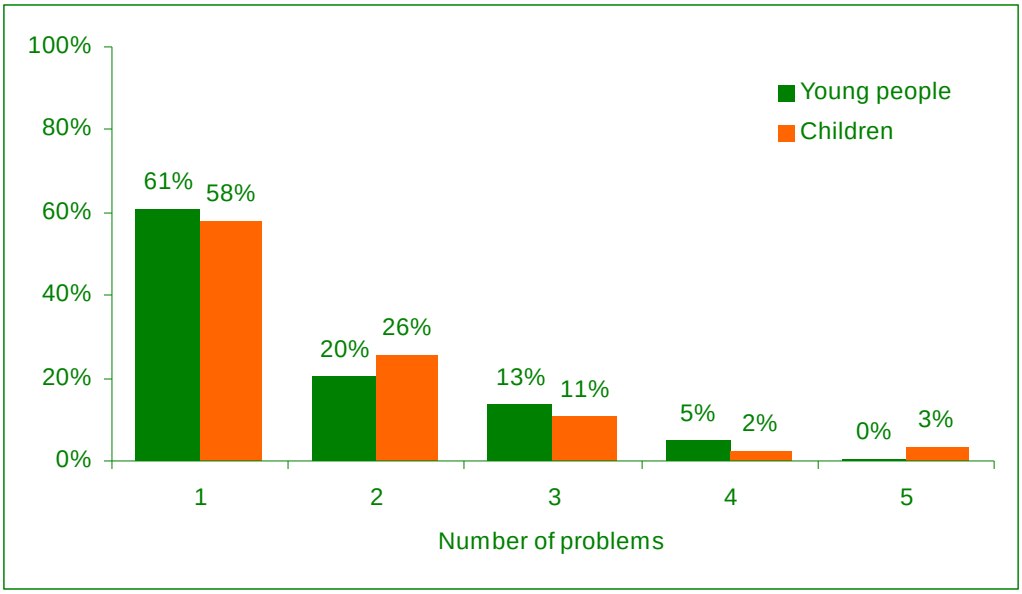

Figure 18. Number of unresolved problems at school – young people and children (2009)

Has an education plan been developed for you because you are in care? (also called an Education Support Plan)

Young people were asked if they have an ESP, and if they do, if it is helpful. To help young people understand what is meant by an ESP, a number of different descriptors for ESPs were provided.

As can be seen in Figure 19, more than half (56.0%) the young people reported having an ESP. Figure 19 shows that there has been a steady and significant increase in reports of having an ESP since 2007 when the proportion was 45.8% and 2006 when the proportion was only 28.9%.

If you have an education plan, has it been helpful to you?

Of those who reported having an Education Support Plan, more than three quarters (77.1%) consider it to be helpful. This figure also represents a significance increase since 2007 when 68.7% of young people considered their ESP to be helpful. In 2006, this figure was only 45.0%.

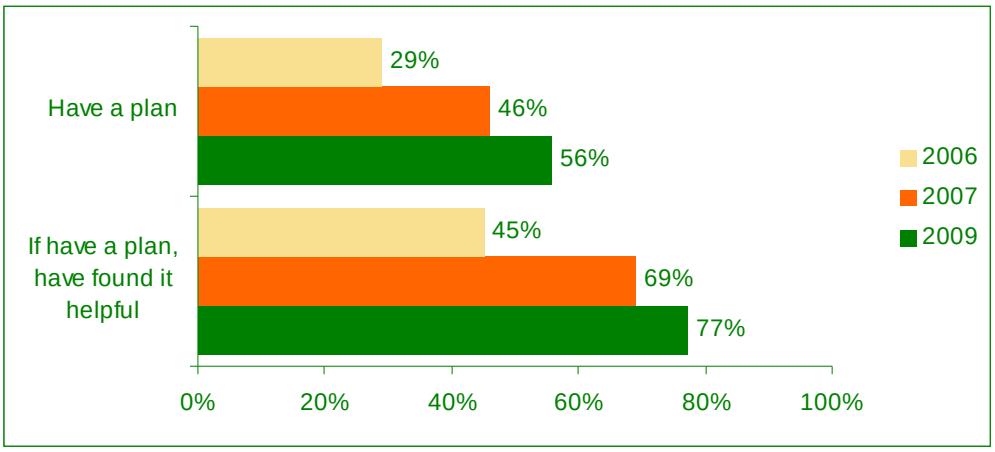

Figure 19. Education Support Plans – young people (2006, 2007, 2009)

If you do not attend school, are you doing any other training or education? If yes, what type?

Of the 5.1% of young people who reported not attending school, more than half (58.7%) indicated that they were participating in some other form of training or education. Comments from these young people suggested many were enrolled in TAFE or similar certificate courses and some were undertaking distance education.

If no, what do you do during the day then?

Those who are not attending school and not participating in other training or education (41.3%) were asked what they do during the day. Comments from these young people indicated that most were working. Of those who reported that they are not working, one noted being a 'stay home Mum', another noted 'help out at home', while a small number indicated that they weren't doing anything in particular during the day.

Summary of findings

- Reports from young people and children indicate that many experience a range of difficulties at school.
- More than one quarter of young people and around 16% of children report having been kept back a year at school on at least one occasion.
- More than four in ten young people report having been suspended from school at some time and almost one in ten have been formally excluded (expelled).
- Around one third of children and young people report experiencing one or more problems at school. For both children and young people, the most commonly reported problem is school work, followed by bullying.
- More than half the young people report having an ESP. Of this group more than three quarters consider their plan to be helpful. These proportions have increased significantly over the years.
- Also encouraging is the finding that, of the small proportion of young people who are not attending school, most are participating in other training or education or are working.

Placement history

Introduction

The need for children and young people in care to have stability in their placements is widely acknowledged. There are a number of reasons why stability is so important with some of the most compelling arising from attachment theory which owes much to Bowlby's (1969) seminal work. According to this theory, children need a close personal bond with at least one primary caregiver to develop emotionally, cognitively and even physically. Frequent placement changes prevent children from forming this vital bond with a caregiver and the resulting harm can be serious and long lasting. Children with poor attachments can have difficulty experiencing empathy, regulating emotions (Schwenke et al., 2006) and forming relationships with others well into adulthood (Sable, 2008). Where children remain in placements for a significant period they form attachments with their carers. Moving a child at this point can be extremely traumatic and can "destroy peer and other social relationships, shatter already fragile trust in the permanence of relationships with adults [and] evoke memories of earlier separations" (CCYPCG, 2006b: 4).

While the department has acknowledged a general preference for a small number of placements it has also noted that in some cases placements can be changed for "positive reasons", for example "to achieve better child-family compatibility". Where a child is in an unsuitable placement a change may be necessary but such upheavals might more rightly be described as the natural result of "poor initial decisions and lack of support to foster-carers" (Fernandez, 2007: 1296). Ideally, carefully decided and well planned initial placements would render such "positive" placement changes unnecessary.

While striving for placement stability, it is necessary to recognise that creating stable placements can be exceedingly difficult. Cashmore notes that where foster care populations expand quickly, as they have in Queensland, child protection authorities are faced with a comparatively "small pool" of carers resulting in "inadequate matching of carers with children…[which] increases the likelihood of placement break-down and carers leaving the system" (2000:18). Gains have been made in Queensland in the recruitment of foster carers although, according to the department, there is still "a critical need for more foster carers to allow the department and community fostering agencies to better match the needs of children with suitable carers".

Another source of instability for children and young people in care is unsuccessful reunification attempts where children are returned home to their parents only to be placed back into foster care at a later date. As the department does not record reunifications in its corporate data system it is

impossible to know how many children are returned home each year and how many of these reunifications are successful. Data from the *Views* surveys are therefore extremely valuable in assessing the stability experienced by children and young people in foster care.

It should be noted that the *Views* survey methodology is likely to under-represent children and young people who have been in foster care for shorter periods of time and this should be considered in interpreting the findings. A full discussion of the limitations of the sample can be found in the *Research Design* section of this report.

Several questions focused on the placement histories of respondents. They were asked how long they have been in their current placement, their age when they first came into care, how long they have been in care altogether, how many placements they have experienced altogether, and how many times they have gone back to live with their family (excluding visits or holidays). For the purposes of analyses in this section, the three cohorts have been combined to form a single respondent group.

How long have you been in this placement?

As Table 4 indicates, the average length of time that respondents have been in their current placement is 3 years and 2 months while the median length of time is 2 years. Placement lengths range from less than 1 year to 17 years. Placement length for the three groups combined was found to be largely consistent with those of previous years.

Table 4.
Length of current placement – total group (2009)

Mean (SD)	Median	Min – Max
3yrs 2mths (3yrs 3mths)	2yrs	<1 – 17yrs

Figure 20 presents the distribution of placement lengths for the three groups combined. As can be seen, 697, or more than a quarter (27.7%) of respondents, have been in their current placement for less than 1 year. In contrast, 160 (6.3%) respondents have been in the same placement for 10 years or more.

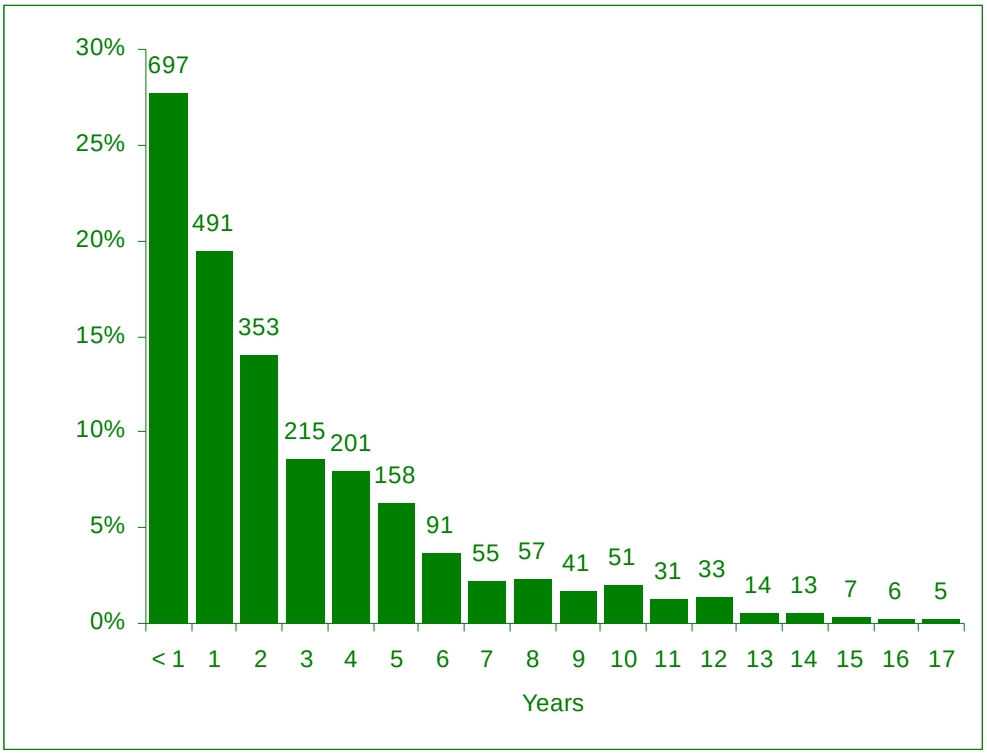

Figure 20. Current placement length in years – total group (2009)

How old were you when you first came into care?

Table 5 reveals that the average age at which the respondents came into care is 4 years and 9 months with a median of 4 years and a range of less than 1 to 17 years of age. In 2007 the mean age for coming into care was lower at 4 years 5 months. This difference is statistically significant.

Table 5.
Age first came into care – total group (2006, 2007, 2009)

	Mean (SD)	Median	Min – Max
2006	4yrs 7mths (4yrs 3mths)	4yrs	<1 – 16yrs
2007	4yrs 5mths (4yrs 1mth)	4yrs	<1 – 16yrs
2009	4yrs 9mths (3yrs 11mths)	4yrs	<1 – 17yrs

The distribution of ages at commencement of care for the total group is presented in Figure 21. As can be seen, the largest single group of respondents, accounting for around 18%, entered care at less than 1 year of age.

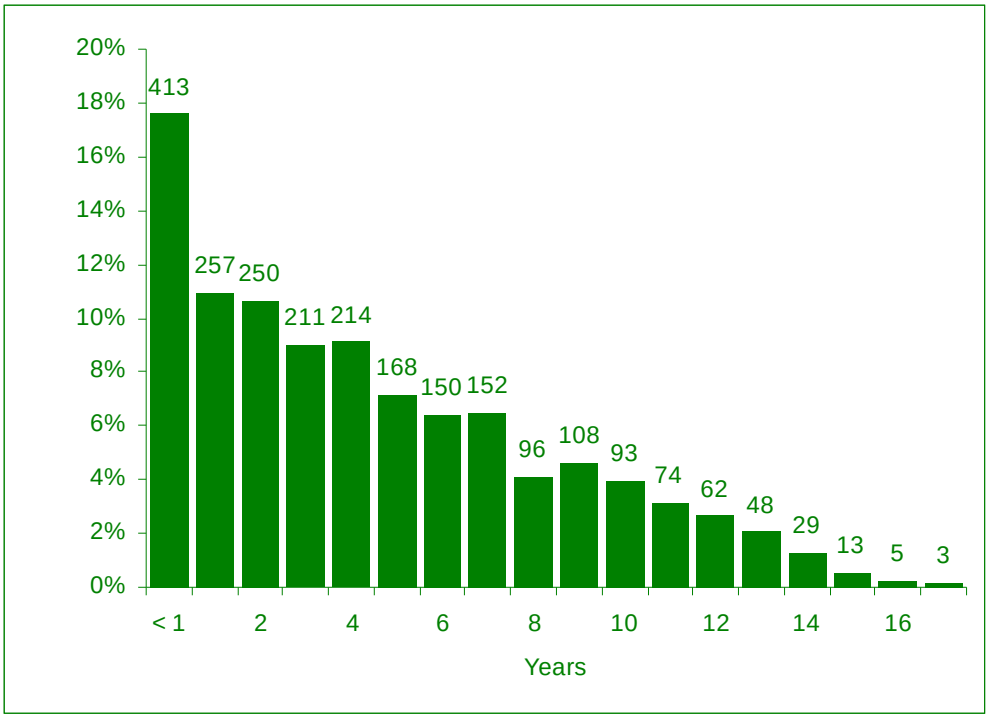

Figure 21. Age at commencement of care – total group (2009)

How many placements have you had altogether?

Table 6 shows that, since 2007, there has been an increase in the number of placements respondents report experiencing. In 2007, the mean number of placements was 2.6, in 2009 this figure is statistically higher at 2.8. The median, minimum and maximum number of placements have, however, remained consistent across the three years.

Table 6.
Total number of placements – total group (2006, 2007, 2009)

	Mean (SD)	Median	Min – Max
2006	2.8 (3.8)	2	1 – 50
2007	2.6 (2.9)	2	1 – 50
2009	2.8 (3.3)	2	1 – 50

The distribution of placement numbers for the three groups combined is presented in Table 7. The table shows that the largest single group of respondents, accounting for 939 respondents or 38.2% of the group, reported having experienced only 1 placement. Six hundred and thirty four respondents (25.8%) reported having experienced 2 placements, while a further 352 respondents (14.3%) have experienced 3 placements. The number of respondents reporting between 4 and 50 placements is 534 or 21.7% of the group. Of this group, 77 reported experiencing 10 or more placements. In 2007, these numbers were 286 and 32 respectively.

Table 7.
Total placements – total group (2009)

Total placements	Number	Percentage
1	939	38.2
2	634	25.8
3	352	14.3
4	163	6.6
5	141	5.7
6	72	2.9
7	30	1.2
8	30	1.2
9	21	0.9
10	15	0.6
11	6	0.2
12	8	0.3
13	5	0.2
14	4	0.2
15	9	0.4
16	3	0.1
17	4	0.2
18	2	0.1
20	6	0.2
21	1	0.0
24	1	0.0
25	3	0.1
26	2	0.1
27	1	0.0
28	1	0.0
30	2	0.1
31	1	0.0
32	1	0.0
42	1	0.0
50	1	0.0
TOTAL	**2459**	**100**

Figure 22 presents the percentage distribution of placement numbers for the three groups combined for 2009.

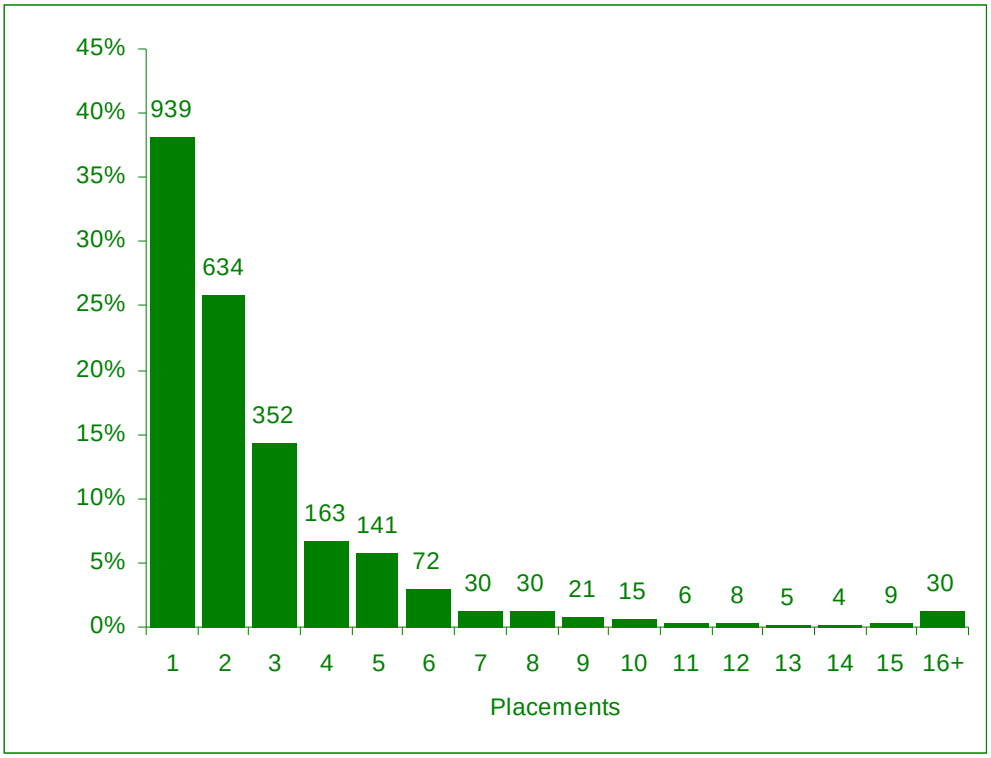

Figure 22. Total number of placements – total group (2009)

How long have you been in care altogether?

Table 8 reveals that the average length of time that respondents report having been in care is 4 years and 7 months. The minimum number of years reported is less than 1, while the maximum is 17 years. These figures are largely consistent with those of previous surveys.

Table 8.
Total length of time in care – total group (2009)

Mean (SD)	Median	Min – Max
4yrs 7mths (3yrs 9mths)	3yrs 9mths	<1 – 17yrs

The distribution of length of care for the three groups is presented in Figure 23. It shows that 10.5% of respondents report being in care for less than 1 year. As can be seen, the most commonly reported length of time in care is 1 year (15.6%), although almost as many have been in care for 2 years (13.4%). More than 300 or 12.4% of respondents report being in care for 10 years or more.

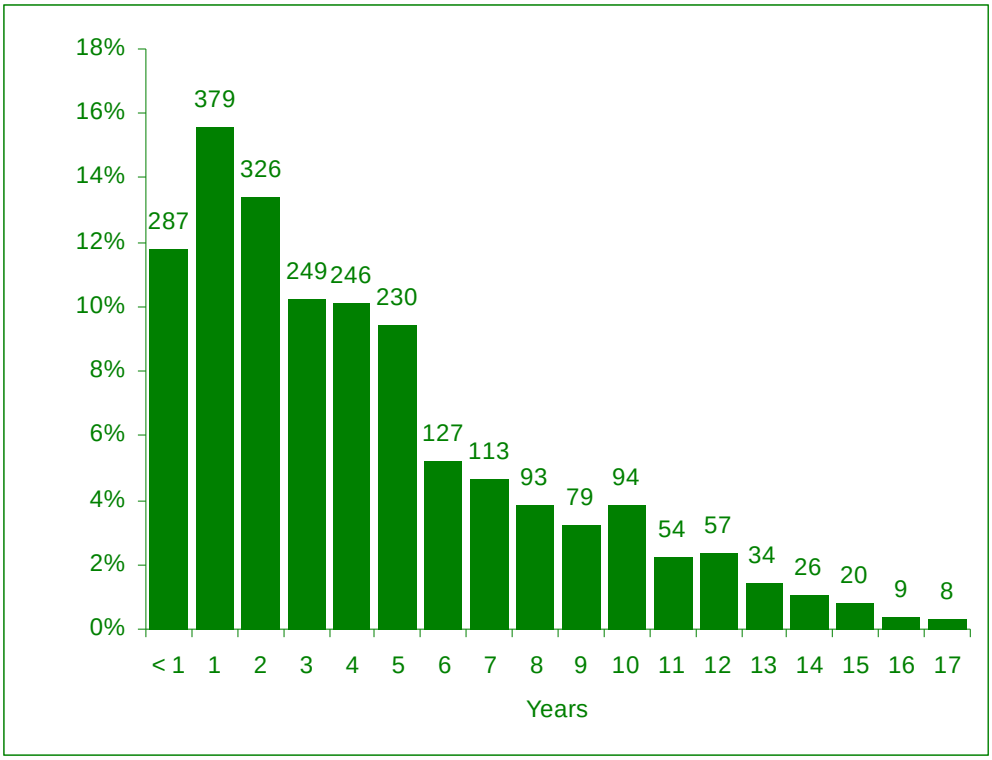

Figure 23. Total length of time in care – total group (2009)

How many times have you gone back to live with your own family (reunified) since you first came into care (not counting visits or holidays)?

Table 9 reveals that the average number of times that the total group reported having been placed back home is .33. The median score is 0, with a minimum and maximum number of 0 and 20 respectively. These figures are largely consistent with those of 2007 and 2006.

Table 9.
Times returned home – total group (2009)

Mean (SD)	Median	Min – Max
0.33 (1.05)	0	0 – 20

The distribution of reunifications presented in Table 10 shows that 2020 respondents (81.6%) have not been returned home at all. Of those who have been returned home, the vast majority have been returned home once. The distribution reveals, however, that 71 respondents (2.9%) reported being returned home 3 times or more. This is compares with 38 respondents in 2007.

Table 10.
Times returned home – total group (2009)

Times returned	Number	Percentage
0	2020	81.6
1	297	12.0
2	87	3.5
3	29	1.2
4	20	0.8
5	6	0.2
6	5	0.2
7	5	0.2
8	1	0.0
9	1	0.0
12	1	0.0
13	1	0.0
18	1	0.0
20	1	0.0
TOTAL	**2475**	**100**

Figure 24 presents the percentage distribution of times returned home for the three groups combined for 2009.

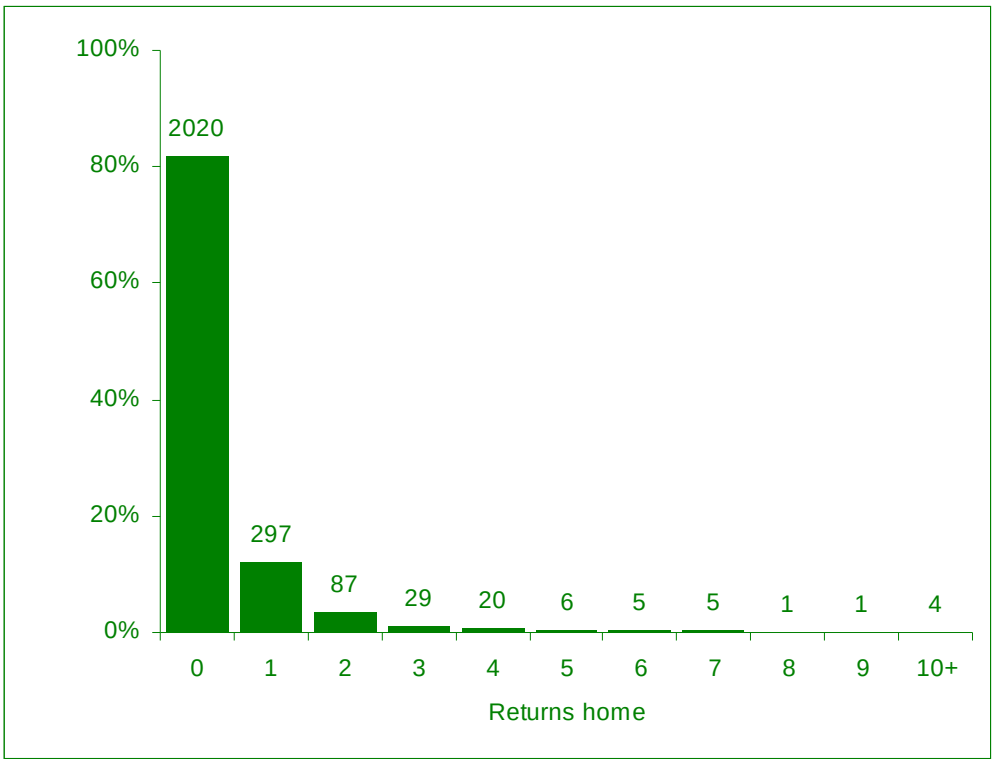

Figure 24. Times returned home – total group (2009)

Summary of findings

- There have been some marked changes over the years in some aspects of respondents' placement histories.
- The mean age at which the current cohort first came into care was 4 years 9 months, compared with 4 years and 7 months in 2006 and 4 years 5 months in 2007.
- The mean number of placement changes has increased significantly from 2.6 in 2007 to 2.8 for the current cohort. More than 60% of the cohort reported experiencing more than one placement, 534 of whom reported experiencing 4 or more placements.
- Of concern are the numbers of children and young people reporting numerous placement changes.
- The number of respondents experiencing 10 or more placements is 77. In 2007, this number was 32.
- Other aspects of placement histories have remained stable.
- The mean length of time that respondents have been in their current placement is 3 years and 2 months while the total length of time in care averages is 4 years and 7 months.
- The mean number of times that respondents have been returned home to their birth family is 0.33. Although this indicates that the majority of respondents have not experienced a failed reunification, 71 respondents reported having been returned home 3 or more times.

Current placement

Introduction

Children's perceptions of their placements and relationships with carers are integral to the fulfillment of their rights. Under the *Child Protection Act 1999* children in foster care have a right to "receive emotional care" and to "experience being cared about and valued." Furthermore, children in care are afforded the right to "receive positive guidance … to change inappropriate behaviour" without being subjected to corporal punishment or any technique likely to humiliate or frighten them. The department provides training and guidelines to carers to fulfill these obligations, however, to determine whether these efforts are having the desired effect it is necessary to find out how children and young people experience their placements.

Positive placement experiences are also important for children's and young people's wellbeing and development. For children and young people who have been removed from abusive and neglectful homes it is particularly important to have a sense of belonging as part of a family and to feel safe and loved to overcome their past traumas (Schofield, 2002). Carers can create this sense of family solidarity through demonstrations of care, making the child feel welcomed and just by listening (Riggs et al., 2009). The benefits of a positive placement experience, including feelings of safety, can even extend into adulthood, predicting high school completion and further educational success (Havalchak et al., 2009).

Positive placement experiences are also linked to more stable placements. Feelings of safety and being well cared for may be indicative of a good match between child and carer, which increases the likelihood of a stable placement. Correspondingly, dissatisfaction with a placement is a strong predictor of placement breakdown and further instability. It has been suggested that children who are dissatisfied with their placement may even act out to make their placement untenable and force the department to relocate them. There are a range of benefits to children and young people having stable placements and forming secure and close relationships with their carers which are outlined in the preceding section, *Placement History*.

This section of the questionnaire asked young people and children a range of questions about their current placement. Questions focused on feelings of safety, perceptions of carers, household size and dynamics, and happiness in placement. Respondents were also asked two open-ended questions, one asking them to comment on the best thing about their placement, the other asking them what they would most like to see changed or improved to make their placement better.

Do you feel safe here?

Figure 25 shows that 98.6% of young people and 97.5% of children reported feeling safe where they live. These figures remain largely unchanged from those of 2007 and 2006.

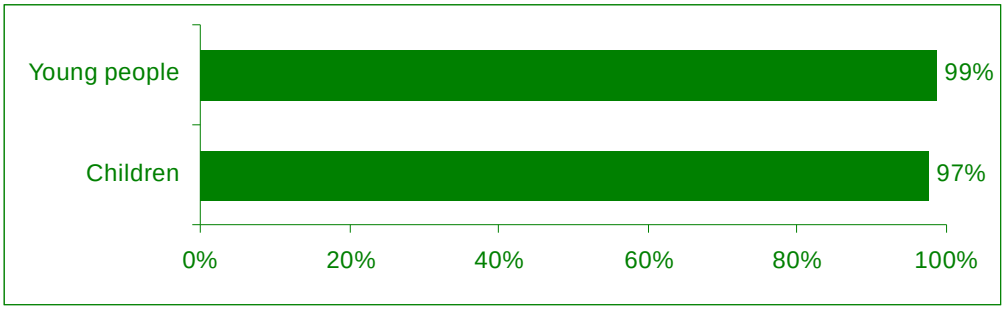

Figure 25. Feel safe – young people and children (2009)

Perceptions of carer

Does your carer listen to you?

The vast majority of young people (96.4%) report that their carer listens to them all or most of the time. Of these, 67.3% feel that their carer listens to them all of the time, while 29.1% reported that their carer listens to them most of the time. Only a small proportion indicated that their carer doesn't listen very often (3.2%) or never listens (0.3%). As Figure 26 shows, there has been an increase, since 2007 and 2006, in the proportion of young people reporting that their carer listens all the time. This increase is statistically significant.

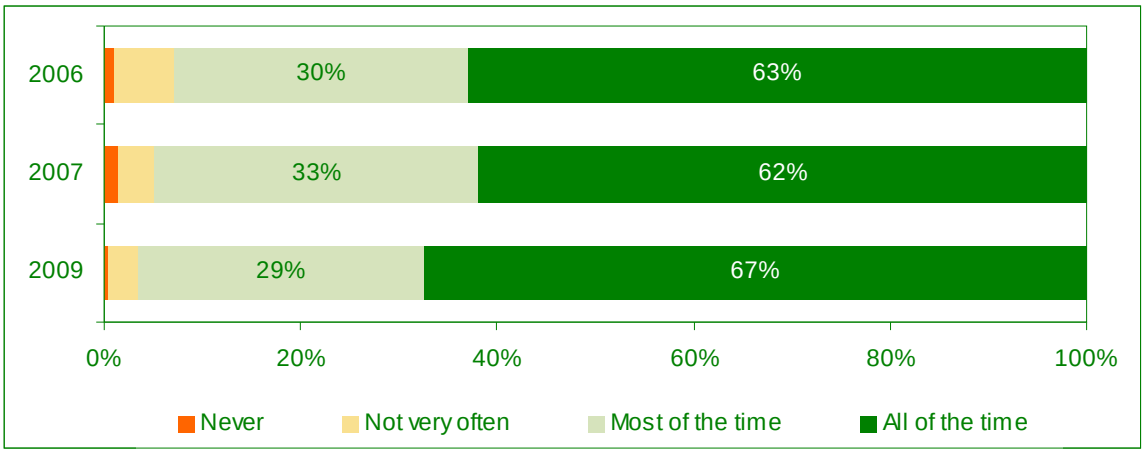

Figure 26. Carer listens – young people (2006, 2007, 2009)

Does your carer treat you well?

When asked if their carer treats them well, almost all young people (99.3%) reported that they do. This figure is consistent with those of previous years.

Figure 27 shows that the vast majority of children reported that their carer listens (96.7%) and is nice to them (97.8%). These results are consistent with those of 2007 and 2006.

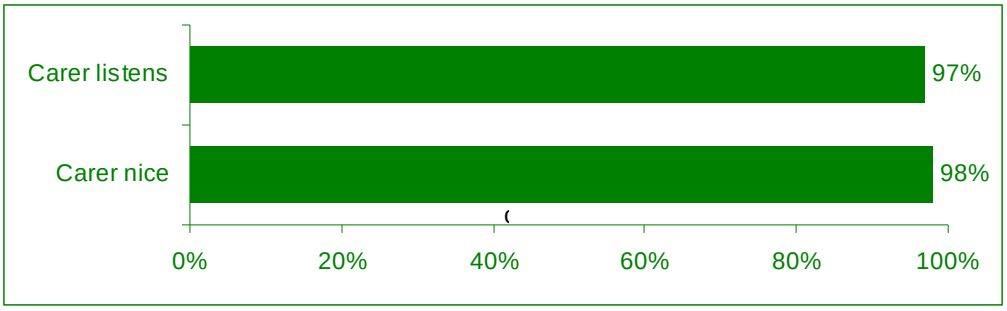

Figure 27. Carer listens, carer is nice – children (2009)

Household size and dynamics

How many children and young people live here (not counting you)?

In order to determine the size of the households in which children and young people in care live, they were asked how many children and young people live with them. Carers were also asked to indicate the number of children and young people, other than the subject child, living in the household. Table 11 shows the combined responses from the three groups. As can be seen, the average number of other children and young people in the household is 2.9. The lowest reported number is 0 while the maximum is 20.

Table 11.
Numbers of other children and young people in household – total group (2009)

Mean (SD)	Median	Min – Max
2.9 (2.2)	3	0 – 20

Figure 28 presents the distribution of the percentage of other children and young people in the household. As can be seen, the size of households in which children and young people reported living varies markedly. Around 10% live in households with no other children or young people, while around 20% live in a household where there is only one other child or young person. More than one third (34.1%), accounting for 895 respondents, live in households with 4 or more other children and young people. Of these households, around 4% comprise 8 or more other children and young people. It must be noted, however, that these figures are only approximate as some who responded to the survey may live in the same household, thus inflating the count.

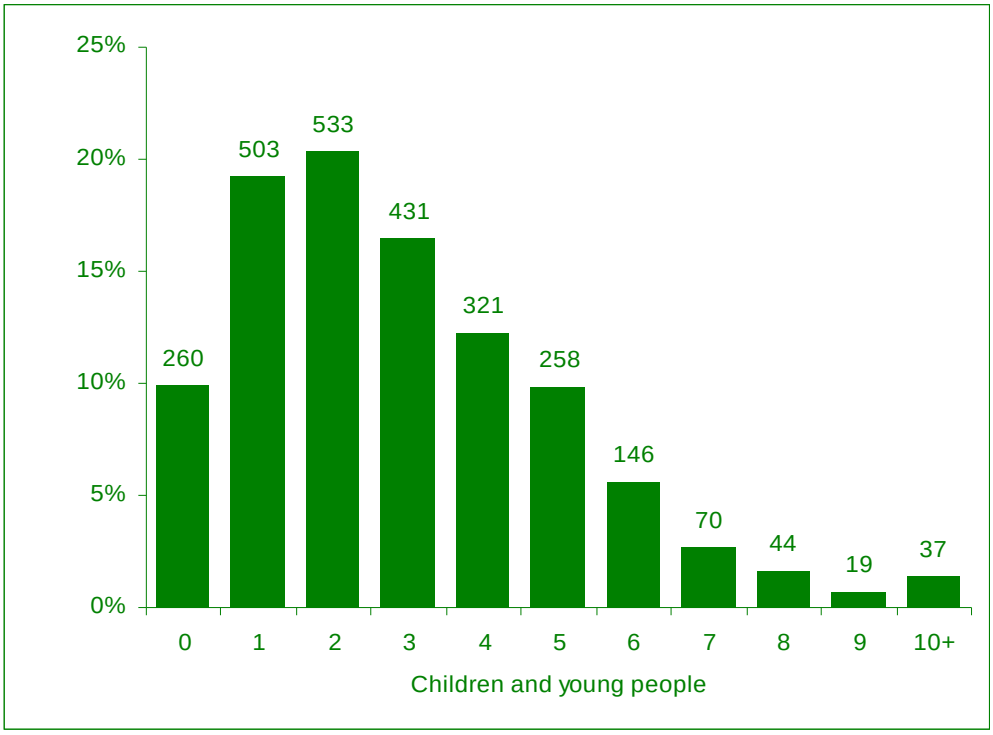

Figure 28. Number of other children and young people in household (not including respondent) – total group (2009) (*n* = 2622)

Are you treated the same as other children or young people living here?

Figure 29 shows that more than two thirds (67.8%) of the young people who are living in households with other children and young people feel that they are always treated the same as others in the household. A further one quarter (25.1%) believe this to be the case most of the time. The remainder, however, reported that they are never (1.6%) or not very often (5.5%) treated the same as others in the household. These figures are largely consistent with those of 2007 and 2006, as are the results for the other questions in this section.

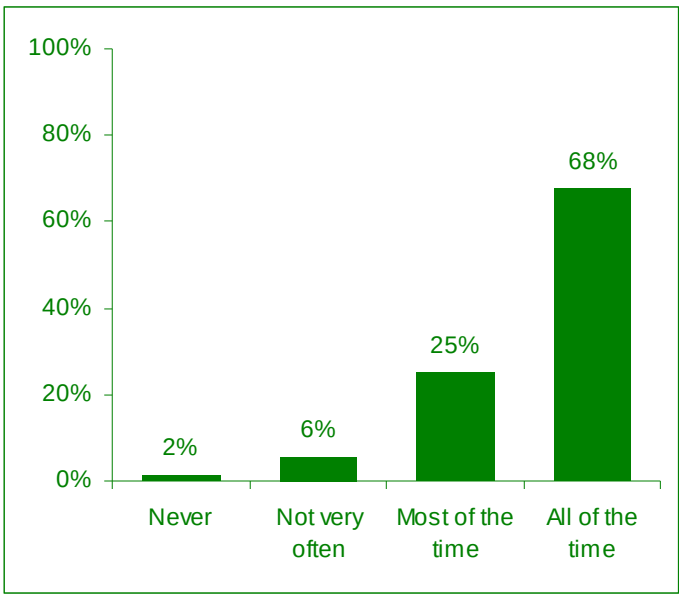

Figure 29. Treated the same as others in the household – young people (2009)

Of those children who indicated that they lived in households with other children, the vast majority (93.2%) indicated that they are treated the same as others.

Are the rules and discipline reasonable?

Figure 30 shows that the vast majority of young people consider the rules and discipline within the household to be reasonable (95.2%).

Are your belongings treated with respect?

Figure 30 also shows that more than nine in ten (91.7%) young people feel that their belongings are treated with respect.

Responses from children are similar to those of young people with 92.3% indicating the rules are fair and 93.1% reporting that their things are being looked after (see Figure 30).

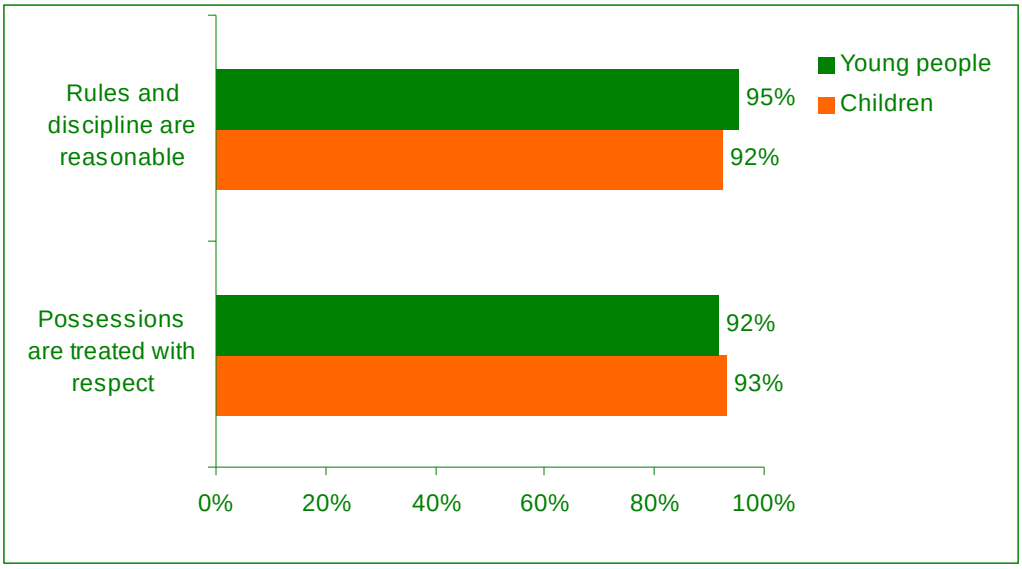

Figure 30. Living conditions and household dynamics – young people and children (2009)

Out of 10, how would you rate your happiness with the placement?

Young people were asked to rate their level of happiness with their current placement on a scale ranging from 1 (really unhappy) to 10 (really happy). Ratings ranged from 1 to 10. Analysis of responses revealed a mean score of 8.8, indicating that most young people are very happy with their placement. This score is consistent with those of 2007 and 2006.

The distribution of scores presented in Figure 31 reveals that more than half (55.6%) of the group awarded their placement a rating of 10.

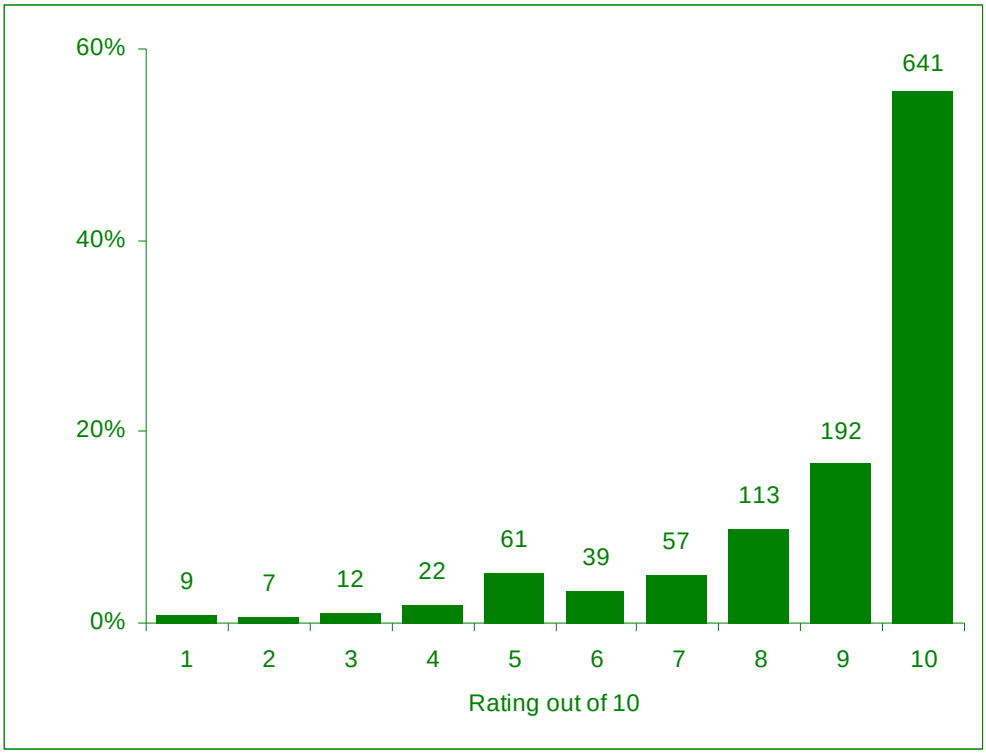

Figure 31. Rating for happiness in current placement – young people (2009)

Children's responses about their happiness are very similar to those of the young people. When asked if they are happy or not, the vast majority (95.4%) reported that they are, while 4.6% reported that they are not. These proportions are identical to those of 2007 and similar to those of 2006 when 97.1% reported being happy and 2.9% not happy in their placement.

Twenty one of the children who indicate that they are not happy in their current placement chose to comment further. The vast majority explained that they are not happy in their placement because they would prefer to live with their biological parent or family. Other reasons included having no one else of their age in the household or wanting to live closer to shops. Examples of children's comments are:

- ***I miss Mum.***
- ***I want to live with Mum and Nan.***
- ***I'd like to be living with Nanna.***
- ***Want to be with Mum and Dad.***
- ***I want to go home.***
- ***I want to go back to Dad. We can watch movies every night and stay up until 11pm.***
- ***Not really because it is not home.***
- ***Because people bashing me up – *** (boy's name) at school.***
- ***No one my age.***
- ***Want to live near a shopping centre.***
- ***Just a crap house.***

What is the best thing about living here?

An open-ended question asked young people and children to comment on the best thing about their current placement. In all, 1112 or 94.2% of the young people commented. Of these, 119 noted 'Nothing', 'Everything/lots of things', 'Don't know' or their comment was unintelligible. A more complete list of comments can be found in the appendix.

Analysis of remaining comments revealed three primary themes, each of which comprise numerous sub-themes. These themes and associated sub-themes are shown in Tables 12 and 13 in order of popularity, along with the comments that exemplify them. In addition, numerous young people also commented on having their basic needs met such as having somewhere to live or sleep and enough food to eat.

Table 12 shows that lifestyle factors such as participating in games and activities, going on holidays, having possessions, pets and space feature prominently, as do having personal freedom, making friends, and having fun. Relationships with carers or particular carer characteristics were also frequently mentioned by young people with many noting that their carer is kind or their carer makes them feel loved, supported, respected and safe. Many young people also appreciated being part of a "normal" family and being able to stay in touch with their biological family.

Table 12.
The best thing about living here – young people (*n* = 993)

1	**Lifestyle**	
	Activities, games, outings, holidays	• *They take me fishing and actually that was my first time. And football. All because of my carers which is good.* • *We get to go camping.*
	Possessions or luxuries	• *Pool, air con, TV.* • *Heaps of presents. Get pocket money.*
	Space, environment, amenity, location	• *I have my own room and a big bed.* • *Live on six acres and have room to ride my bike.*
	Social, friends, other children around	• *They let me have birthday parties and they let my friends sleep over.* • *Being close to friends.*
	Food, cooking, eating	• *Getting the best dinners and best dessert – like stewed apple and custard.* • *I cook dinner, I am a good cook.*
	Personal autonomy/development	• *Achieved and learnt more about life and responsibilities.* • *I am guided into a lovely place and have transformed into a lovely nice young lady.*
	Pets	• *I'm allowed to have pets.* • *Dogs, animals, ***.*
	Fun	• *The best thing about living here would have to be that it is fun and it's great living here.* • *You get to have fun.*
	Education	• *Having a bright education which I really do need.*
2	**Relationship with/qualities of carer**	
	Love, support, care, understanding	• *Knowing that you have someone that cares for you.* • *Everything. I'm allowed to go home but I choose to stay! My carer is just brilliant!!*
	Fair treatment and respect	• *Everyone is treated equally.* • *Not getting hit.*
	Protection and safety	• *I feel protected and I am not forced to do stuff and go places I don't want to.* • *I feel secure and safe. Haven't needed to move around.*
	Nice/good people	• *A wonderful lady.* • *My carer is more of a friend than a parental unit.*
3	**Family**	
	Family life, being part of a "normal" family	• *Feel like I am their real children.* • *It's fair and like a proper family. It's a real family!*
	Being in kinship care	• *I love living with my grandmother.* • *I live with my grandmother and she raised me and my sister.*

	Being in placement with relatives/siblings	• *I get to be with my little sister ***.* • *Living with my sister. No bitchiness or trouble here.*
	Maintaining contact with biological family	• *I live with my nan and pop but I still see my mum when she visits.* • *Get to see Mum and brothers sometimes.*
4	**Basic needs met**	• *Umm, not sure. A roof over my head and clothes to wear.* • *Get fed. Somewhere to sleep. Unlike some other places, that's all.*

Six hundred and ninety eight or 90.8% of the children commented on what they think is the best thing about their placement. Of these, 53 noted 'Nothing', 'Everything/lots of things', 'Don't know' or their comment was unintelligible.

Table 13 presents the themes that emerged from the remaining comments. As can be seen, the things that children value are consistent with those valued by young people. There is also little variation between children and young people in how often they mentioned these factors. Children, like young people, are most likely to mention lifestyle factors as being the best thing about their current placement. Their relationship with, or qualities of, their carer is the next most likely aspect of care to be mentioned, followed by family factors, such as being able to maintain contact with their biological family. Children also implied that their basic needs were now being met for instance, having shelter, food to eat, and being taken care of.

Table 13.
The best thing about living here – children (*n* = 645)

1	**Lifestyle**	
	Activities, games, outings, holidays	• *Playing games. Jumping on trampoline.* • *We get to go out to the movies, the beach and go bowling on the holidays.*
	Having possessions or luxuries	• *I get nice clothes and toys and digital camera for my birthday.* • *Heaps and heaps of treats.*
	Food, cooking and eating	• *Having breakfast: we get Weetbix and toast.* • *The food. My favourite is homemade sausage rolls!*
	Space, environment, amenity, location	• *I have my own room.* • *It's a beautiful house to live in here.*
	Social, friends, other children around	• *I like playing with my friends.* • *I get heaps of friends and at my other school I had only four friends.*
	Pets	• *I like the horses.* • *I like playing with my dog.*
	Having fun	• *We have fun; we have fun together.* • *That they really like me and they are fun to play with.*
	Education	• *We get to go to school and make stuff.* • *Going to school and getting dropped off.*
2	**Relationship with/qualities of carer**	
	Love, support, care, understanding	• *They love me and take care of me.* • *All the love I get in this home.*
	Carer is nice/good/the best	• *Nice people and lovely family. Give me anything I need.* • *My carer is very nice and she is helpful.*
	Protection, safety, no violence	• *No yelling or screaming.* • *That I'm safe and nobody can hurt me.*

	Fair treatment and respect	• *Mum and Dad and most other people here respect me.* • *We are all respected and treated very well. My carers support me a lot, and go to the end of the world for me.*
3	**Family**	
	Maintaining contact with biological family	• *I can talk to my mum on the phone.* • *Get to see cousins and my grandma.*
	Family life, being part of a normal family	• *Part of a family.* • *I have a good family here and my sister plays with me.*
	Being placed in kinship care	• *Being with my Nana and brother and sisters.* • *Get to play with cousins. Be with family. Bushwalking with Nanna.*
	Able to contribute	• *Is I can help.* • *Building fences.*
4	**Basic needs met**	• *Eating, having a bed.* • *Food, shelter, happiness, fun.*

What would you most like to see changed or improved to make your placement better?

Nine hundred and eighty three or 83.1% of the young people responded to an open-ended question asking them what would make their current placement better. Of these, 554 young people noted 'Nothing' and 52 indicated that they 'Don't know' or are 'Not sure'. Analysis of the remaining comments reveal five primary themes. These themes and associated sub-themes are presented in Table 14 in order of popularity. Comments illustrative of each sub-theme are also provided. A more complete list of comments is provided in the appendix.

As can be seen in Table 14, the improvements suggested most often by young people focus on changes in the membership or management of the household. Many young people, for instance, would like some members of the household to leave, to behave more appropriately or to get along better with others. A considerable number of young people also thought that their placement could be improved with the acquisition of material goods, possessions or services. Changes to the physical structure, appearance or size of the household premises was also frequently mentioned as was relationship with birth family such as being returned home or having more contact with family. Many young people expressed a desire for greater access to activities or opportunities to see friends or have pets, while some wished to be treated differently such as being afforded more freedom or respect.

'Other' comments referred to improved support or understanding from the department (11) and the need to make changes to self, such as improving their behaviour (11). Numerous one-off suggestions were also received from young people including the need to *find out who my father is*, *neighbours move out – parties every night* and *want to work more*.

Table 14.
Most like to see improved or changed – young people (*n* = 377)

1	**Management or membership of household**	
	Changes to household membership	• *For other young people to leave.* • *Another boy my age in care too so I have someone to play with.*
	Improved household relationships	• *My brother being nicer to everybody.* • *People get along.*
	Better behaviour, rules, cleanliness	• *Like to have no rules.* • *Better rules, no yelling.*
2	**Material goods/services**	
	Personal possessions, luxuries	• *A better TV.* • *If I had my own laptop.*
	Household items	• *Dishwasher.* • *Air conditioner (too hot).*

3	**Premises**	
	Larger house, yard or bedroom	• *Bigger house/unit with a reasonable backyard.* • *A bigger house.*
	Own room/more privacy	• *Get my own room.* • *More bedrooms/space.*
	Renovations, repairs, rearrangements	• *Computer working.* • *To have ***(brother) room moved away from mine.*
4	**Relationship with birth family**	
	More contact	• *See my mum everyday.* • *Start seeing my brothers again.*
	Reunification	• *Moving back home.* • *Living with Mum.*
5	**Opportunities and activities**	
	Activities, games, adventures, family time	• *More turn at the Xbox 360.* • *Mum and Dad to play more games with us.*
	Social, making/having friends	• *See my mates.* • *Bigger social life.*
	Having pets/more pets	• *Having a kittens.* • *I want a pet reptile but the carers don't.*
6	**Treated differently**	
	More respect or fairer treatment	• *Kids not going through my stuff.* • *If I was trusted more.*
	More autonomy	• *More say on what we get to do.* • *Not really. Just more freedom. Seeing friends outside of school.*
7	**Other**	
	Changes to self/behaviour	• *I stop having tantrums.* • *Me behaving myself at school.*
	More support, understanding, action or resources from the department	• *I want the Department to help the carers more.* • *More help from CSO.*

Summary of findings

- Consistent with 2006 and 2007 findings, almost all the young people and children report feeling safe and happy in their current placement.
- The vast majority also report that: their carer listens to them and treats them well; they are treated the same as other children and young people in the household; the rules and discipline are reasonable; and their possessions are treated with respect.
- For most children and young people, the best things about their placement are lifestyle factors and the relationship they have with their carer.
- Suggestions for improvements include the need for changes to the household membership or management, more material goods and services, alterations to the premises, more contact with birth family, and greater access to opportunities and activities.
- Household sizes vary considerably with numbers of other children and young people in the household ranging from 0 to 20 with an average of 2.9.

Child protection system

Introduction

Under Article 12 of the *United Nations Convention on the Rights of the Child*, to which Australia is a signatory, children and young people have the right to freely express their views on all matters affecting them and for those views to be given “due weight in accordance with the age and maturity of the child”. For children and young people in care in Queensland, this right is enshrined in the *Charter of rights for a child in care* in the *Child Protection Act 1999*. The charter provides that children have a right to be consulted about decisions affecting them and also to be informed about plans and decisions concerning them as well as their own personal history “having regard to the child’s age or ability to understand.”

Gilligan (2000) identifies pragmatic and therapeutic advantages to involving children and young people in decision-making beyond what she refers to as "ethical" and "philosophical" reasons. Where young people are involved in a decision they are more likely to adhere to it and participating in decision-making can build young people's self esteem and agency. To realise these benefits, however, it is necessary for young people to feel that their input is valued and that the decision makers will follow through on promises (Cashmore & O'Brien, 2001).

Determining the extent to which a child or young person should be involved in a decision can be complex. A particular challenge is striking the appropriate balance between their right to participate and the state's obligation to protect them. Adults may not want to burden children and young people with too much responsibility and may be reluctant to discuss difficult issues for fear that they will upset or re-traumatise children. It can also be difficult to determine what is age-appropriate and how much weight should be given to a child's views in a particular situation.

In Queensland the key formal mechanism for decision-making is case planning. Case plans contain a range of important information that guide the actions of the department, carers, parents and children in meeting children's needs while they are in care. It includes an explanation about why the child is in need of protection, the goal of the department's ongoing intervention (e.g. reunification or permanent out-of-home care) and what specific actions are to be undertaken by relevant parties to achieve goals. According to the department's Practice Manual "all activities, discussions and contact with the child and family will be guided by the case plan while it is in effect."

In late 2004, case planning became a legislated requirement under the *Child Protection Act 1999*. The initial case plan is to be developed after consulting all relevant parties through a family group meeting. Where it is developmentally appropriate, children and young people must be given an opportunity to attend the meeting and must be provided with a copy or alternatively an age-appropriate explanation of the contents of the plan. Case plans are to be reviewed or updated at least every six months.

The questions in this section focus on general issues relating to children's and young people's experiences of care and the child protection system. They include questions on case plans, having a say in decisions, having decisions explained and being listened to, as well as the everyday impacts of being in care such as obtaining permission to do things and maintaining contact with family. Also included in this section are questions on awareness and use of support services and how the system could be changed to improve the lives of those in care.

Case plans

Do you have a case plan? If yes, do you know what's in it?

Figure 32 shows that there has been a considerable increase since 2006 in the proportion of young people reporting to have a case plan. In 2009, 63.1% of young people reported having a case plan, compared to 39.9% in 2007 and 26.3% in 2006. These differences are statistically significant.

Figure 32 also reveals substantial increases in the proportion of young people reporting that they know what is in their case plan. This proportion has risen from 18.2% in 2006 to 26.9% in 2007 and 42.1% in 2009. While these differences are statistically significant and encouraging, the majority (57.9%) of young people continue to report being unaware of what is in their case plan.

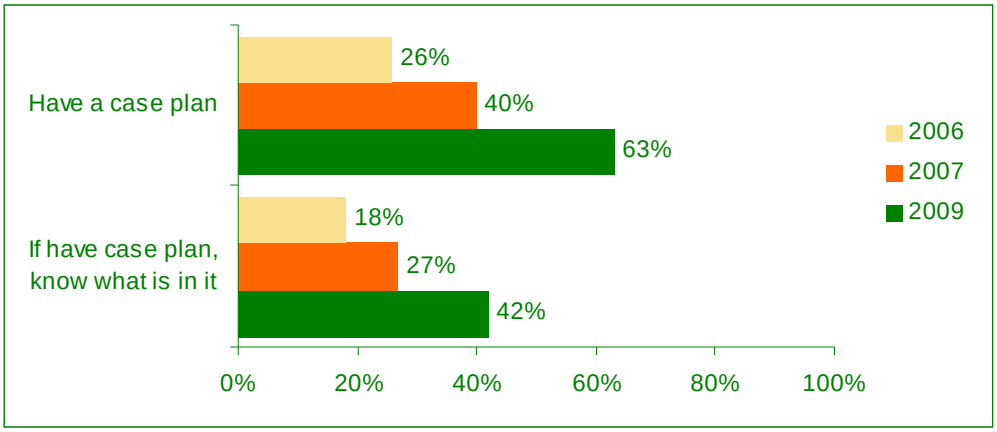

Figure 32. Have a case plan – young people (2006, 2007, 2009)

A new question in the 2009 survey for carers asked if the child in their care has a case plan. According to 83% of carers, their child does have a case plan. The remaining 17% of carers indicated that their child does not have a case plan.

Having a say

Do you have a say about what happens to you (such as your case plan)?

As can be seen in Figure 33, just over half (52.7%) the young people reported that they have a say most or all, of the time, while 47.3% indicated that they never have a say or don't have a say very often. Figure 33 also shows that the proportion of young people reporting having a say most, or all, of the time has decreased significantly since 2007. At this time, 59.4% of young people reported having a say most, or all, of the time.

One hundred and forty one (11.9%) of the young people commented on the question about having a say in what happens to them. Many stated that they 'Don't know' or are 'Not sure'. Some examples of the other comments provided are:

- ***I am always involved in things.***
- ***I choose to go to **** [place name] netball carnival, and the choir, and scouts.***
- ***Thanks to CREATE.***
- ***I guess I have a say. Why wouldn't I it's about me?***
- ***I get to have a say but it doesn't always happen.***
- ***YES, but they never listen.***
- ***Sometimes depends what it is.***
- ***Not with CSO. She thinks my ideas are unacceptable.***
- ***Have a new CSO so may be better now.***
- ***Wish I could.***
- ***I would like to.***
- ***Never been included – never been asked.***

When children were asked whether or not they have a say in what happens to them, 60.2% responded that they do (see Figure 34). This figure is marginally higher than that of 2007 (53.1%) but the difference is not significant. While this slight increase is encouraging, there remains a substantial proportion (39.8%) of children who feel that they do not have any say in matters that affect them.

Do people explain decisions made about you?

Responses from young people suggest that the majority are satisfied with how often people explain decisions to them. More than two thirds (68.0%) of young people indicated that decisions are explained to them all (27.4%) or most (40.6%) of the time. This is similar to the responses from 2007 when only 65.4% reported that decisions are explained to them all or most of the time. As Figure 33 shows, these proportions are considerably higher than that of 2006 when 53.5% reported that decisions are explained all, or most, of the time. While this trend is encouraging, a substantial proportion of young people continue to report that decisions are never explained or not explained very often.

Eighty nine (7.5%) of the young people commented about people explaining decisions. The majority of these comments centred on a lack of explanation on the part of the department. Examples of what young people had to say are:

- ***CSO just tells me but doesn't explain.***
- ***Counsellor has explained some things.***
- ***Carers talk to me department don't talk.***
- ***CV spoke with CSO and asked her to talk why children came into care as they wanted to know.***
- ***Carer tells me what she knows.***
- ***You find out the day before changes are going to happen.***
- ***Carer does but Dept doesn't.***

Figure 34 shows that when children were asked if decisions are explained to them, 68.5% reported that they are. The remaining 31.5% reported that decisions are not explained to them. These results remain largely unchanged from those of 2007 and 2006.

Do people listen to what you want?

The vast majority (87.0%) of young people reported that they are listened to most (51.5%) or all (35.5%) of the time. A further 11.4% indicated that they are not listened to very often and 1.5% indicated that they are never listened to. As shown in Figure 33, the proportion of young people reporting that they are listened to has increased significantly over the years. In 2007 and 2006, the proportions who reported that they were listened to most or all of the time were 83.8% and 75.4% respectively.

Seventy six (6.4%) of the young people commented further on people listening to them. Their comments included:

- ***Sometimes but they don't always do anything.***
- ***I talk to my carers.***
- ***Last CSO did.***
- ***Sometimes the things I want are impossible to have.***
- ***We must say we would 'like' something not 'want' it as Mum says 'want' is demanding.***
- ***Depends which people. Parents, CSO & CV do.***
- ***It's okay, I expect a lot.***

Children were also asked if people listen to what they want. As Figure 34 reveals, the vast majority (86.0%) reported that they are listened to while 14.0% reported that they are not. These proportions are largely consistent with those of other years.

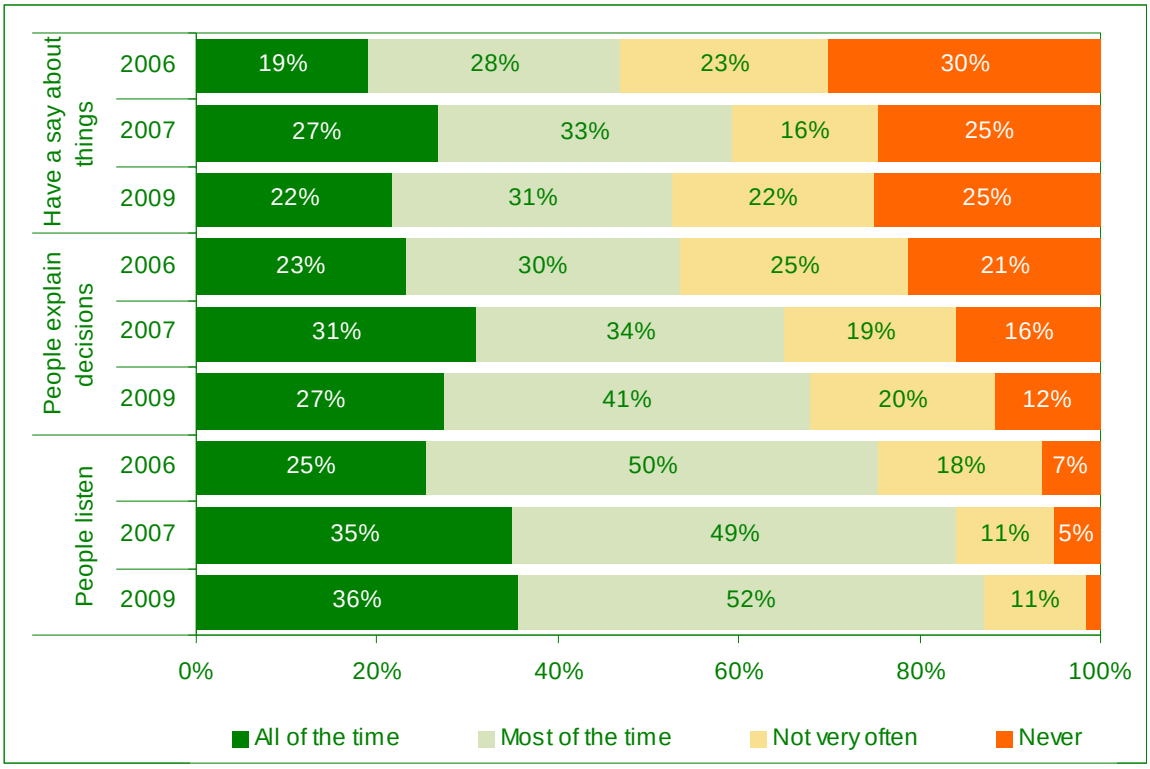

Figure 33. Involvement in decision-making – young people (2006, 2007, 2009)

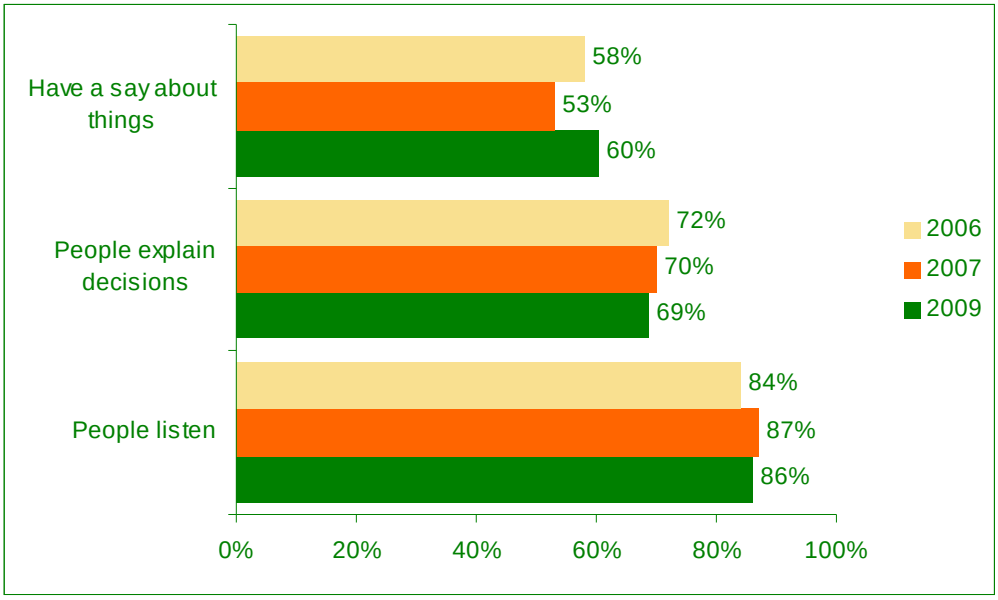

Figure 34. Involvement in decision-making – children (2006, 2007, 2009)

Carers were asked if the views and wishes of the child in their care are taken into account. More than half (50.9%) indicated that the question is not relevant as the child in their care is too young to have their views considered. Of the remainder, around one third (34.5%) indicated that the child's views are taken into account, while 14.6% indicated that they are not. These figures are similar to those of 2007 and 2006.

Related to this, carers were also asked if they feel that decisions are generally made in the best interests of the child in their care. Around 71% responded that they are. This figure is consistent with those of previous years.

One hundred and fifty (19.3%) of the carers commented further on the issue of decisions being made in the best interests of the child. Examples of comments from those who agreed that decisions tend to be made in the child's best interests are:

- ***Well provided for.***
- ***As have a good CSO at this time.***
- ***Always but sometimes some advocacy is needed.***
- ***Generally but not always. The decision makers don't usually know enough about the children.***

The vast majority of comments, however, were from carers who thought that decisions made were contrary to the child's best interests. These comments included:

- ***They want their paperwork right not the kids.***
- ***Decisions are made to suit mother.***
- ***Dept pushing for reunification too soon. Focus is on parent not child.***
- ***Not a child centred focus. Admin issues, legal issues seem to take priority.***
- ***Department refuses to care about this child.***
- ***Made in favour of the birth mother despite her refusal to make necessary changes to her lifestyle.***

Has anyone explained to you why you came into care? (you don't have to give any details)

Figure 35 shows that 68.8% of young people and 51.9% of children reported that someone had explained to them why they came into care. These figures are similar to those of 2007 suggesting that a considerable proportion of children and young people remain unaware of why they came into care.

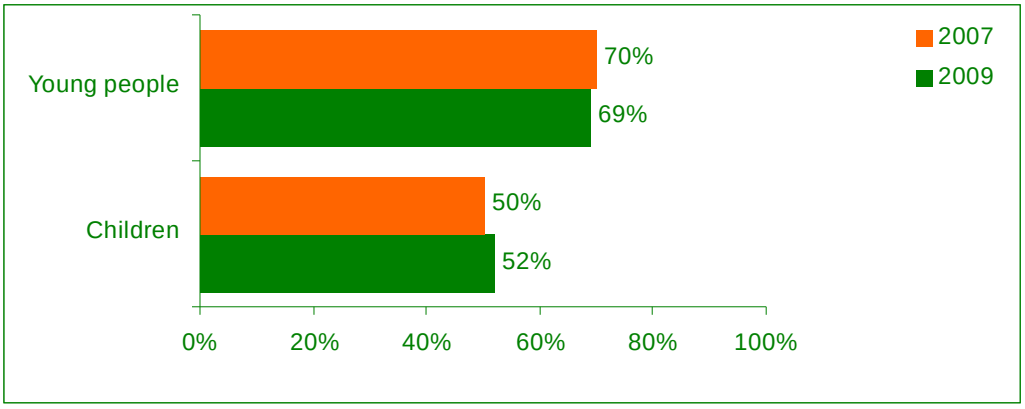

Figure 35. Explanation for coming into care – young people and children (2007, 2009)

Comments from 192 (16.3%) young people help shed light on this issue. Many of these young people stated that they would have been too young to understand at the time of coming into care or they have since "figured it out" themselves. Some commented that they 'still don't know ' and 'would like to be told', while others actually stated what they understand is the reason for coming into care. Some examples of young people's comments are:

- ***Not really. But I can kinda guess why.***
- ***We figured it out ourselves.***
- ***Figured it out.***
- ***I understood a bit but it was confusing. Thought I'd be here only for a short time.***
- ***They told me but I don't get it.***
- ***That's hard because my nan tells me something and the carers tell me different.***
- ***Just my Mum couldn't handle me.***
- ***Mum an alcoholic.***
- ***Mum was too young to look after me.***
- ***I can't live with my mum because she can't look after me.***
- ***Because I was violent and hurting my family.***
- ***Because of Dad bashed me up.***
- ***I really want to know.***

- *I want to know, please.*
- *Not at all! Not a single speck.*
- *No nobody told me anything. They just sat me on a chair and left me there.*
- *You know no-one never. Now even my sister and she's almost eighteen.*
- *Real mum and step-dad mean to me.*

When you first came into care, were you told what to expect?

Figure 36 shows that, despite more than two thirds of young people being told why they came into care, only one third (33.3%) reported being told what to expect about being in care. This figure remains largely unchanged from 2007 when 31.5% of young people reported being told what to expect but it is significantly higher than that of 2006 when only 23.1% reported being told what to expect.

Three hundred and seven (26.0%) of the young people commented further on this issue. Again, many simply noted that they were very young or too little at the time to understand or that they can't remember or don't know. Comments from other young people included:

- *By CSO.*
- *By Nan.*
- *Wish someone had explained.*
- *I had no clue what foster care was about. I was at Police Station for 5 hours and all I remember is Maccas food. It was very scary.*
- *I was taken from school. Then brought to some strange house. Seriously it's just so rude!*
- *I wasn't told anything, I was thrown in a car and taken to a place and slept the night. I was kicking and screaming.*
- *They just said it would be like a normal family.*

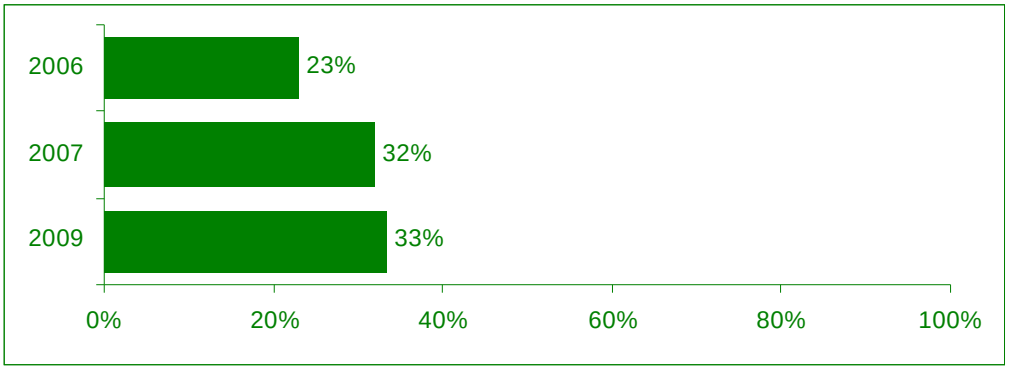

Figure 36. Told what to expect in care – young people (2006, 2007, 2009)

Are you worried that you will have to move to another place in the next few months?

Although the majority (80.4%) of young people are not concerned that they will have to change placements in the coming months, almost one fifth (19.6%) of young people are. This figure is consistent with that of 2007 when 19.9% expressed concern about having to change placements.

One hundred and sixty four (13.9%) of the young people commented further on the question of changing placements. Some explained that they would be happy to move, some were confident that they would not have to, whereas others expressed concern that they may be moved despite being happy in their placement. Examples of these comments are:

- *I want to move in with my sister's carers.*
- *Not at all. I would be happy to move.*
- *I've never lived with someone over a year.*
- *Nanna said we are always staying here till we are 18.*
- *Have told me I can stay here until I'm 18 then I can choose.*
- *Nan & Pop have got me a caravan.*
- *My carers are building me a granny flat.*
- *Grandma not give up on me she said.*
- *I don't want to leave my family but it has to happen.*

- ***Feel a little insecure sometimes.***
- ***I worry sometimes, I'm a worry wart.***
- ***Because Nan & Pop are saying they are getting old.***
- ***I want to stay here and never move out.***
- ***Because I'll have to meet new faces & lose my other friends.***
- ***I am worried that I will move cause the most I have stayed with a family member is 3 years.***
- ***I don't want to keep moving like some kids in care have to.***
- ***Sometimes I get worried that I'll have to move. I don't want to, really love the carer & placement.***
- ***Mum says we will go back to her in October.***

Summary of findings

There have been positive changes in relation to case plans and young people's perceptions that they are listened to and have decisions explained to them.

- Almost two thirds of young people report having a case plan – a significant increase on the proportions in 2006 and 2007. Furthermore, responses from carers reveal that more than 80% of young children have a case plan.
- There have also been significant increases over the years in the proportion of young people reporting that they are listened to all or most of the time. A similar proportion of children also report that they are listened to.
- Young people's reports of having decisions explained have increased significantly since 2006 and 2007, although almost one third continue to feel that decisions are not explained to them.

In contrast to these improvements, having a say in matters that affect them appears to be a growing source of discontent for many young people.

- Almost half indicated that they rarely or never have a say in what happens to them – significantly more than the 2007 proportion of 40.6%.
- Almost one fifth of young people continue to report being worried that they will have to change placements in the coming months.
- In addition, only one third of young people reported having been told what to expect about being in care. Around one third of young people and almost half of the children reported that no one had explained to them why they came into care. It was evident from their comments, however, that many already knew the reason or felt they would have been too young at the time to understand.

Impacts of being in care

Introduction

While home-based foster care is intended to create a family environment for children and young people in care, there are a number of ways in which foster families differ from other families. Some of these differences flow from the legal status of children in foster carer. Guardianship is not held by the carer, rather it is held by parents or the department and this means permissions for certain activities must be sought from parents and/or the department. If there are delays in gaining permission children and young people may miss out on activities. Children and young people may also miss out on activities that they have enjoyed in the past if their new carer and/or the department have more restrictive rules than they were accustomed to with their family of origin. In addition, there are a number of meetings and processes that children and young people in care may be involved in that other children and young people are not, including family group meetings, case planning and regular visits from Child Safety Officers (CSOs) and Community Visitors (CVs).

Issues may also arise based on children's and young people's social status and interpersonal relationships. The NSW Community Services Commission (2000) explored the ways that children and young people in care feel different to other children and young people. As well as talking about guardianship arrangements and permissions, children and young people spoke about the stigma of being in foster care and how this impacted on their self esteem, feelings of isolation and rejection from peers. The report also noted that children and young people may feel different to other members of their foster family and even that they may feel as though they no longer fit into their family of origin.

In this section of the questionnaire questions focused on the impact that being in care can have on the daily lives of children and young people. Responses to these questions are presented in Figure 37. The questions and their responses are as follows.

Do you ever miss out on things (such as sport, sleepovers or excursions) because you are in care?

The majority of young people (79.3%) reported that they never (50.3%) or not very often (29.0%) have to miss out on doing things with their friends or playing sport. As Figure 37 shows, however, around one fifth reported missing out on such things most (14.8%) or all (6.0%) of the time. These figures are largely unchanged from 2007 but are significantly different to those of 2006 when more than one quarter (27.1%) of young people reported missing out on doing things all, or most of, the time.

Three hundred and one (25.5%) young people commented on the types of things that they have missed out on lately. By far the most common response was sleepovers, followed by visiting friends and going on school excursions. Some examples of other things that young people stated that they have missed out on are:

- ***Going out of Queensland for the holidays.***
- ***A church party (city point).***
- ***Halloween party.***
- ***Camping, ear piercing, tattoo etc.***
- ***I don't have people over to my house.***
- ***Yes grandparent and brother birthdays.***
- ***Friends birthday party.***
- ***Last year missed my graduation.***
- ***Wasn't given permission to go away with carer.***
- ***Trip to the coast with my mates.***
- ***Sport (away games).***
- ***Soccer, AFL, Touch, netball, swimming.***
- ***Sport games are on Sat, have visit with parents this day.***
- ***Boxing, horse riding, motorbike riding.***
- ***Sleepovers, going on camps, going to events.***
- ***Excursion, paper work, I couldn't be bothered, & too expensive.***
- ***Miss out on photos being taken – for group photos in newspaper etc.***

Children were also asked if they feel that they miss out on things due to being in care. Although more than three quarters (76.7%) reported that they do not miss out on things, almost one quarter (23.3%) reported that they do. These figures are similar those of 2007 but substantially different to those of 2006 when 33.0% of children reported that they miss out on things because they are in care. This difference is statistically significant.

Are you made to feel different because you are in care?

For most young people, being in care does not make them feel any different from those who are not in care. Figure 37 shows that more than half (55.1%) of the young people reported that they never feel different, while a further 23.7% reported feeling different only some of the time. Around one fifth of young people reported feeling different from others all (13.3%), or most (7.9%), of the time. These responses are largely unchanged from previous years.

Do you have to do things, such as see people or go to meetings, that you don't want to do?

The majority of young people also indicated that they rarely have to do things (such as see people or go to meetings) that they do not want to do. As Figure 37 illustrates, 40.9% of young people report never having to do these things while a further 38.9% reported not having to do these things very often. Nevertheless, around one fifth reported having to do things that they do not want to do most (14.4%), or all (5.8%), of the time. These figures are similar to those of 2007 and 2006.

Children were also asked a similar question. Around three-quarters (74.5%) reported that they do not have to do things that they do not want to do, however, the remainder (25.5%) indicated that they do have to do such things. These findings are similar to those of 2007 but significantly different from 2006 when almost one third (32.2%) of children reported having to do things that they did not want to do.

The 2009 survey for carers asked how often the child in their care has to do things, such as see people or go to meetings, that they clearly do not want to do. Around 90% of carers indicated that their child never (62.8%), or not very often (26.9%), has to do things that they do not want to do. The remainder indicated that their child has to do these things most (6.7%) or all (3.6%) of the time.

Are you able to get permission in time to do things?

Responses from many young people suggested that obtaining permission from the department in time to do things is an ongoing problem. Figure 37 shows that 69.2% indicated that they are able to get permission in time most (48.0%), or all (21.2%), of the time. Nevertheless, 30.8% reported that such permission is not often, (23.0%) or never (7.8%), given in time. These figures are consistent with those of 2007 but are significantly different to those of 2006 when 36.5% of the young people reported that they were not often or never able to get permission in time to do things.

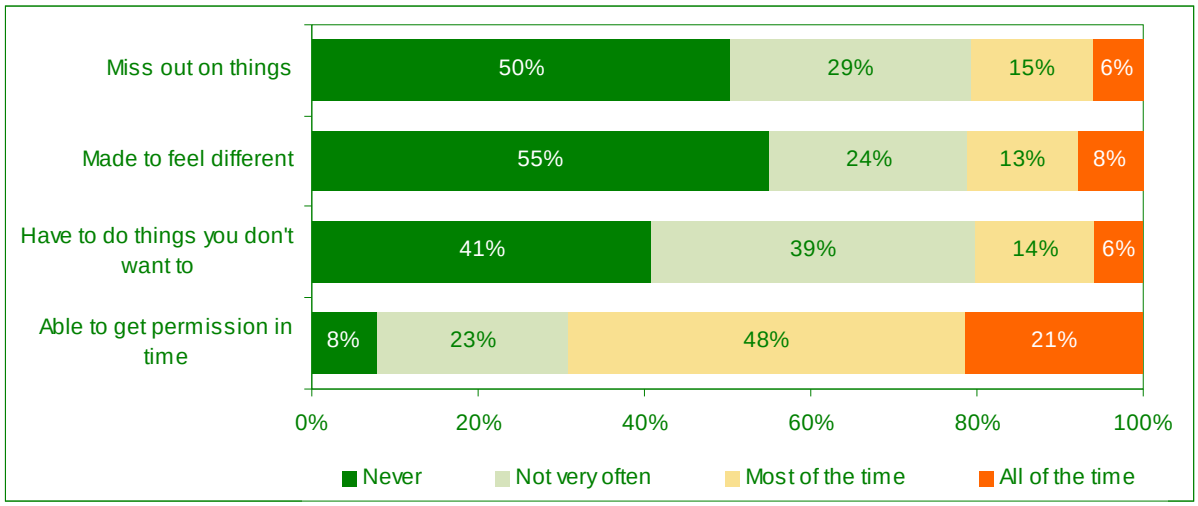

Figure 37. Impacts of being in care – young people (2009)

One hundred and fifty five (13.1%) young people commented on the issue of gaining permission in time. Some noted that the process has improved or that they no longer ask permission but many expressed frustration at missing out on things because permission was not received in time or relevant paper work was lost. Examples of some of these comments are:

- ***I didn't before. But since the new CSO everything is good.***
- ***My foster Mum makes sure things happen.***
- ***Has gotten better.***
- ***I don't ask permission.***
- ***Most of the time it is too late to do stuff.***
- ***Passport was applied for 12 month prior to departure, no decision made so trip wasn't able to happen.***
- ***Very slow always last minute.***
- ***They don't get back to you until after whatever you want to do is finished.***
- ***CSO takes too long or paperwork is lost.***
- ***Most of the time but you have to be on them or they lose the paperwork.***
- ***Take too long and they misplace the paper.***

Are the things you have to get the Department's permission for reasonable?

For many young people, permission requirements are another source of continued dissatisfaction. Figure 38 shows that although just over half (53.2%) feel that the things they have to get permission for are reasonable, almost as many (46.8%) feel that they are not. There has been little change in these proportions since 2007 and 2006.

A new question in the 2009 survey asked carers if they consider the things they need to get departmental permission for in relation to the child in their care to be reasonable. While the majority (70.4%) indicated that requirements are reasonable, a considerable minority (29.6%) feel that they are not.

One hundred and forty five (18.6%) carers commented further on the issue of permissions. Analysis of these comments revealed three primary themes: greater autonomy for carers; issues with obtaining permissions; and involvement of birth parents. A considerable number of carers also made specific reference to the types of things for which they feel gaining permission is difficult or unnecessary. These themes and examples of comments which reflect them are presented in Table 15.

Table 15.
Issues with departmental permission requirements – carers (*n* = 145)

1	**Greater autonomy for carers**	• *Carers should have more freedom, particularly when parents clearly don't care.* • *Need to allow us to make decisions like holidays, immunisations.*
2	**Issues with obtaining permission**	
	Too difficult	• *Child is on long term order. Permission for many things can be difficult to obtain at times.*
	Takes too long	• *Constantly missing out on things waiting for a response. This also undermines the relationship with carer.*
	Communication problems	• *My issue is lack of communication.*
3	**Involvement of birth parents**	• *Parents can be unreasonable.*
4	**Specific/common issues**	
	Medical	• *Being the child's grandmother do I need their permission for a flu injection? Simple things made into dramas.* • *Glasses, basic health needs. Have to fight for her rights continually.* • *Permission from parents regarding vaccination delayed so long child unable to [receive] required rotovirus vaccination.*
	Haircuts	• *Carer has to ask permission to get hair cut.*
	Holidays	• *Permission to take interstate as we do this occasionally.*
	Education/sport activities	• *Permission for basic activities e.g. horse riding etc.* • *Certain things like haircuts and swimming lessons.*
	Family contact	• *E.g. excursions, haircut, doctors visits, maintaining sibling contact. Siblings need this.*

When the Department says you can do something, or have something, do you feel sure that it will happen?

Figure 38 shows that just under half (48.6%) the young people feel confident that when the department says they can do or have something it will happen, while just over half (51.4%) do not feel confident. These proportions are similar to those of 2007, but point to a significant improvement since 2006 in young people's confidence in the department when only 41.1% of young people expressed confidence in the department's assurances.

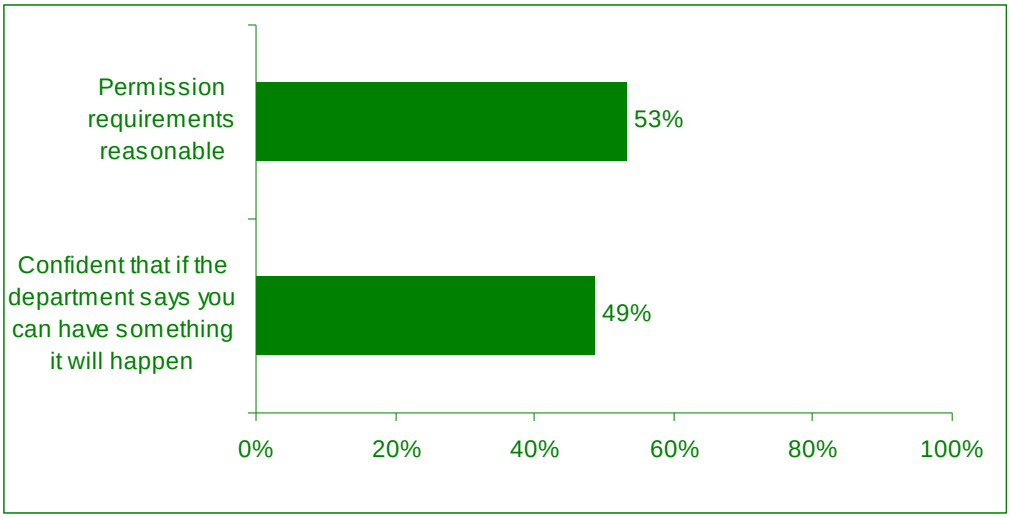

Figure 38. Department's permission requirements reasonable, confident in department's promises – young people (2009)

Summary of findings

- Children's and young people's views about the daily impacts of being in care were varied.
- Most report that they do not miss out on things, have to do things that they don't want to do, or are made to feel different because they are in care.
- According to many young people, however, obtaining permission to do things is a problem. For almost one third (30.8%) permission is not often or never given in time to do things and for 46.8% the types of things that permission is required for are not reasonable.
- Permissions are also an issue for carers with around 30% reporting that the types of things that they need permission for in relation to the child in their care are not reasonable. Many carers commented on difficulties obtaining permission and the need for more autonomy when it comes to making decisions about medical interventions, hair cuts, holidays, and outings.
- Confidence in the department's assurances is another issue for young people. Less than half (48.6%) reported feeling confident that when the department says they can do or have something it will happen.

Contact with family and community

Introduction

Section 87 of the Child Protection Act requires that children have appropriate contact with their family except in circumstances where this would not be in the child's best interests. That is, it is considered desirable for children and young people to have contact with their parents except where there are specific concerns about their safety or wellbeing.

Attachment theory provides a strong justification for maintaining contact with family wherever possible. Children need to feel a close emotional bond with a caregiver to develop emotionally, cognitively and even physically as they grow. These attachments are formed very early in a child's life and even in cases of maltreatment these attachments are strong, even if they are of a low quality, including avoidant or disorganised attachments (Dozier, Stovall, Albus & Bates, 2001). This means that as children enter care they face a disruption to a very important relationship.

Research suggests that when a child's attachment relationships are disrupted they may have difficulty relating to other individuals in their lives including their new foster carers. By maintaining a child's attachment to their parents in a safe and supported way through regular family contact, children may relate better to their new carers, improving their overall wellbeing and even reducing the rate of placement breakdown (McWey & Mullis, 2004). Of course, where reunification is the goal, regular family contact is essential to ensure the transition back into their parents' care is as smooth as possible. This is particularly important for very young children who have not yet formed an attachment with their parents when they are taken into care (Haight, Kagle & Black, 2003). Although family contact is beneficial for many children and young people it is not always easy.

Haight et al. (2003) suggest that difficult and upset behaviour from both children and parents is not necessarily a sign of a poor relationship but can be a result of re-experiencing the trauma of being separated. These feelings "may be expressed through tears, angry outbursts and withdrawal" (Haight et al., 2003: 198). In such cases, intensive support for both children and parents around visits is necessary. However, as alluded to by the Act, there are cases where visits with family may in fact be dangerous or harmful to children and in such cases it is entirely appropriate to restrict or deny contact even where this contact is desired by a child or young person.

Given the strength of attachment relationships, it is not surprising that when children and young people are consulted, they often express a strong desire to spend time with their family. Gilligan (2000) refers to a "preoccupation" with parents, and connection to family has been identified as a strong theme in qualitative research with children and young people in foster care (Community Services Commission, 2000; CREATE, 2004).

As well as provisions about family contact, the Child Protection Act recognises Aboriginal and Torres Strait Islander children's and young people's special needs for connection with their culture. Under s83 the department must give consideration to placing Aboriginal and Torres Strait Islander children, in order of priority, with a family member, a member of the child's community or language group, or another Aboriginal or Torres Strait Islander person. Where this is not possible, the department must try to place the child in close proximity to their family or community with carers who are willing and able to facilitate their involvement in their culture and maintain their sense of cultural identity.

In addition to the requirements outlined above, the Act states that the department must aim for "optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom" and that the department must provide opportunities for Aboriginal and Torres Strait Islander children to have contact with appropriate members of their community or language group.

Young people and children were asked about the contact they have with their families. Carers with young children were also asked about the contact that the child in their care has with their family.

Are you able to see your family as much as you would like?

Figure 39, shows that young people's opinions concerning the contact they have with their family are divided. Around half (50.9%) appear satisfied with how often they see their family but 42.5% would like to see their family more often. The remaining 6.7% indicated that they would prefer to see their family less often. These figures are consistent with those of previous years.

Compared with young people, children generally appear to be less satisfied with how often they see their family. As Figure 39 reveals, 44.7% would like to see their family more, while 15.0% would like to see them less. Only 40.7% indicated that they are happy with how often they see their family. This nevertheless represents a considerable increase in satisfaction since 2007 and 2006 when less than one quarter reported being happy with how often they see their family and around two thirds wanted to see their family more often. These differences are statistically significant.

The majority (75.1%) of carers, on the other hand, feel that the child in their care sees their family as often as they need to (refer Figure 39). Only 16.4% of carers feels that the child should see their family more often, while 8.5% feel that they see them too often. Since 2007 the proportion of carers reporting that their child sees their family often enough has increased (up from 69.4%), but so has the proportion who feels that the child doesn't see their family enough (up from 11.0%). There is a corresponding decrease in the proportion who feel that their child sees their family too often (down from 19.5% in 2007). These differences are statistically significant.

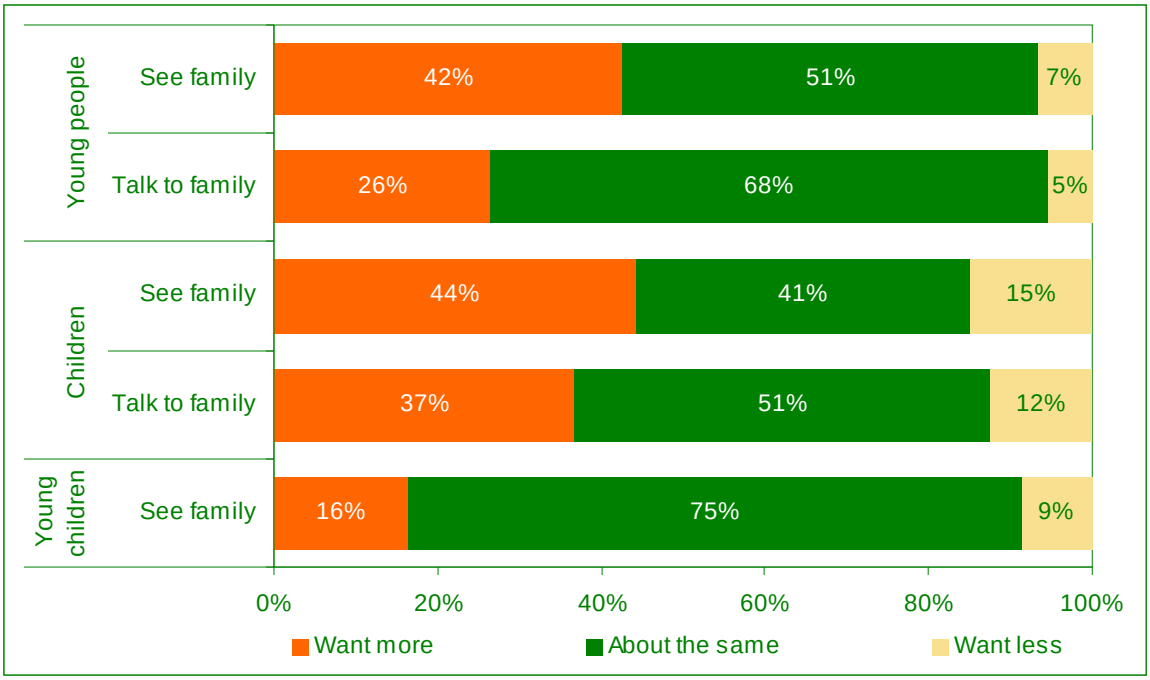

Figure 39. Want to see and talk to family – young people, children, young children (2009)

Are you able to speak to your family as much as you would like?

Young people appear to be more satisfied with how often they get to speak to their family. As Figure 39 shows, more than two thirds (68.2%) indicated they get to talk to their family enough while around one quarter (26.3%) reported wanting to speak to their family more often. Only 5.5% would prefer to talk to their family less. These figures are similar to those of previous years.

Reports from children point to an increase in their satisfaction with how often they are able to talk to their family. More than half (50.8%) reported speaking with their family as much as they want, compared with only 30% in 2007 and 2006. These differences are statistically significant. While this improvement in satisfaction is encouraging, almost half (49.2%) remain dissatisfied with how often they speak with their family. Of these, more than one third (36.8%) want to speak with their family more often and 12.4% would prefer to speak with their family less.

If you are an Aboriginal and/or Torres Strait Islander, do you feel that you are still in touch with your community?

A question for young people who indicated they are of Aboriginal or Torres Strait Islander background asked if they are still in touch with their community. Of the 343 young people indentifying as Aboriginal and/or Torres Strait Islander, 300 responded to the question. As can be seen in Figure 40, around 71% of these young people indicated that they are in touch with their community, an increase from 63.0% in 2007. This difference is statistically significant.

Some young people commented on the nature of contact that they have with their community. These comments included:

- ***Carer and CSO take me to relatives.***
- ***I have Indigenous excursions at school.***
- ***I have an Aboriginal teacher I see at school.***
- ***Yes via group at school.***
- ***Sometimes visit Palm Is.***

Other comments from young people reflected limited community contact or awareness of their culture and a desire to change this. For instance:

- ***But we are planning a trip to Thursday Island and the T.S.I.***
- ***No one talks to me about it.***
- ***I haven't been there for a long time. I don't want to go on my own.***
- ***I only visit once a year.***

- ***I don't know much about them.***
- ***No one from AICCA comes to see me.***
- ***Would like to do more.***
- ***Would like more contact with other Aboriginal people.***
- ***Want to know about being Aboriginal. What sort of language do Aboriginals do?***

As can be seen from the following comments, however, some young people are not concerned about being in touch with their community:

- ***I don't really know what that means. Not that interested.***
- ***I don't want to be.***
- ***I feel like it has been forced upon me.***
- ***Don't feel the need.***
- ***I am Aboriginal but I don't take any notice.***

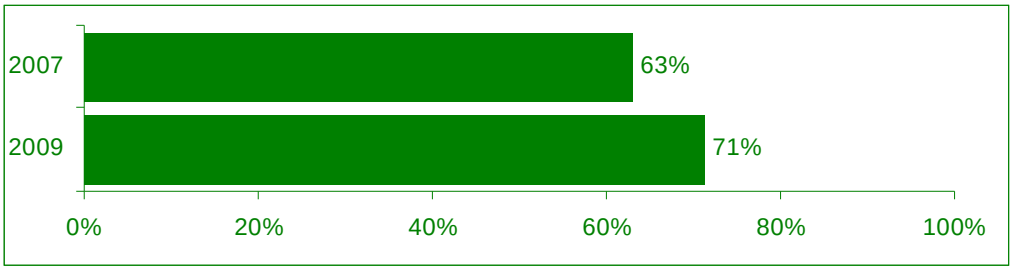

Figure 40. Aboriginal and/or Torres Strait Islander young people who feel in touch with their community (2007, 2009)

Figure 41 points to the important role that the carer's cultural background plays in young people feeling that they are in touch with community. As can be seen, 77.8% of those young people with a carer who shares their cultural background reported feeling in touch with their community compared with 59.8% of those whose carer did not share their cultural background. These differences are statistically significant.

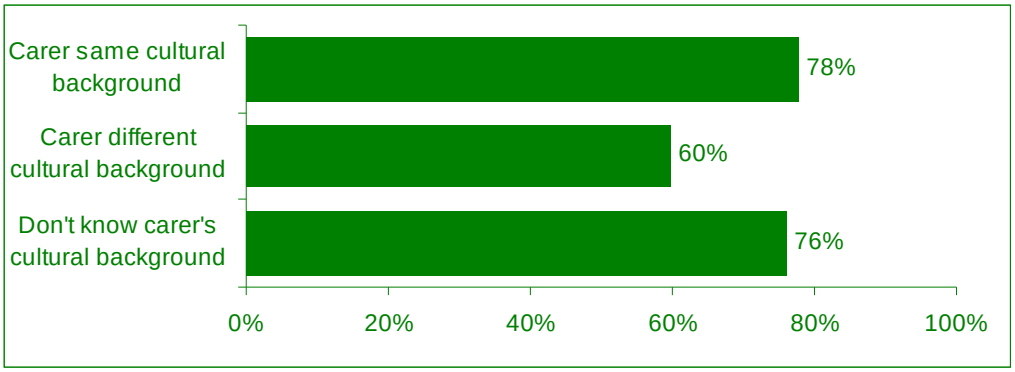

Figure 41. Aboriginal and/or Torres Strait Islander young people who feel in touch with their community by carer's cultural background (2009)

Summary of findings

- Contact with family continues to be a source of discontent for many children and young people although there have been some notable improvements over the years.
- More than 40% of children and young people would like to see their family more often. For children, however, this figure represents a significant improvement since 2007 when almost 70% reported wanting to see their family more.
- In contrast, only 16% of carers feel that the child should see their family more often. Nevertheless, this is significantly more than the 11% of carers in 2007.
- Children and young people are more likely to be satisfied with how often they get to speak to their family. More than two thirds of the young people and just over half of the children indicated being happy with how often they talk with their family. It is noteworthy that the

proportion of children reporting to be satisfied with how often they see and speak to their family has increased significantly since 2006 and 2007.

- Of those with Aboriginal and Torres Strait Islander backgrounds, more than 70% report being in touch with their community – significantly more than the 63% in 2007. Those with a carer of the same cultural background were significantly more likely than those with a carer of a different background to report being in touch with their community.

Support and advocacy

Introduction

The 2003 Crime and Misconduct Commission (CMC) Inquiry into Abuse of Children in Foster Care uncovered widespread systemic failures in Queensland's child protection system. The CMC found that where children's rights were infringed they had few avenues to complain other than through their carer. It was noted that this "produces an obvious conflict of interest when the child wants to complain about the foster carer" (CMC, 2004: 105) and much the same can be said about children and young people wishing to complain about a CSO. The report highlights the importance of robust external accountability measures including the need for appropriate avenues of complaint.

Today, children and young people in care have access to a variety of complaints mechanisms in addition to their CSO and carer. As well as the Commission's CVs who regularly visit children and young people in out-of-home care to monitor their safety and wellbeing, the Commission has a dedicated complaints function. The Commission is able to address complaints that relate to a child or young person in the child protection or youth justice systems. The Commission deals exclusively with issues affecting children and young people and while it can take complaints from people other than children, it can only act to the extent that the issues affect a child or young person. Children and young people can contact the Commission's complaints service through their CV or directly by telephone, email or SMS. Where systemic issues emerge, these are referred to other areas of the Commission for further monitoring, investigation and advocacy.

Another avenue of complaint is the Queensland Civil and Administrative Tribunal (formerly the Children Services Tribunal). This body is able to review and, if necessary, overturn or amend certain departmental decisions. Of particular relevance for children and young people in foster care are decisions about placements and family contact. Unlike the Commission, the Queensland Civil and Administrative Tribunal can act on applications from parents, carers and other concerned parties (including the Commission) as well as children and young people in care.

While QCAT is designed to be responsive to the needs of children and young people and is less formal than a court, as a review body that operates within a legal framework, it is considerably more formal than the Commission's complaints function. Children and young people may receive support from a variety of people including a separate representative to guide them through the process, however, the overwhelming majority of applications are from adults with only one young person making an application in 2007–08 (Children Services Tribunal, 2008).

As pointed out in the CMC's report (2004) the effectiveness of these complaints functions relies on children and young people being aware of their existence and how to access them. Both the Commission and the Queensland Civil and Administrative Tribunal provide information to children entering foster care about their services.

Throughout legal proceedings, children may be appointed a separate legal representative to protect their interests and to provide independent advice to the court or tribunal. Separate representatives differ from other legal representatives in that they do not act directly on the instructions of their client. While they must present children's views, they must advocate for whatever is in the child's best interests even where this is contrary to the child's wishes. Furthermore, they must provide all relevant evidence to the court or tribunal and therefore cannot offer the same level of confidentiality as other legal representatives (Children Services Tribunal, 2008).

In this section, four questions focused on children's and young people's awareness or experience of available supports. Respondents were asked if they know who to contact should they need help, if

they are aware of the role of the Children Services Tribunal, if they have ever contacted the Commission about a complaint or concern, and if they had their own lawyer if their case went to court.

Do you know who to ask for help if you need it?

When asked if they know who to contact for help, 11.8% of young people indicated that they have not yet needed to ask for help. As Figure 42 shows, of the remainder, around two thirds (66.1%) report knowing who to ask all of the time, while a further 27.5% know who to ask most of the time. The remaining 6.4% of young people indicated that they never (2.5%) or not very often (3.2%) know who to ask for help. These figures are consistent with those of 2007 although they represent a significant improvement since 2006 when only 59.8% of young people reported always knowing who to ask for help.

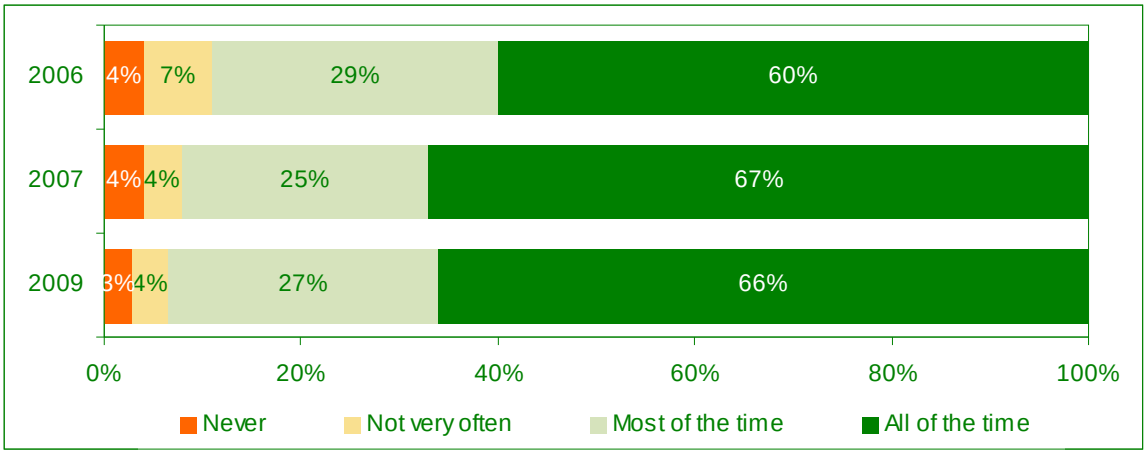

Figure 42. Know who to ask for help – young people (2006, 2007, 2009)

When children were asked if they know who to ask if they need help, the vast majority (94.0%) reported that they do. Only 6.0% indicated that they do not. These figures are similar to those of previous years.

Have you ever contacted the Commission about a complaint or concern?

When asked if they have ever contacted the Commission about a complaint or concern, 8.9% of young people reported that they have.

Do you know that you can contact the Children Services Tribunal if you have a problem with a decision made by the Department?

Figure 43 shows that only around four in ten (41.6%) of the young people are aware that they can contact the Children Services Tribunal in the event that they are unhappy with a departmental decision. This is similar to the 2007 figure of 44.5%.

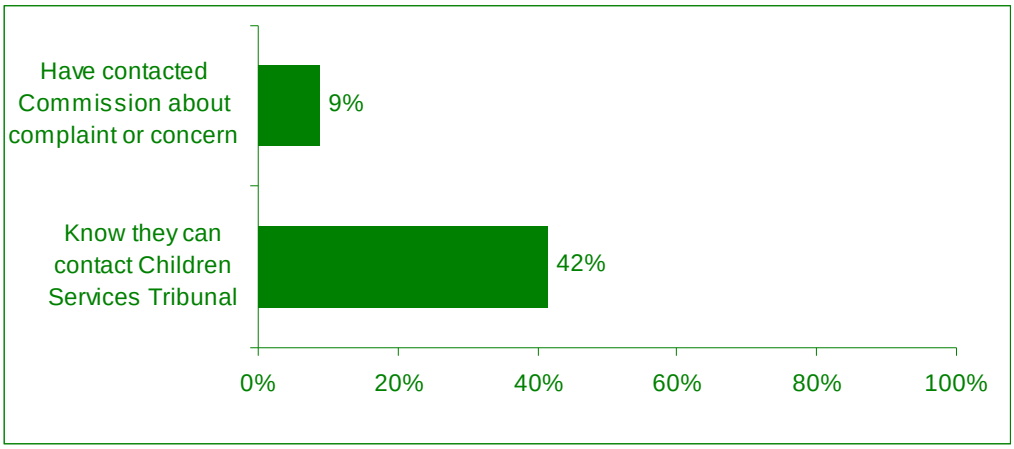

Figure 43. Advocacy services – young people (2009)

If your case went to court, did you have your own lawyer?

Figure 44 shows that, of the young people who indicated that their case went to court, the majority (57.7%) reported not knowing if they had their own lawyer. More than one quarter (25.2%) indicated that they did not have a lawyer and only 17.0% reported that they did have their own lawyer.

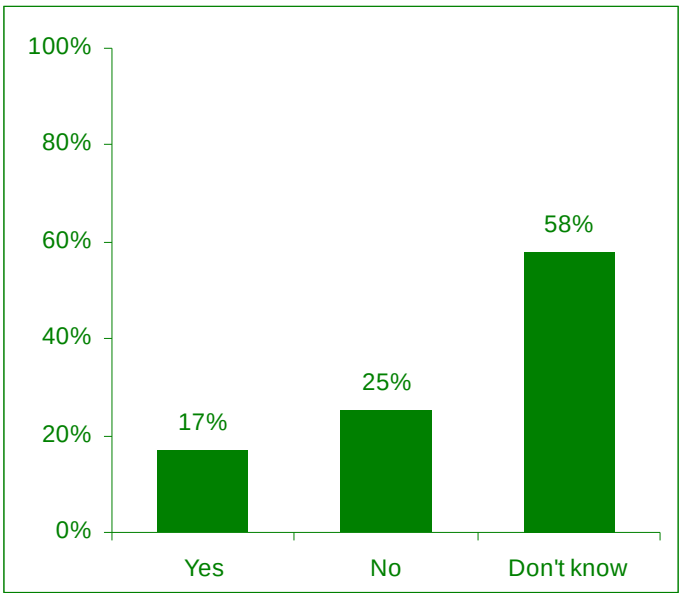

Figure 44. Had own lawyer if case went to court – young people (2009)

Summary of findings

- It is encouraging that the majority of children and young people appear to know who they can contact if they need help. That said, less than half the young people are aware that they can contact the Queensland Civil and Administrative Tribunal if they are unhappy with a departmental decision.
- Around 9% of young people reported having contacted the Commission about a concern or complaint.
- Only 17% of young people whose case went to court reported having their own lawyer.

Areas for improvement

Respondents were asked several questions about improvements, namely if they feel that they are better or worse off since coming into care, if there is anything that they would like to have happen that no one is listening to and how the system could be improved for children and young people in care generally. Carers were also asked if something needs to be done differently for the child in their care and how the system could be improved.

Are you better or worse off since coming into care?

Figure 45 shows that the vast majority (88.1%) of young people report feeling better off since coming into care while 11.9% feel that they are worse off. The figure also reveals a decrease since 2007 in the proportion of young people reporting that they are better off. In 2007, this figure was 92.6%. This difference is statistically significant.

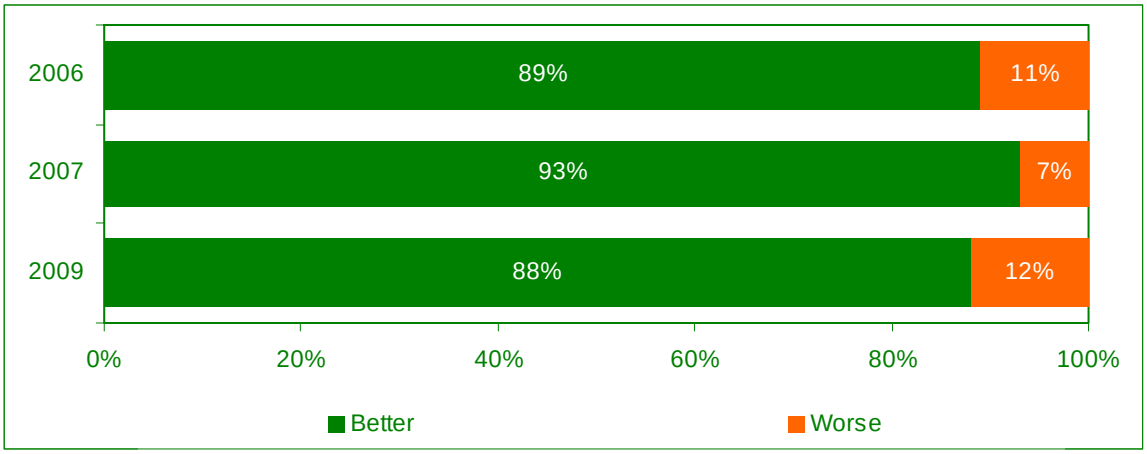

Figure 45. Better or worse off since coming into care – young people (2006, 2007, 2009)

Comments from 164 young people (13.9%) offered some insight into why some feel better or worse off since coming into care. Examples of comments from those who feel they are better off are:

- ***Now I am here with my sister I don't feel like I am in care.***
- ***In current placement – I have learnt all my tables.***
- ***My life's healthier safer and happier.***
- ***Way better.***
- ***Because I love to be safe.***
- ***My Dad made a very wise decision that I didn't realise until I hit secondary school.***
- ***Heaps, I'm off Marijuana, grades are a lot better & I actually feel loved, cared for & I'm able to feel like a normal teenager.***
- ***I have more stuff and I know more stuff.***
- ***A lot better because when I lived with my birth mother I didn't get looked after and had to find my own food. I had a carrot out of the fridge and had pea jaffles.***

Comments from those who reported feeling worse off since coming into care include:

- ***Living with my parents was better than living in care.***
- ***Prefer to be with Dad.***
- ***I love Mum & want to live with her.***
- ***School behaviour is going downhill. More emotional than I used to be.***
- ***I don't feel comfortable or comforted.***
- ***I don't get to sleep in my own bed by myself.***

A number of young people clearly have mixed feelings about whether or not they are better off in care. Some examples of their comments are:

- ***Both – I miss my family but I like it here.***
- ***Not sure, I'm kinda lost in it all.***
- ***Physically better, emotionally worse.***
- ***I wish I wasn't in foster care but feel I wouldn't necessary be better with Mum.***
- ***Both, I have lost and gained things.***

Is there anything that you would really like to have happen that no one is listening to you about?

Just over one quarter (27.1%) of the young people indicated that there is something that they would like to have happen that no one is listening to them about (see Figure 46). This figure is similar to that of 2007 and 2006.

When children were asked if there is anything that they would like to have happen that no one is listening to them about 29.3% indicated that there is. This figure represents a statistically significant decrease since 2007 and 2006 when 37.3% and 38.1% reported there was something they would like to be different that no one was listening to them about.

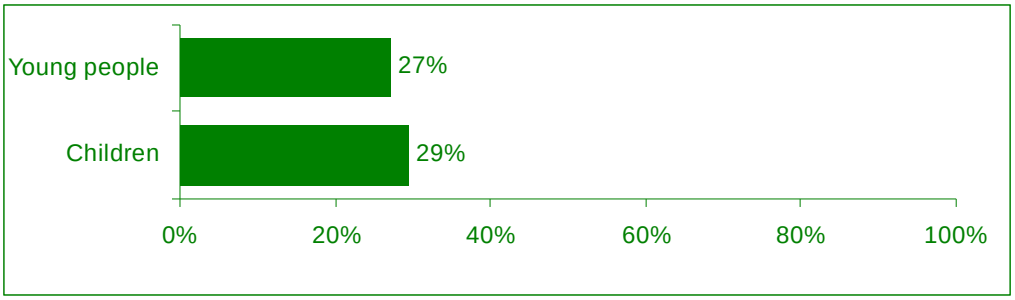

Figure 46. Have something would like to have happen that no one is listening to – young people and children (2009)

Young people and children were invited to comment further on this issue. Comments were received from 292 (24.7%) young people, 24 of whom simply indicated that they 'Don't know'. Themes emerging from the remaining comments along with their sub-themes and examples are presented in Table 16 in order of popularity. A more complete list of comments can be found in the appendix.

The table shows that the main issues of concern to young people centre on the desire for reunification or increased contact with family or friends, increased material assistance or access to services, wanting changes or no changes to the current care arrangements, wanting to live elsewhere or wanting their carer to have guardianship. Many young people also want permission or resources to participate in activities, go on holidays or change their appearance (such as their hair). A number of 'Other' comments referred to improved departmental action or follow up, more support and understanding from the department and problems with school.

Table 16.
Things that no one is listening to you about – young people (*n* = 268)

1	**Family and friends**	
	Reunification	• *Go home, but they won't listen or let me – it's like lock me in a prison or tower.* • *Go back to Mum and Dad.*
	More contact with birth parents	• *More time with Mum.* • *Visit my dad.*
	More contact with other family members	• *Sleep at Nan's more.* • *I want to see my brothers.*
	Issues with/want to see friends	• *Having friends over, sleepovers.* • *Friends don't listen sometimes.*
2	**Material assistance/services/possessions**	
	Money, resources, possessions	• *New phone, laptop.* • *Laptop/shoes.*
	Medical/therapeutic attention	• *Braces.* • *Getting my ears tested.*
3	**Care arrangements**	
	Like to live elsewhere	• *To change accommodation. I want to live somewhere that I can have friends to. I live in a motel room now.* • *To live on my own.*
	Want to live with siblings	• *Live with my brother and sister.* • *The department won't listen about my brother and sister living with me.*
	Conflict in household	• *Arguments.* • *Yelling.*
	No changes to current arrangements	• *Not going back to Mum's because I'm scared.* • *Really want to stay here and not ever have to live with my father.*

	Carer to have guardianship	• *Guardianship – Mum has too much control.* • *I want to live here but I don't want to be in foster care.*
4	**Permission/resources for participation in activities**	
	Want holidays/go places	• *Going to Canada as an exchange student.* • *I want to holiday wherever Zac Efron lives.*
	Sports activities	• *Go jet skiing. Ride a quad.* • *Out of school sport.*
	Permission to change appearance	• *Freedom on piercing.* • *My belly button piercing*
5	**Other**	• *Moving school.* • *Australian citizenship.* • *Be listened to.* • *Not being slack and actually do their job properly.* • *Less department involvement in decisions in long term placements.*

Comments were received from 196 (25.5%) children. Of these, 30 indicated they 'Don't know' or wrote 'Nothing'. Themes emerging from the remaining comments along with their sub-themes and examples are presented in Table 17 in order of popularity. A more complete list of comments can be found in the appendix.

As can be seen the issues raised by children surrounded their level of contact with family, their current care arrangement, participation in activities, and the need for more material possessions. In addition several other comments made reference to school problems, the need for more food and changes to self.

Table 17.
Things that no one is listening to you about – children (*n* = 166)

1	**Family and friends**	
	More contact with birth family	• *Asked to see my mum more.* • *Have more visits arranged.*
	More contact with other family members	• *Would like to go to see Nanna more often.* • *I want to ring my other mummy. I don't get to ring her, but I get to ring my Grandma ***.*
	Reunification	• *Want to go home in June.* • *Going back to live with Mum but it isn't possible at the moment.*
	More contact/issues with friends/peers	• *Phoning my friends.* • *People call me names at school.*
2	**Care arrangements**	
	Different carer/live somewhere different	• *No one listens when I say I want to live with Nana.* • *Going back to *** and *** because they give us porridge for breakfast and these people don't know how to play hide and go seek.*
	Changes to household arrangement or rules	• *My own bedroom.* • *That we are allowed to walk by ourselves to school.*
	Permanency/guardianship for carer	• *I'd like to live with Nanna forever.* • *I will like to have the name of my carer.*
3	**Participation in activities**	
	Sport	• *I'd like to do gymnastics.* • *Swimming at the pool.*
	Holidays	• *Going camping.*

		• *Go to New Zealand for a month.*
	Other/not specified	• *Do more fun stuff.*
4	**Material possessions**	
	Computer games	• *Get an Xbox.*
	Vehicles	• *Get a new motorbike.*
	Pets	• *A new horse.*
	Other/not specified	• *Skateboard.*
5	**Other**	
	School	• *I would like to go to a different school.*
	Food	• *More McDonalds.*
	Changes to self	• *Not getting in trouble.*

Carers were asked if there is something that should be done differently for the child in their care. More than one third (36.1%) indicated that there is. This proportion is largely unchanged from those of previous years.

Two hundred and seventy two (35.0%) of the carers also commented on the types of things that should be done differently for the child in their care although 16 of these noted "nothing", "don't know'" or "everything". Analysis of the remaining responses reveal three primary themes, each comprising several sub-themes. These and some of the comments that typify them are presented in Table 18.

Table 18 reveals that the most common suggestions made by carers focused on the need for better case planning and better case management by the department, particularly in relation to prioritising permanency planning, reducing placement instability and awarding guardianship to the carer. Numerous carers also called for greater emphasis on the best interests of the child, rather than the interests of parents. Another common theme among the responses was more support or understanding from the department, the need for resources to address the individual needs of the child and quicker decision-making processes. Issues related to family or parent contact were also raised such as considering the needs of carers, increasing or reducing family contact, and better organisation or supervision of visits.

Table 18.
Things that need to be done differently for child – carers (*n* = 256)

1	**Better case planning and case management by department**	
	Prioritise permanency planning/stability/ guardianship in care	• *We need to have guardianship – so she's not afraid of being taken away to **** • *Allow guardianship to us.*
	Greater focus on best interests of child	• *Needs of child need to be put before parents, particularly with reunification.* • *Realise the danger child is put in with violent parents.*
	Reunification issues	• *Stop trialling reunification and lock in stability with a long term order.* • *Not reunified – not in child's best interest.*
	More autonomy for carer	• *All carers to be involved in decision-making and listened to for safety of child.* • *Day to day choices left to carers – haircuts.*
	Child/carer involved in case planning	• *All carers to be involved in decision-making and listened to for safety of child.* • *She needs to be listened to. Every time she has contact, her behaviours are very bad.*
	More appropriate placement (including kinship placement)	• *Needs to be placed with kinship carer.* • *They need to be with their Indigenous kinship carers.*
2	**Departmental support, understanding, resources, action**	
	More support, understanding from	• *More contact from CSO.*

	department/CSO	• *Department needs to stop saying they will do things for her than just don't do it.*
	Therapeutic/medical interventions required	• *Mental health assessments done more quickly.* • *Full paediatric assessment.*
	Quicker action/decision-making	• *Speed up paperwork! e.g. for counselling.* • *Process is too slow, she is growing up fast.*
	More money, resources	• *DChS needs to get needed equipment to support young people without a battle over funding.* • *High needs support payment for this child.*
3	**Family/parent contact arrangements**	
	Arrangement to suit child/carer needs	• *Access visits should be better organised. She sits in an office when a parent doesn't show up.* • *Look at contact visits *** not happy.*
	More parental/family/sibling contact	• *More interaction towards his birth mother.* • *He needs to have visits from his mother. Mother hasn't seen him since May 2008. Thanks to Child Safety.*
	Visits better organised/supervised	• *Visits need to be better supervised.* • *Picked up by someone other than mother.*
	Less/no parental contact	• *Amount of contact reduced 4 times a week. 4 hours each. Child never put down for sleep.* • *Cut down visits to maybe fortnightly.*
	Other contact issues	• *Contact, maybe look at different ways etc.* • *Proper reimbursement for costs for transport when carers have to transport for visits.*

What would you most like to see improved or changed to make the system better for kids?

A total of 897 (75.8%) young people responded to an open-ended question asking them to comment on how the system can be improved for others in state care. Of these, 323 stated “don’t know”, “not sure” or “nothing”. Analysis of the remaining comments reveal seven primary themes or categories of responses. Within these themes were a range of sub-themes. The themes, sub-themes and examples of comments that typify them are presented in order of frequency in Table 19. A more complete list of comments can be found in the appendix.

As the table shows, young people’s most common suggestions centre on improving the care system focused on departmental decision-making and communication processes. Young people highlighted problems with obtaining permissions and commented on the need to be listened to, kept informed and involved in decisions. Many also called for more support, understanding and resources from the department for both themselves and their carers as well as a desire to be treated like a ‘normal’ child. Increased contact with family or being allowed to go home to live with family were also frequently mentioned as were issues with CSOs, particularly wanting to see CSOs more, wanting better trained or consistent CSOs or more CSOs (so that their workloads would be reduced thereby allowing more time to be spent with children and young people). Other comments focused on the need for faster departmental decision-making, enabling carers to make decisions, increasing the number or quality of foster carers and supporting parents so that children and young people do not have to be placed in foster care.

Table 19.
Suggestions for improvements or changes to the system – young people (*n* = 574)

1	**Departmental decision-making and communication processes**	
	Issues with permissions	• *To not be so strict on what activities kids can do.* • *Make it less complicated and do things on time.*
	Listen to children/young people more	• *The department to hear what kids have to say. Believe the little kids.* • *Listen to, don't judge us because we come from a bad background; give us respect and be honest.*
	Greater input by children/young people in decisions about them	• *Let us have more say.* • *To give kids more of a say because we're not dumb, we know what we're saying.*
	Keep all parties informed about what is going on	• *More info on what is happening from CSOs.* • *Gettings calls from DChS and on time. Being kept informed by DChS, without having to chase them.*
	Follow through on decisions/promises	• *For them to be nicer. Do what they say for kids. Do not lie to the kids.* • *I would like to see them go ahead with things they plan and not just drop it without notice. And better planning and action on transitions from care.*
	Explain decisions	• *Tell them what is going on and why it is happening and how it has happened.* • *Explain to parents when they take kids away. Don't sign things if it's not fair.*
	Return phone calls, improve availability/ contactability	• *When kids want to ring up and talk to their CSO they should be able to get them right away instead of them calling them back later.* • *CSO to visit and to return phone calls.*
2	**More support, understanding, resources from department**	
	Money, resources, possessions	• *I would give free toys, free clothes, free hobbies, free activities and a good fair education for all foster kids.*
	Planned activities for those in care	• *Maybe have a day in the year where activities are made for everyone to attend with family?* • *Make friends with other kids in care.*
	Support/understanding for young people	• *The department to help with problems we have.* • *Kids should be able to get more support through the Department of Child Safety.*
	Treat those in care like normal kids	• *To be treated as a normal child. Feel different, for instance can't see Mum or Dad. Feel isolated. Know they are out there.* • *That we are allowed to do the same things as everyone else.*
	Support for carers	• *Get more carers and treat the carers with respect. Get things quicker.*
3	**Relationship with birth family**	
	More contact	• *See your dad or mum twice a week.* • *Need more time for visits with family and for them to be better organised.*
	Reunification	• *Let them go home.* • *I want all the foster children to be back with their parents.*

4	**CSO issues**	
	More contact with CSOs	• *To see CSO more please.* • *CSOs to be more honest and visit kids more often.*
	More or better CSOs	• *The department would listen, and the CSOs were more educated and had more experience. (You can't learn how to fully understand and know how to take care of children by reading books!).* • *Allow/try to get more case workers so when children have case officers they are able to have a bit more time with them.*
	Stability/permanency of CSOs	• *Nice CSOs. Same CSO.* • *Stop changing CSOs, so they know us.*
5	**Other issues with departmental practices**	
	Quicker action by department/CSO	• *They should get quicker at stuff.* • *Let me go to my friends, and when I ask for thing to be done it means NOW and not in two years, and buy me smokes.*
	Less departmental involvement, more carer autonomy	• *Too many rules which don't make sense. Freedom from dept.* • *Stay out of my life!*
	Other	• *That kids are not removed in the middle of the night and taken away.* • *Inspect the house first and then check up on the person weekly when they first go into care.*
6	**Foster care issues**	
	More/better foster care and carers	• *Carers that care about looking after their children.* • *Get more parents to foster children who really want them.*
	Prevent kids from having to go into care	• *To have their parents be nice to them so they don't need to be in foster care.* • *Leave the kids that don't want anything to do with the department alone and start supporting parents.*

Four hundred and seventy nine (61.6%) carers also commented on what they would like to see changed or improved to make the system better. Of these, 47 stated “don’t know”, “not sure” or “nothing”, “everything” or “lots” or their comment was not relevant. Analysis of the remaining comments reveal seven primary themes or categories of responses. Many comments were complex and covered multiple themes. The themes, sub-themes and examples of comments that typify them are presented in order of popularity in Table 20.

Table 20 shows that the greatest number of comments from carers related to departmental policies and practices. Carers’ comments included the need for improved communication, prioritising the best interests of children over the interests of their parents, and quicker decision-making. Carers also spoke of the need for greater involvement of carers and children and less involvement of parents in decision-making and harsher consequences for parents who continue to let their children down. Many carers raised a number of issues relating to CSOs such as increasing the number of CSOs so that individual caseloads can be reduced and increasing the frequency with which CSOs visit children and young people. More respect and support for carers and greater support for parents were also frequently mentioned as were the need to prioritise permanency planning and minimise the number of times that individual children are returned home.

Table 20.
Suggestions for improvements or changes to the system – carers (*n* = 432)

1	**Departmental policies and processes**	
	Better communication/access to information	• *Communication, info sharing regarding case plans.* • *Carers and children to be listened to. To get an answer when phoned or emailed.*
	Best interests of the child	• *Change views to child focused instead of parent focused.* • *Consider best interests of child not just Indigenous placement policy.*
	Speed up processes	• *Faster decisions regarding long term placements. Kids can be in limbo for three years or so; too long.* • *Faster approval for finance and children's requests. E.g. bedding, clothing, school lap tops.*
	Issues with family contact	• *Keeping family and very close friends in contact with children after being put in care.* • *More contact with parents who want to see their children. Once a month for young children is not enough for long term.*
	Follow through/take action	• *If department says they will do something to actually follow through would be better.* • *Make decisions and stick to them. Too much leeway with parents.*
	Consistent rules	• *Ensure there are no contradictions in rules. Better communication between departments and information sharing.*
2	**Input into decision-making**	
	More input/authority for carers	• *To give kinship carers more rights and support.* • *Foster carers listened to more as they are more aware of the child's needs and are with the child 24/7.*
	Less power/more accountability/ harsher consequences for parents	• *Three strikes and you're out for parents. Too many chances for parents at the children's emotional expense.* • *Look out more for child's interest not the parents. Need to draw a line about how many chances to give a slack parent.*
	Involve kids/listen/share info	• *Children should be given a choice/say about who cares for them.* • *Children's allegations of abuse biological parents to be acted on; no need for physical evidence if disclosures are detailed, frequent and shared by siblings.*
	Listen to others (e.g. extended family)	• *Listening more to extended family members, not just what the parents say.*
3	**CSOs**	
	More competent/experienced/trained	• *Mature CSOs to take on complex families. Don't put a 24 yr old child in charge of families that have complex issues.* • *Better CSOs that have time to follow through on things.*
	Consistent CSO	• *If staff were to stay longer case plans might go to plan not stuffed up because of new staff not knowing case or child and making wrong*

		decision for children. • *Consistency with CSOs – too many staff changes. New CSOs do not know case.*
	More CSOs/reduced caseloads	• *More staff for dept to perform according to its own policies and procedures then the system would work. It's a good system for all concerned. Just under-staffed and under-resourced.* • *Less case loads for case workers.*
	More CSO visits/contact	• *Regular visits from CSO. She is making decisions without visiting to see how the decisions affect the children.*
4	**Respect and support**	
	More support/respect for carers	• *Department not so quick to judge carers.* • *Communication between carers and department. Department not treat carers as brain-dead idiots.*
	More support for children	• *More outings and general activities.* • *More open and effective communication ensuring child has best and appropriate supports and services in place*
	More support/early intervention for parents	• *Increased resources for prevention/early intervention.* • *Parenting workshops for parents to attend.*
	Better/more qualified carers	• *Carers to be screened more carefully.*
5	**Permanency and stability**	
	Reunification	• *To acknowledge that reunification is not always in the best interest of children. To listen to carers more.* • *Children not going to parents to live and back into care over and over again.*
	Greater stability	• *Don't move them around when its not necessary.* • *They need to have stability in their placements – not be moved on all the time.* • *More focus on the "one chance at childhood policy".*
6	**Other**	• *Maybe shared guardianship.* • *Indigenous placement could be more flexible.*

Summary of findings

- Findings indicate that the vast majority of young people feel that their lives have improved since coming into care. Notwithstanding, comments from young people, children and carers pointed to how the current placement or the system in general might be changed or improved.
- Although 88.1% of young people acknowledged that they are better off since coming into care, this figure represents a decline since 2007 when 92.6% reported feeling better off.
- Related to this, a substantial proportion of young people (27.1%) and children (29.3%) indicated that there is something that they would like to have happen that no one is listening to them about. The issues most commonly raised were more contact with family and friends, more material assistance or improved access to services, changes to care arrangements such as a placement change or guardianship for carer, and more participation in activities.
- More than one third of the carers would like things to be done differently for the child in their care. Their comments focus on better case planning and management by the department, greater support and understanding, and changes to family arrangements.
- Numerous young people and carers offered suggestions for how the system could be improved for those in care. Young people's suggestions included improved departmental communication and decision-making, greater support and understanding, more contact with birth family and CSOs, and more and better foster carers.

- Improvements suggested by carers included greater involvement on their part in decision-making, more experienced CSOs and more frequent visits from CSOs, prioritising permanency planning, improved communication processes, and greater focus on the best interests of the child.

Child Safety Officers

Introduction

Every child in foster care has a Child Safety Officer (CSO) assigned to manage their case. As the representative of the department, CSOs take a central role in decision-making for children and young people in foster care. At the same time, CSOs are required to support children and young people, carers and parents to achieve agreed goals (outlined in the case plan), monitor and review children's and young people's development and undertake a variety of administrative functions. Departmental guidelines state that all children living in out-of-home care should be visited by their CSO at least once per month and more often where indicated by the child's needs and the contents of the case plan.

The relationship between a child or young person and their CSO is an extremely important one. In recent research carried out by the Office of the Guardian for Children and Young People in South Australia (2009), the point was made that "the quality of the relationship between a child and their case worker can make or break the important but fragile links between a child and the 'state' in its guardianship role". (Office of the Guardian for Children and Young People, 2009:i). Important aspects of this relationship identified in the research include the frequency of contact, continuity of case workers, accessibility of workers, the quality of the contact as perceived by the child and the extent to which children can participate in decisions.

CSOs face a number of challenges and internal conflicts in performing their role, particularly when making decisions about children and young people. While the department's primary consideration is always the immediate safety and well being of children and young people, in reality CSOs make decisions within a complex framework. CSOs must balance their own professional judgement against the views and wishes of children and young people, carers, parents and at times other professionals and experts including educators, health care providers and recognised entities. Furthermore, CSOs' decision-making power is restricted by custody and guardianship arrangements (particularly where parents retain guardianship), relevant court orders, placement agreements and budgetary and resourcing considerations.

In recent years workforce issues including high staff turnover and understaffing have compounded these issues, however, some progress is being made towards rectifying these issues. In its Final Report 2008–09 the former Department of Child Safety reported an overall increase in staff numbers, a shift towards permanent rather than temporary staff and a 29% reduction in the number of CSOs who left the department in the reporting period when compared with the previous year (2009).

This section of the questionnaire comprised questions for young people, children and carers of young children about their Child Safety Officer (CSO). To ensure that respondents understood what is meant by CSO, the following explanation was provided: *A CSO is your Child Safety Officer, or person from the Department who looks after you*. The questions in this section sought information on issues such as awareness of the CSO's name, frequency of contact with the CSO and perceived receptiveness and helpfulness of the CSO. Due to a small number of handwritten comments from respondents to the previous surveys indicating that they did not have a CSO at the time of the survey, it was decided to include an additional response option to the question about knowing the CSO's name. This extra response option was worded: *Don't have a CSO right now*. Those who ticked this option were prompted to move to the next section of the survey and were excluded from analyses in this section.

Do you know the name of your CSO?

A small proportion of young people (2.6%), children (2.5%) and carers on behalf of the child in their care (3.1%) reported not currently having a CSO. Figure 47 shows that 84.9% of young people, 69.3% of children and 96.9% of carers who did have a CSO reported knowing their CSO's name. The figure not only shows that carers are considerably more likely than the other groups to know the CSO's

name, it reveals a significant increase over the years across all groups in the proportion reporting that they know their CSO's name. These increases are statistically significant.

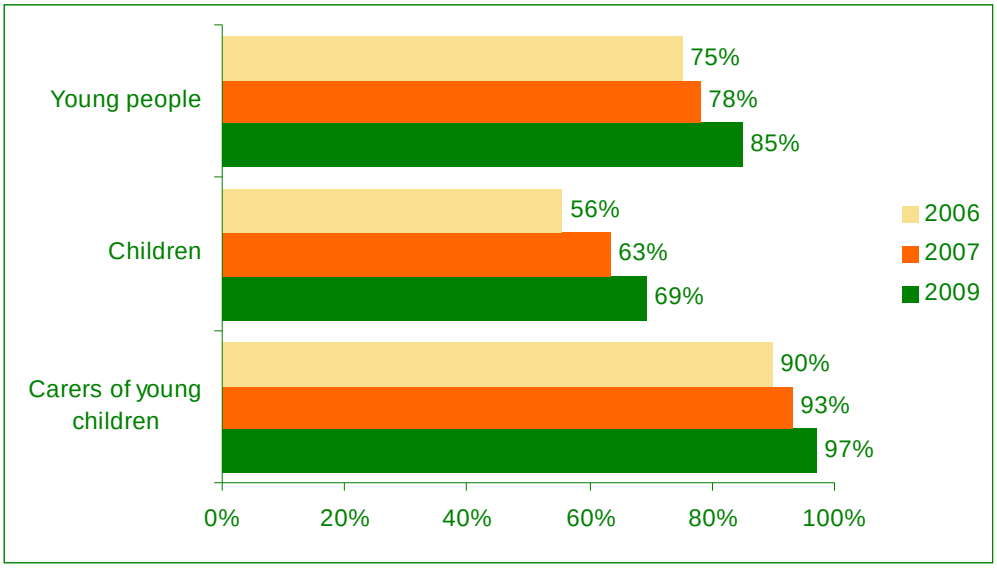

Figure 47. Know CSO's name – young people, children, carers (2006, 2007, 2009)

How often do you see your CSO?

Reports from young people indicate that most have reasonably frequent contact with their CSO. As can be seen in Figure 48, more than half (53.9%) report seeing their CSO about once per month, while a further 25.2% report seeing their CSO about every three months. Taken together then, more than three quarters (79.1%) report seeing their CSO at least every three months. Around 12% report seeing their CSO once a year or less. The figure reveals the considerable increase, since 2007, in the proportion of young people reporting that their CSO visits monthly. This difference is statistically significant.

Like the young people, carers were asked about the frequency of CSO visits. According to 51.5% of this group, the CSO visits the child in their care monthly. Around one quarter (24.6%) reported that the CSO visits every three months and 10.8% every 6 months. More than 13% reported that the CSO visits once a year or less. While these proportions are largely unchanged from 2007, Figure 48 shows the significant increase since 2006 in the proportion of carers reporting that the CSO visits monthly.

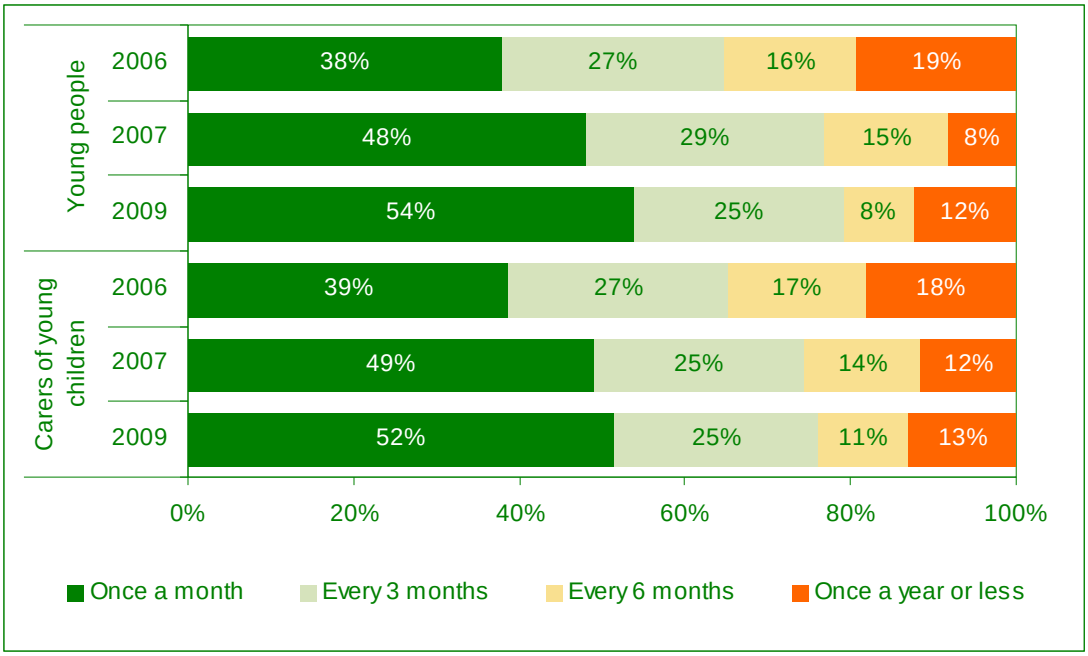

Figure 48. Frequency of CSO visits – young people and carers (2006, 2007, 2009)

Reports from children also point to a statistically significant increase over the years in the proportion reporting that they see their CSO much. In 2009 when children were asked if they see their CSO much, just over half (51.6%) responded that they do (refer Figure 49). Around 48% responded that they do not see their CSO much or never see their CSO. By comparison, in 2007 and 2006 the proportions of children reporting that they see their CSO much were only 38.4% and 32.4% respectively.

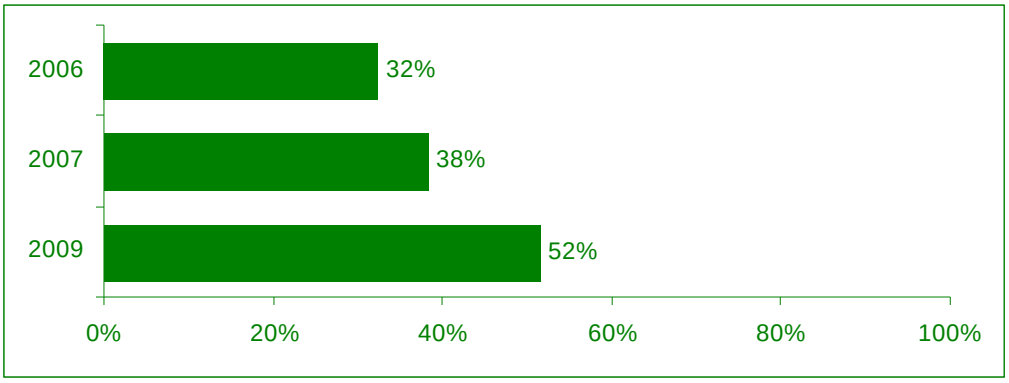

Figure 49. See CSO much – children (2006, 2007, 2009)

How often do you want to see your CSO?

Figure 50 shows that more than half (51.1%) the young people are happy with the level of contact they have with their CSO. However, around one third (32.3%), would like to see their CSO more often and 16.6% less often. These responses are largely consistent with those of 2007 and 2006.

Children, and carers on behalf of young children, were also asked how often they want to see their CSO. Figure 50 shows that of the children who responded, 41.7% are happy with their current level of contact, 45.3% would like to see their CSO more often, and the remaining 13.0% would like to see their CSO less. Figure 50 also highlights the statistically significant increase since 2007 and 2006 in the proportion of children who appear happy with the level of contact they have with their CSO and corresponding decrease in the proportion who would like to see their CSO more often. In 2007, just over one third (34.4%) were happy with their level of contact, while more than half (51.1%) wanted more contact with their CSO. In 2006, less than one third (32.1%) were happy with the level of CSO contact.

Compared with young people and children, carers are substantially more likely to report being satisfied with the current level of CSO contact (64.2%). That said, almost one third (29.1%) would prefer to see the CSO more often. Figure 50 shows that only 6.7% reported that they would like to see the CSO less. Although there has been a slight decrease, since 2007, in the proportion of carers indicating that they are satisfied with how often they see the CSO, this difference is not statistically significant.

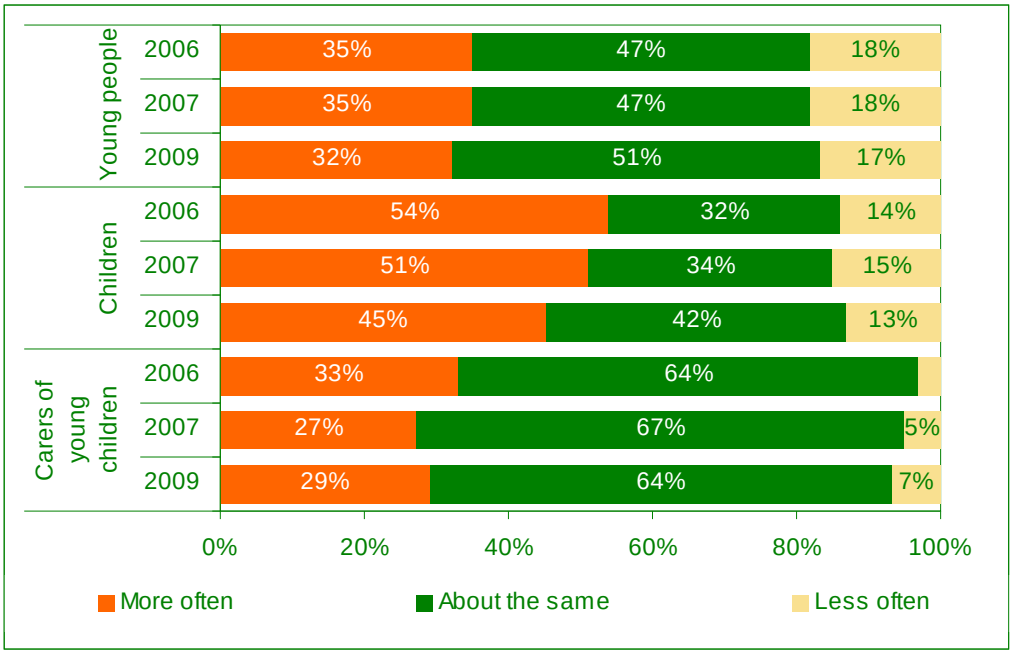

Figure 50. Desired contact with CSO – young people, children, carers (2006, 2007, 2009)

Are you able to contact your CSO when you need to?

When asked if they are able to get in touch with their CSO when needed, 31.7% of young people indicated that they have not yet needed to contact their CSO. Of those who have needed to contact their CSO, 40.2% of young people reported being able to contact their CSO all of the time and a further 30.7% most of the time. Around 30% of young people indicated that they are never (11.5%), or not very often (17.6%), able to contact their CSO. As evident in Figure 52, there has been a statistically significant increase (up from 25.4% in 2006 to 36.6% in 2007 and 40.2% in 2009) in the proportions of young people reporting that they are able to contact their CSO all of the time.

Carers were also asked if they are able to contact the CSO when they need to. Around 4% indicated that they have not yet needed to contact the CSO. Figure 53 shows that, of those who have, around 81% indicated that they can contact the CSO at least most of the time, although 17.6% reported that they are never or not very often able to contact the CSO. While these figures are comparable to those of 2007, there has been a notable increase since 2006 in the proportion of carers reporting that they can contact their CSO all the time. This difference appears to be statistically significant.

Is your CSO nice to you?

Young people and children were asked if their CSO is nice to them. As shown in Figure 51, the vast majority of young people (94.3%) and children (97.5%) feel that their CSO is nice to them. The remaining 5.7% of young people and 2.5% of children indicated that their CSO is not nice to them. As can be seen in Figure 51, there have been increases in the proportions of young people and children reporting that their CSO is nice. These increases are statistically significant.

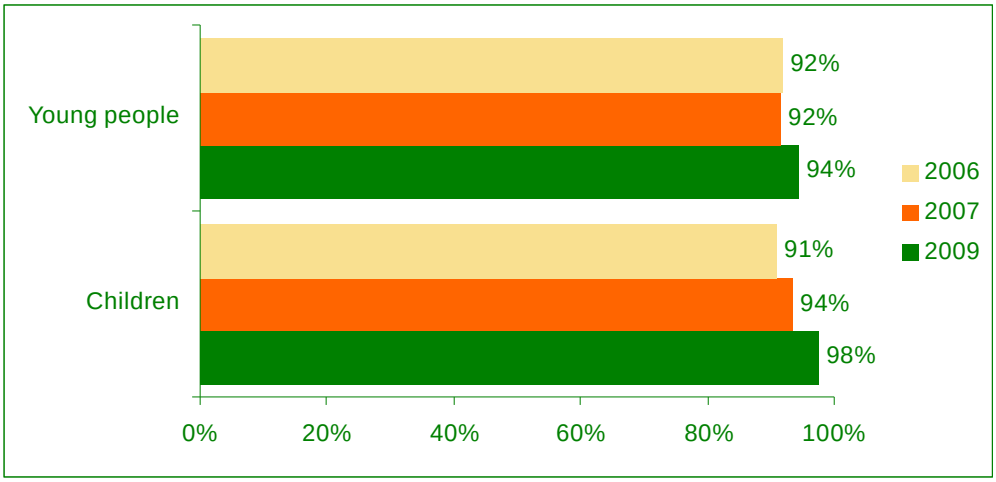

Figure 51. CSO is nice to you – young people and children (2006, 2007, 2009)

Two hundred and fourteen (18.1%) of the young people commented further on their CSO. Many explained that they had yet to meet their CSO or had not known them long enough to know. Other comments included:

- ***She takes me for ice cream and to the park.***
- ***She is understanding and supportive.***
- ***She buys me lunch all the time.***
- ***He listens and is kind.***
- ****** is the best CSO so far (3rd) one.***
- ***Don't talk to him. He doesn't talk to me.***

Does your CSO listen to you?

Young people were also asked to indicate the extent to which their CSO listens to them. According to 58.1% of young people, their CSO listens all the time while a further 28.4% reported that their CSO listens most of the time. The remaining 14% feel their CSO never listens or doesn't listen very often. As can be seen in Figure 52, young people's respones point to significant increases over the years in the extent to which CSOs listen. In 2007, less than half (47.1%) the young people reported that their CSO listens. In 2006 this figure was 39.7%.

A similar trend is also apparent from children's responses to whether or not their CSO listens to them. As can be seen in Figure 55, the vast majority (94.7%) reported that their CSO does listen to them, a significant increase on the 2007 and 2006 proportions of 85.5% and 82.9%. Only 5.3% of the 2009 cohort reported that their CSO does not listen.

Does your CSO care about what is best for you?

Since 2006 and 2007 there has also been a substantial increase in the number of young people reporting that their CSO cares about what is best for them and a corresponding decrease in number of young people reporting that their CSO does not care (refer Figure 52). In 2009, 88.7% of young people reported that their CSO cares about what is best for them all, or most of, the time compared with 79.4% in 2007 and 75% in 2006. The proportion of those reporting that their CSO never, or not very often, cares about what is best for them has decreased from around 24% in 2006 to 20% in 2007, to the current level of 14.5%. These differences are statistically significant.

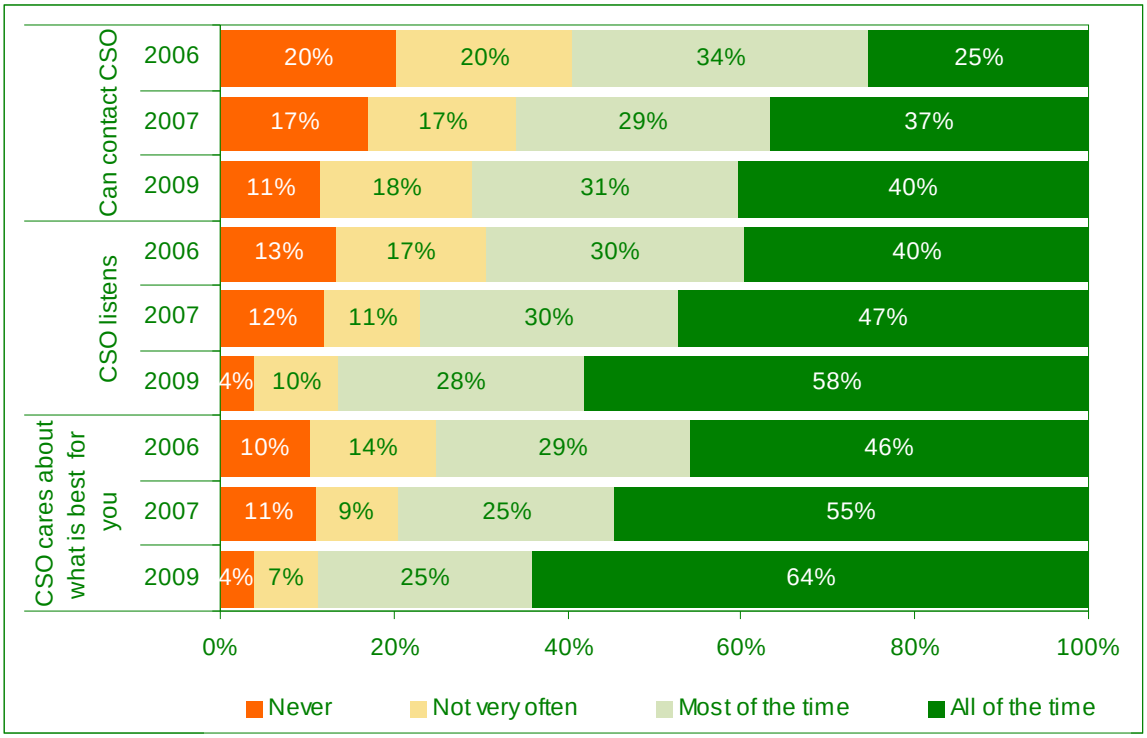

Figure 52. Able to contact CSO, CSO listens, CSO cares – young people (2006, 2007, 2009)

Figure 53 points to a steady increase over the years in the proportion of carers reporting that the CSO cares what is best about the child all, or most of, the time. This trend is accompanied by decreasing numbers of carers reporting that the CSO does not care at all or very often. As can be seen, in 2009 84.9% of carers indicated that the CSO cares all or most of the time. This figure compares with 79.5% in 2007 and 75.6% in 2006. The increase since 2006 is statistically significant. Despite this encouraging trend, there remains a considerable number of carers (15.1%) who believe that the CSO never cares about the child's best interests or does not care very often.

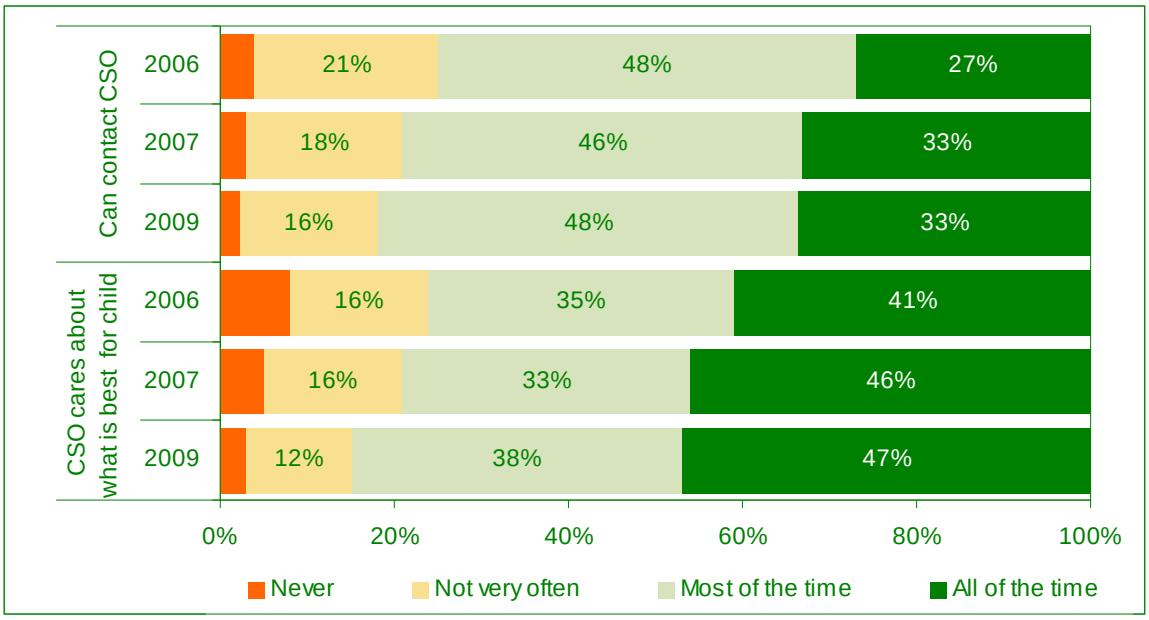

Figure 53. Able to contact CSO, CSO cares – carers (2006, 2007, 2009)

Figure 55 reveals a statistically significant increase in the proportion of children reporting that their CSO cares about what is best for them. The current proportion of children reporting that their CSO cares is 93.0%, compared with 89.8% in 2007 and 87.3% in 2006.

Out of 10, how helpful has your CSO been?

The final question in this section asked young people to rate their CSO's helpfulness from 1 (really unhelpful) to 10 (really helpful). In the 2009 questionnaire, young people were provided with a scale ranging from 1 to 10 for this purpose, unlike previous years' surveys which asked respondents to write a number between 1 and 10. Table 21 shows that the mean score awarded to CSOs is 7.3. This represents a statistically significant increase on the 2007 and 2006 mean scores.

Carers were also asked to rate out of 10 the helpfulness of their child's CSO. Ratings ranged from 1 to 10 with an overall mean score of 7.1. As can be seen in Table 21, this score is significantly higher than the previous years' mean scores.

Table 21.
Rating of CSO helpfulness – young people and carers (2006, 2007, 2009)

		Mean (SD)	Median
Young people	2006	6.4 (3.1)	7
	2007	6.6 (3.2)	8
	2009	7.3 (2.9)	8
Carers	2006	6.5 (2.8)	7
	2007	6.7 (2.8)	8
	2009	7.1 (2.8)	8

Figure 54 compares the distribution of 2009 scores for young people and carers. It reveals that young people (37.9%) were considerably more likely than carers (30.2%) to award their CSO the maximum score of 10.

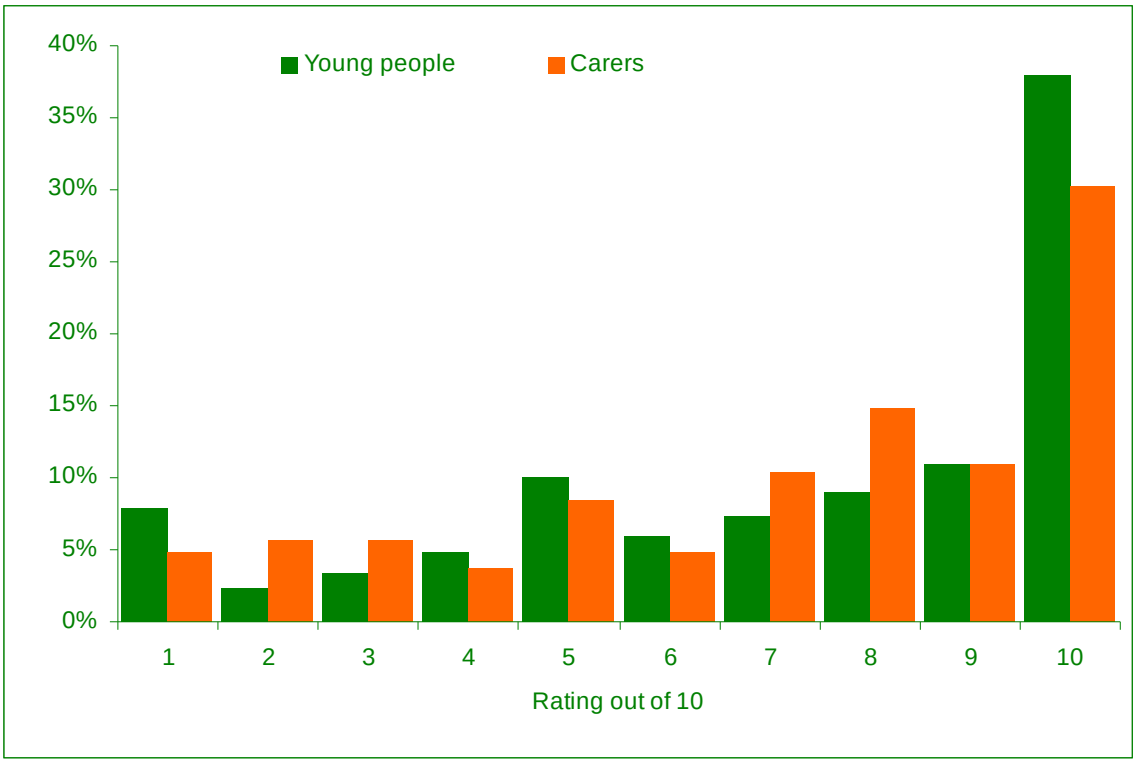

Figure 54. Rating for helpfulness of CSO – young people and carers (2009)

Children were also asked whether or not their CSO has been able to help them with anything. Of the respondents, 67.6% indicated that the CSO has been able to help, while 32.4% indicated that the CSO has not. Figure 55 shows that there has been a slight increase since 2007 and 2006 when 62.3% and 61.2% reported that their CSO had been able to help with something. These differences, however, are not statistically significant.

Comments from 221 children (28.7%) provided insights into how their CSO has or has not helped them. Some children simply wrote “nothing” or “I don’t know”, or “haven’t needed help” but many others provided examples of the types of help their CSO has provided. As can be seen from the following, the types of help included assistance with school issues, contact with family members and support with problems.

- ***She was there for me when I was confused about high school.***
- ***She came to my school.***
- ***Helps with ESP at school.***
- ***Getting help at school.***
- ***Tell me why my parents were not visiting.***
- ***Helped find Mum.***
- ***Find my brothers & sisters.***
- ***She has been glad to help me get back with mum.***
- ***Contact with dad extra hour.***
- ***Approved a holiday to my nana's home town.***
- ***Get thru the bad stuff.***
- ***She helps us with some problems.***
- ***Counselling.***
- ***Making the bullies stop.***
- ***My last CSO helped me with being angry.***
- ***Giving me a good home.***
- ***She helps Nan (the carer) look after us.***

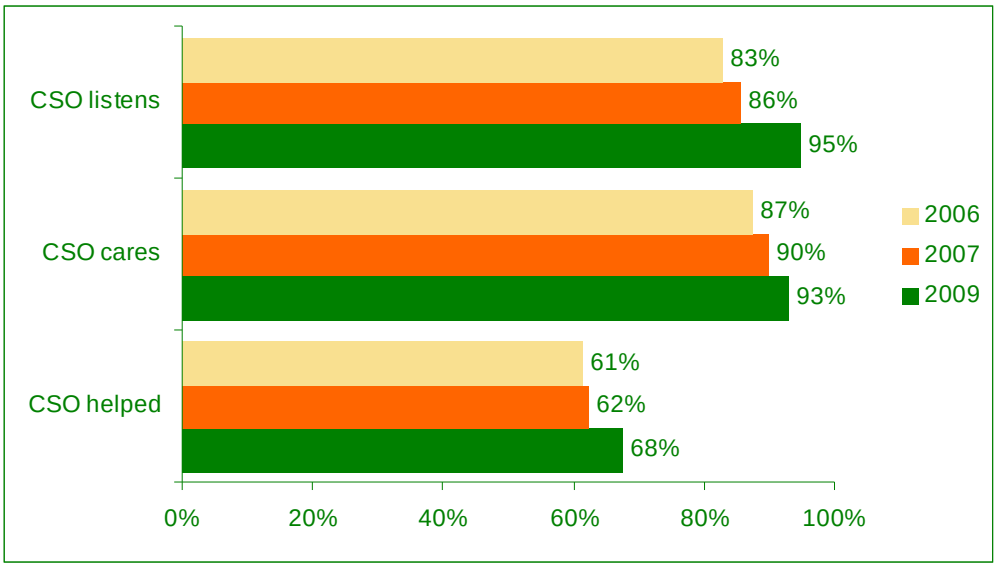

Figure 55. CSO listens, CSO cares, CSO has helped – children (2006, 2007, 2009)

Summary of findings

- Overall, there appears to be widespread and growing satisfaction with the nature of contact that respondents have with CSOs although many would still like to see their CSO more often.
- The vast majority of children and young people also feel that their CSO is nice to them, listens to them and cares about what is best for them. Likewise, most carers report that the CSO cares about the interests of the child in their care. Analyses also reveal significant improvements in these responses over the years.
- Most young people and carers consider their CSO to be helpful with ratings of helpfulness increasing significantly since 2006 and 2007.The majority of children also reported that their CSO has helped them with something.
- Things that respondents mentioned CSOs had helped with include help at school and help with finding family members.
- Just over half (53.9%) the young people and 51.5% of carers report seeing their CSO around once per month. When asked if they see their CSO ‘much’, more than half (51.6%) of the children reported that they do.

- Although reports from young people and children point to a significant increase over the years in the frequency with which CSOs visit, a substantial proportion of young people (32.3%), children (45.3%) and carers (29.1%) would like to see their CSO more often.

Leaving care (16 to 18 year olds)

Introduction

There is growing recognition that young people leaving care are one of the most vulnerable and disadvantaged groups in society. Despite experiencing multiple disadvantages stemming from their abuse or neglect prior to entering care and their sometimes negative experiences whilst in care (Mendes, 2009), they are expected to make their journey to independence far younger and far more quickly than their peers. Stein and Dixon (2006) explain that unlike their peers who tend to remain at home well into their twenties and have the option of a gradual or extended transition or the opportunity to return home in times of difficulty, most in care leave their foster care family permanently to begin independent living at 16 or 17 years of age. As many are no longer in contact with their biological family or have a close relationship with their foster care family (Bruskas, 2008), this transition often has to occur without the emotional, financial and practical supports typically afforded by families (Stein, 2006).

The implications are that many care leavers commence independent living feeling isolated, insecure and overwhelmed. Research shows that, compared to those who have not been in care, care leavers are more susceptible to mental health problems and are less likely to have completed secondary schooling, or be participating in tertiary education or full-time employment. Instead, they are more likely to be unemployed or engaged in part-time or casual work in poorly paid and low skills jobs, to experience homelessness and early parenthood (Bruskas, 2009; Cashmore, Paxman & Townsend, 2007; Fowler, Toro & Miles, 2009; Stein & Dixon, 2006; Tweddle, 2007). Research also demonstrates higher rates of criminality among care leavers compared to the general population (Bruskas, 2008; Fowler, Toro & Miles, 2009; Stein & Dixon, 2006; Tweddle, 2007), along with poorer subjective health and greater dependence on government assistance (Schneider, Baumrind, Pavao, Stockdale, Castelli, Goodman & Kimerling, 2009; Tweddle, 2007).

Studies indicate that thorough planning before leaving care coupled with effective specialist supports and services post care can help ameliorate “poor starting points” and minimise the risk of social exclusion for care leavers (Moslehuddin & Mendes, 2006; Ofsted, 2009; Stein, 2006; Stein & Dixon, 2006). Research also highlights numerous benefits associated with enabling young people to remain in care well beyond the age of 18, namely higher rates of participation in tertiary education, increased earnings and delayed parenthood (Courtney, Dworsky & Pollack, 2007).

Despite this evidence, there is considerable variability across Australian jurisdictions in the policies and programs designed to assist young people transition from care. Little consensus exists in terms of the age at which planning for leaving care should commence, the nature of supports provided to young people during and after their transition from care and the time at which government responsibility for care leavers is relinquished.

In Queensland, as in the Northern Territory, South Australia, Western Australia and Tasmania, it is recommended that planning for leaving care commence at or around 15 years of age. At this time, a *Leaving Care Plan* is required to be developed in consultation with the young person that identifies their likely needs and articulates the types of supports required to meet these needs. In other jurisdictions this planning is expected to commence at least 18 months (ACT) or 12 months (New South Wales and Victoria) prior to leaving care. A recent Australian study involving 471 15 to 25 year olds who were in care or had left care, however, revealed that only 30% reported having a leaving care plan (McDowell, 2009).

As noted by McDowell (2009), most jurisdictions in Australia provide financial support for care leavers up to the age of 25 years. The exceptions are Victoria, where care leavers are entitled to support until they turn 21 years of age, ACT where support is provided for up to 5 years from the time that a young person leaves care, and Queensland where the duration of support is not expected to exceed 12 months from the date of leaving care.

The final section of the questionnaire for young people comprised questions intended for those aged 16 to 18 years. For the purposes of analyses, responses from any participants aged less than 16 years were excluded leaving a cohort of 133. Of these, 124 responded to the questions about leaving care. To permit reliable comparisons with earlier survey data, responses from any 2007 and 2006 respondents aged less than 16 years have also been excluded from analyses. For this reason, retrospective data presented here may differ from those presented in earlier reports.

Questions in this section include those on leaving care plans, young people's expectations of leaving care, their feelings of preparedness for leaving care and types of help that they anticipate needing and that the types of assistance that they would like to receive upon leaving care.

Has anyone spoken to you about what happens to your care situation when you turn 18?

Over two thirds (70.8%) of 16 to 18 year-olds reported that someone had spoken to them about what happens to their care situation once they turn 18. This is consistent with the 2007 figure of 69.5%.

Has a leaving care plan been developed for you? If you have a leaving care plan, were you involved in its development?

More than one third (37.2%) of the 16 to 18 year-olds reported having a leaving care plan. As can be seen in Figure 56, this proportion is similar to that of 2007 but considerably higher than 2006 when only 22% indicated that they had a leaving care plan.

Analyses of responses from those aged 16 to 18 years who reported having a leaving care plan, revealed that 95.5% have been involved in its development. The proportions in 2007 and 2006 were 92% and 100% respectively. It should be noted, however, that in 2006 only 22% of 16 to 18 year olds reported having a leaving care plan.

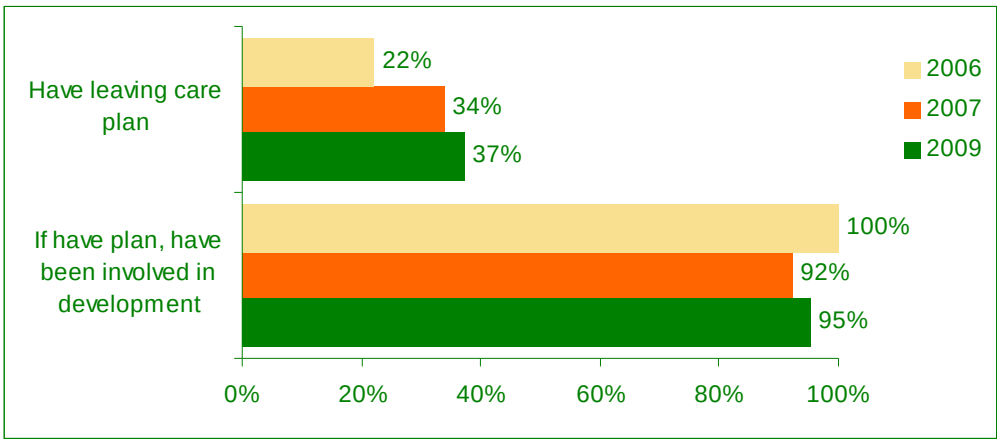

Figure 56. Leaving Care Plan – young people 16–18 years (2006, 2007, 2009)

Do you think you'll be able to manage independent living when you turn 18?

Encouragingly, the majority of young people aged 16 years and over feel confident that they will be able to manage living independently once they turn 18. As can be seen in Figure 57, 31.4% reported that they will 'definitely' manage and a further 48.3% feel that they will 'probably' manage. Nevertheless, a substantial minority (20.3%) indicated a lack of confidence about their ability to live independently. As shown in the figure, more than one fifth reported that they will 'probably not' (14.3%) or 'definitely not' (5.9%) manage independent living.

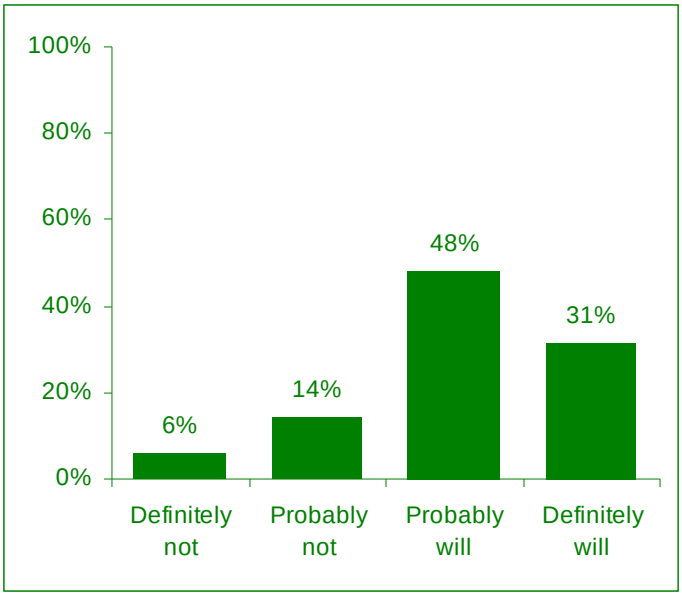

Figure 57. Able to manage independent living after turning 18 – young people 16–18 years (2009)

Many young people commented further on their ability to manage independent living when they turn 18. Comments from those who expressed confidence in their abilities include:

- ***Because my foster mum has taught me how to live.***
- ***I know how to cook & pay bills & go to Post Office.***
- ***I'll make it work.***
- ***I am very mature with the way I live.***

On the other hand, comments from those who do not feel so confident include:

- ***Don't know how I'll get income.***
- ***Don't know what the future [holds].***
- ***Need lots of help in everyday tasks.***
- ***Depends on whether I get citizenship or not.***
- ***Maybe. Often plan those things in my head.***
- ***Probably not at this stage.***
- ***Too early!***

Others anticipated not having to leave their foster care family:

- ***Can stay in current placement if you want to.***

Would you like to stay living with your foster care family after you have turned 18?

Reports from most young people indicated that they would like to remain with their foster care family after they turn 18. Figure 58 shows that more than half (54.2%) would prefer to stay with their family, while more than one quarter (28.3%) are undecided. In contrast, only 17.5% would prefer not to remain with their foster family once they turn 18.

Comments from those who expressed a preference for staying with their foster care family include:

- ***For a while till I have my own place where I can live.***
- ***If I need them for support if things don't go right.***
- ***Until I finish school, then I will live at Uni Campus, but still visit carer.***
- ***Already ok'd.***
- ***Yes for a while unless a job comes up away from here.***
- ***Until I get my own house.***
- ***Until I get my car.***

Examples of comments from those who do not wish to stay with their foster care family are:

- ***No way sorry.***
- ***I want my own house & car.***
- ***Only if cannot return to Mum.***
- ***I want to be independent.***

Comments from those who remain undecided include:

- ***Depends on educational plans.***
- ***Depending on my situation.***

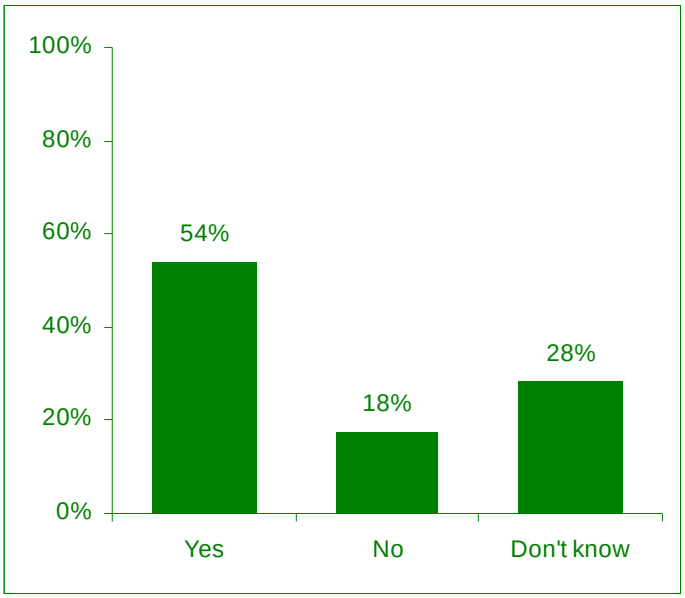

Figure 58. Would like to stay living with foster family after turning 18 – young people 16–18 years (2009)

What do you think you will need help with once you leave care?

To gain insight into the types of help that young people anticipate they will need once they leave care, young people were presented with a range of select response options from which they could select as many options as relevant. These options and the percentage of respondents who selected them are presented in Figure 59. More than one quarter (25.2%) selected only one type of help, while 62.5% selected multiple forms of help. As the figure shows, the type of help that young people most commonly anticipated needing was help with finding accommodation (57.3%), closely followed by income support or financial assistance (56.5%). More than 40% of the young people also anticipated needing help with finding employment and help with life skills such as budgeting. Around 30% expected to need help with getting into training or education and more than one fifth (21.8%) thought they would need help to get information on health services. A further 16.1% anticipated needing access to legal services and 12.1% counselling services.

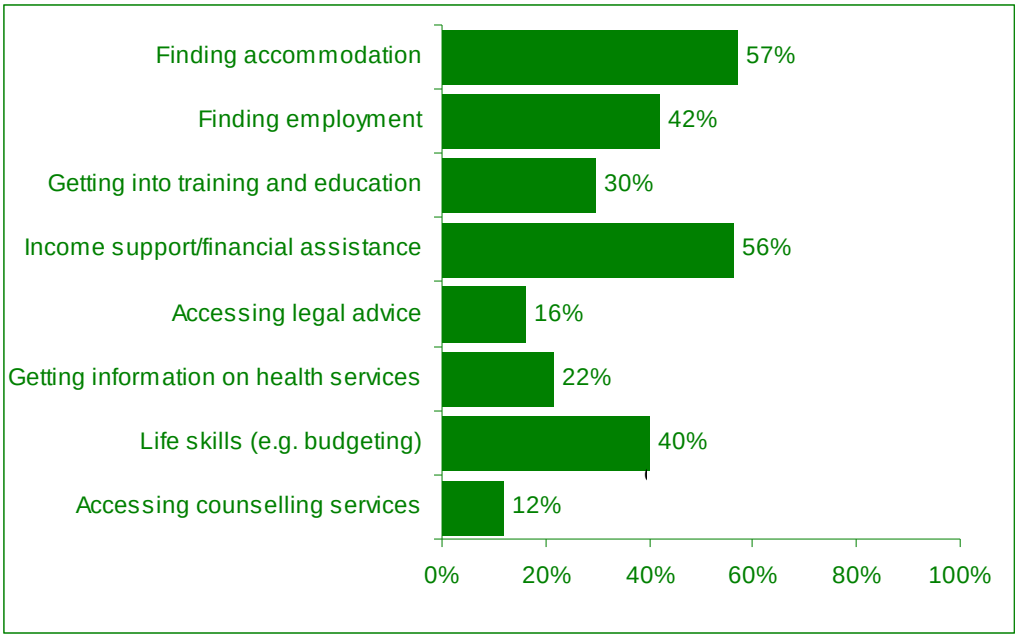

Figure 59. Things that will need help with upon leaving care – young people 16–18 years (2009)

When you leave care, would it assist you to:

Young people were asked to indicate from a range of options, the things that would be of assistance to them when they leave care. These options were 'staying in contact with foster care family'; 'have a peer support group'; 'have a mentor'; and 'receive help in regaining contact with birth family (if currently not in contact)'. As many options as relevant could be selected.

Around 86% of young people selected at least one form of assistance. As Figure 60 shows, by far the most commonly selected form of assistance was staying in contact with the foster care family. More than three quarters (78.2%) of the young people selected this option. Having a mentor was selected by more than one quarter (26.6%) of the group, while more than one fifth chose having a peer support group. Only 13.7% indicated that regaining contact with their birth family would help in their transition from care.

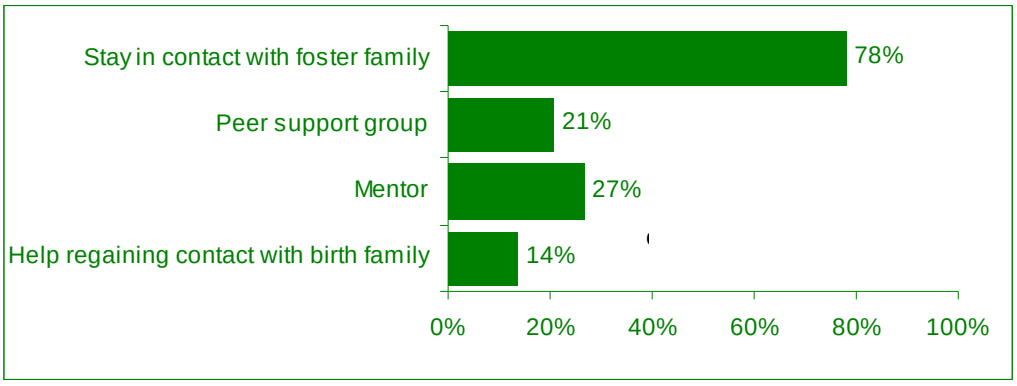

Figure 60. Things that would be of assistance upon leaving care – young people 16–18 years (2009)

Summary of findings

- The majority of young people aged 16 years and over feel confident that they will be able to manage living independently when they leave their foster care placement.
- Around 70% indicated that someone had spoken to them about what will happen to their care situation when they turn 18 and more than three quarters (79.7%) reported feeling confident that they will be able to manage independent living.
- Despite this, more than half (54.2%) expressed a preference to stay with their foster care

family beyond 18 years of age.

- The vast majority (87.7%) also anticipate needing help once they leave care, particularly help with finding accommodation and gaining financial support. A similar proportion (86.0%) also acknowledged that some forms of assistance, most commonly staying in contact with the foster care family, will assist their transition from care.
- Only 37.2% reported having a leaving care plan. The vast majority of these young people reported being involved in the development of their plan.

Satisfaction with Community Visitors

Introduction

The Commission's Community Visitor Program is a unique initiative designed to advance the safety and wellbeing of a vulnerable group of children and young people – those living in foster care, residential care and detention centres throughout the state. Community Visitors (CVs) are employed by the Commission to regularly visit and listen to these children and young people to see that they are safe and receiving appropriate care, to advocate on their behalf to help resolve any concerns or grievances and to offer support if required. CVs come from a wide range of backgrounds and have varied skills and professional experience. All receive comprehensive training to prepare them for their role.

CVs operate under the *Commission for Children and Young People and Child Guardian Act 2000* and are independent of government departments and service providers. They are required to report to the Commission on each visit. As well as the CV's role to resolve issues for a child locally, information from the reports is used by the Commission to identify any issues which require changes in the way a department or organisation operates and to advocate for systemic improvements in service provision or changes to legislation, relating to children and young people.

The Commission monitors the way CVs conduct their work through a range of mechanisms including: an information system which ensures that CVs visit and report regularly; frequent contact with Zonal Managers and central support staff; and, through the Commission's biennial surveys of children and young people in state care. To date, data from these surveys indicate that Community Visitors are highly valued and play an important role in the lives of these children and young people.

Questionnaires focusing on Community Visitors (CVs) were offered to children and young people in care. Questionnaires were also distributed to carers for them to complete on behalf of young children or those who, because of a disability, were unable to express an opinion. A total of 2227 questionnaires were received, 922 from young people and 527 from children, along with 778 from carers. This represents a substantial increase on the 1375 surveys received in 2007 as a result of 548 young people, 338 children and 489 carers (on behalf of young children) responding.

Where noteworthy, findings from the 2006 and 2007 surveys are compared with those from 2009 in order to identify any changes that have occurred during this time.

Respondents' characteristics

Demographic profile

Table 22 provides a summary of background information on those who responded to the CV questionnaires. As the table shows, the average age of young people is 12 years and 7 months, children average 7 years and 9 months and young children, 3 years and 6 months. Females slightly outnumber males among the young people and children, whereas males outnumber females among the young children.

Around two thirds of respondents are in foster care. Most of the remaining respondents are in kinship care, although a small percentage, particularly young people, are in specialist foster care. The demographic profile of respondents remains largely consistent with that of previous years.

Table 22.
Profile – young people, children, young children, and total group (2009)

Characteristic	Young people (9–18 years) *n = 922*	Children (5–8 years) *n = 527*	Young children (0–4 years) *n = 778*	Total group *N = 2227*
Age in years and months				
Mean	12yrs 11mths	7yrs 6mths	3yrs 11mths	8yrs 5mths
SD	4yrs 7mths	4yrs 7mths	3yrs 0mths	5yrs 5mths
Median	12yrs	7yrs	3yrs	8yrs
Sex				
Male	47.1%	44.6%	53.1%	48.6%
Female	52.9%	55.4%	46.9%	51.4%
Zone				
Far Northern	7.9%	7.6%	7.1%	7.5%
Northern	2.6%	3.1%	2.9%	2.8%
Central North	6.6%	7.4%	6.4%	6.7%
Central South	8.5%	7.1%	11.0%	9.0%
Ipswich	9.3%	13.7%	11.5%	11.1%
Toowoomba & Western	13.5%	13.5%	14.0%	13.7%
Brisbane North	6.0%	7.3%	7.3%	6.8%
Sunshine Coast	3.8%	4.8%	6.5%	5.0%
Brisbane South	4.6%	6.1%	7.5%	6.0%
Gold Coast	9.0%	6.9%	9.9%	8.8%
Moreton & South Burnett	7.9%	7.1%	4.7%	6.6%
Logan	7.6%	7.3%	5.4%	6.7%
Brisbane West	12.6%	8.2%	5.9%	9.2%
Type of care				
Foster care	67.6%	68.4%	70.6%	68.8%
Kinship care	28.6%	29.9%	26.4%	28.1%
Specialist foster care	3.8%	1.8%	3.0%	3.0%

Cultural background

As Table 23 shows, around two thirds (65.1%) of the total group of respondents is of Caucasian Australian background. Those of Aboriginal background comprise just over one quarter (27.7%) of respondents, while Torres Strait Islanders make up 3.7%. Around 8% of all respondents indicated they are from “other” backgrounds. Comments from these respondents reveal they were born in countries such as New Zealand, Fiji, Papua New Guinea and China. As some respondents selected more than one option (for instance, Caucasian Australian and Aboriginal or Caucasian Australian and Other), the percentages exceed 100.

Table 23.
Cultural background – young people, children, young children, and total group (2009)

Characteristic	Young people (9–18 years) *n = 922*	Children (5–8 years) *n = 527*	Young children (0–4 years) *n = 778*	Total group *N = 2227*
Cultural background				
Caucasian Australian	65.7%	63.6%	65.3%	65.1%
Aboriginal	25.8%	29.4%	28.7%	27.7%
Torres Strait Islander	3.7%	3.6%	3.9%	3.7%
Both Aboriginal & Torres Strait Islander	2.3%	1.3%	2.3%	2.1%
Other	8.4%	6.6%	7.6%	7.7%

Summary of findings

- 2227 young people, children and carers on behalf of young children participated in the survey.
- The overall mean age for the three groups combined is 8 years 5 months.
- Slightly more females than males participated.
- Around two thirds of the group is in foster care and 28% in kinship care.
- Almost two thirds are of Caucasian Australian background and around 30% of Aboriginal and/or Torres Strait Islander background.

Community Visitors

Respondents were asked a range of questions about their CV. To ensure that respondents understood what is meant by CV, the term was further described as *Your CV or person from the Children's Commission.*

Do you know the name of your CV?

The first question in this section asked young people, children and carers of young children if they know the name of their CV. As can be seen in Figure 61, the vast majority of young people (98.6%), children (96.2%) and carers (99.2%) report knowing the name of their CV. The proportion of young people reporting that they know the name of their CV has increased steadily since 2006. Responses from children and carers remain largely consistent with those of previous surveys.

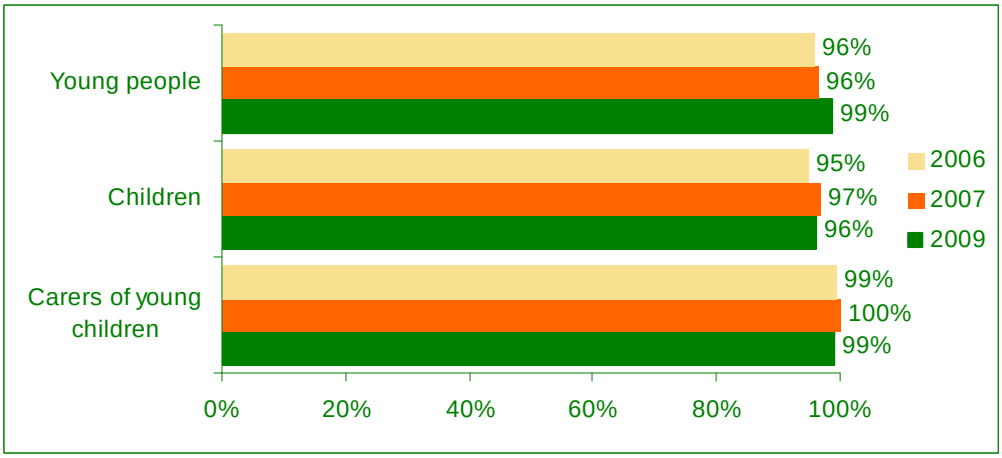

Figure 61. Know CV's name – young people, children, carers (2006, 2007, 2009)

How often do you see your Community Visitor?

Almost all (97.5%) the young people reported that their CV comes to see them once a month. As Figure 62 shows, only 2.2% indicated that their CV visits about every 3 months, and less than 1% once a year or never. These figures highlight a statistically significant increase, since 2007, in the proportion of young people reporting that their CV visits once a month.

Carers of young children were also asked about the frequency of CV visits. Almost all (99.5%) indicated that the CV visits every month. Less than 1% reported that the CV visits less frequently than this (i.e. every 3 months). Figure 62 shows that the proportion reporting to see their CV monthly is largely consistent with those of 2007 and 2006.

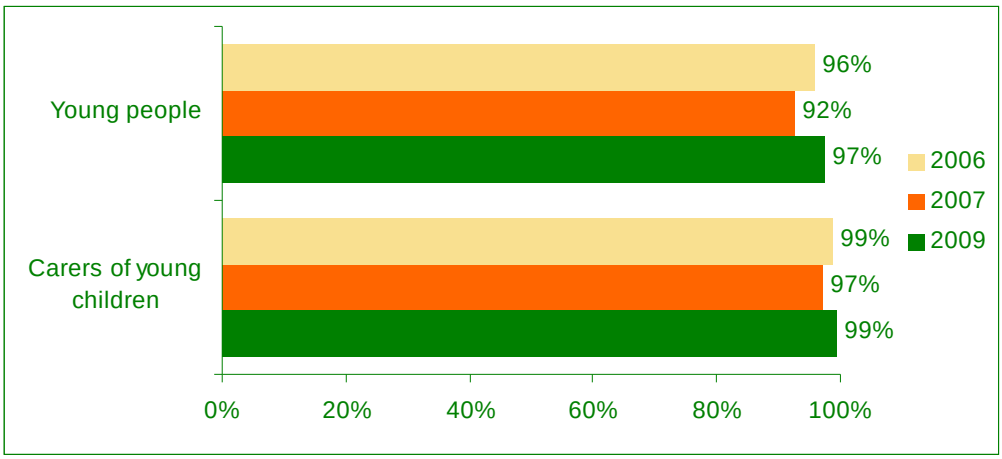

Figure 62. See CV monthly – young people and carers (2006, 2007, 2009)

When asked if they see their CV much, 93.2% of children reported that they do. This is slightly higher than the 2007 and 2006 figures of 89.4% and 87.3% respectively.

How often do you want to see your CV?

As can be seen in Figure 63, the majority of young people (76.6%), carers (88.4%) and, to a lesser extent, children (68.5%), report being satisfied with the frequency of contact they have with their CV. That said, more than one quarter (25.3%) of the children and 14.0% of young people would like to see their CV more often. This contrasts markedly with the views of carers, only 1.0% of whom feel that CV visits to young children should be more frequent. The figure also shows that some young people (9.3%), children (6.2%) and carers (10.6%) feel that CV visits should occur less frequently.
The proportions of young people and children who report being satisfied with the frequency of contact they have with their CV have increased since 2007. This increase is statistically significant.

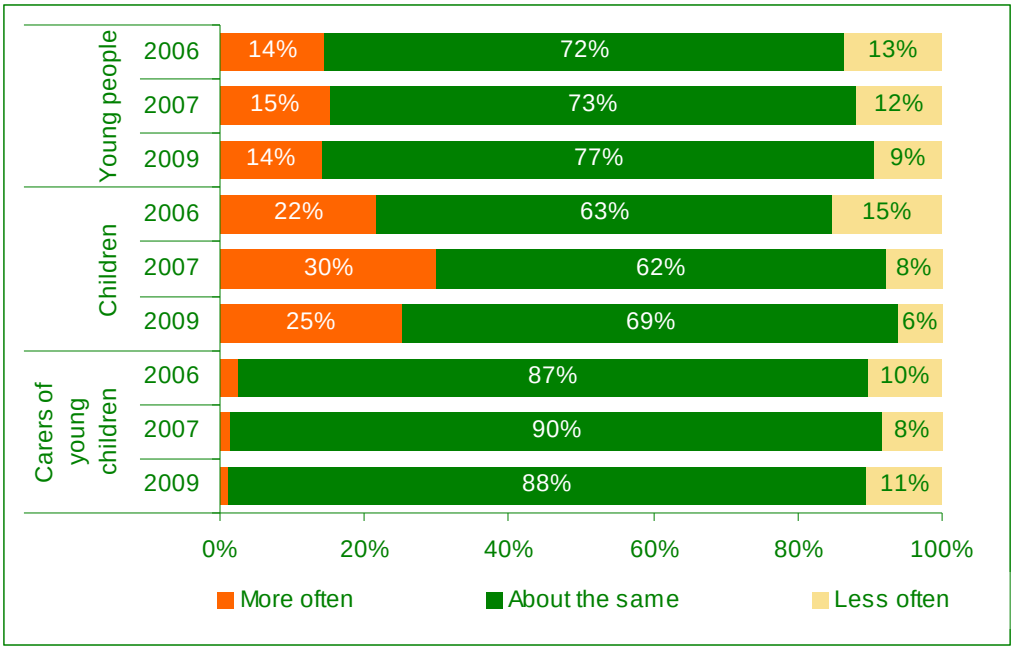

Figure 63. Desired contact with CV – children, young people, carers (2006, 2007, 2009)

Are you able to get in contact with your CV when you need to?

Young people and carers were asked if they have been able to get in touch with their CV when they need to. More than one third (35.4%) of young people and 13.8% of carers reported that they have not yet needed to contact the CV. Figure 64 shows that, of those who have needed to contact their CV, 80.6% of young people and 90.9% of carers report that they are able to contact the CV all of the time. Only 1.4% of young people and none of the carers reported never being able to contact the CV. These figures remain largely unchanged from those of previous years.

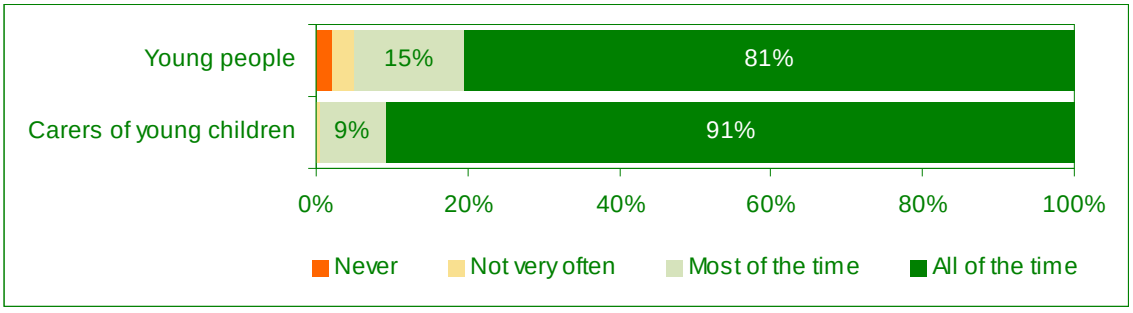

Figure 64. Able to contact CV when needed – young people and carers (2009)

Is your CV nice to you?

As can be seen in Figure 65, almost all the young people (99.0%) and children (99.6%) reported that their CV is nice to them. These figures are largely consistent with those of previous surveys.

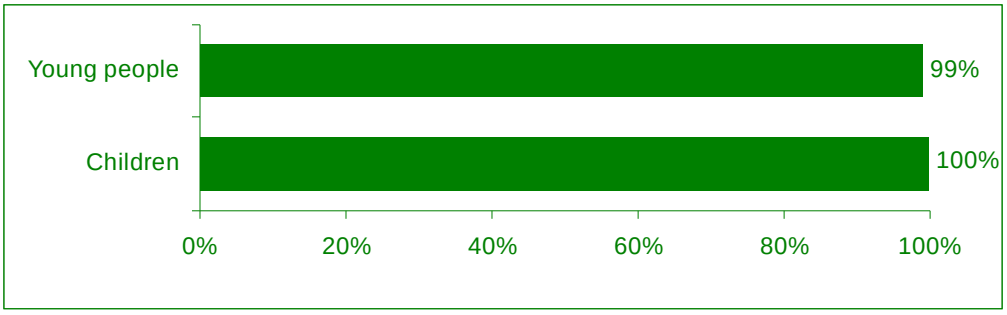

Figure 65. CV is nice to you – young people and children (2009)

Does your CV listen to you?

When asked to indicate the extent to which their CV listens to them, the vast majority (85.0%) of young people reported that their CV listens all of the time. A further 13.7% indicated that their CV listens to them most of the time. Only 1.2% reported that they are never or not very often listened to. These figures, shown in Figure 66, are similar to those of previous years.

When children were asked if their CV listens to them, almost all (99.2%) responded that their CV does listen. This figure is largely consistent with those of 2007 and 2006.

Does your CV care about what is best for you?

Young people were also asked about the extent to which their CV cares about what is best for them. Figure 66 shows that the vast majority (85.6%) reported that their CV cares what is best for them all of the time, while a further 13.1% reported that their CV cares most of the time. A small proportion (1.4%) feel that their CV never cares or doesn't care very often. These figures are similar to those of 2007 but differ from 2006 when 80.1% of young people reported that their CV cares about their best interests all the time.

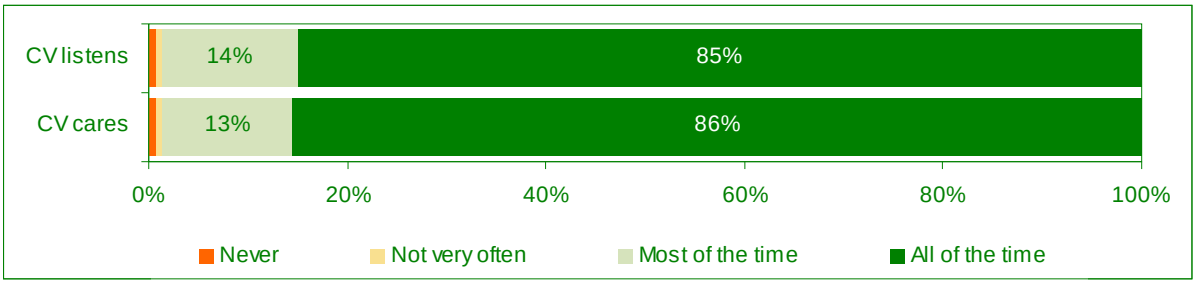

Figure 66. CV listens to you and CV cares about what is best for you – young people (2009)

Carers are even more likely than young people to report that the CV cares about what is best for the child. Almost all 99.7% reported that the CV cares all (93.0%) or most (6.7%) of the time. These figures are consistent with those of 2007 and 2006.

Children were asked whether or not their CV cares about what is best for them. Almost all (99.8%) feel that their CV does care. This is largely unchanged from those of 2006 and 2007.

Is there anything in particular that your CV has been able to help you with?

Young people, children and carers on behalf of young children were each asked if their CV has been able to help with anything in particular. Figure 67 shows that young people (60.0%) and children (78.6%) are more likely than carers (51.6%) to identify that their CV has been able to help with something. The proportion of young people and carers reporting that their CV has been able to help with something has remained largely consistent across the years. There has been, however, a significant increase, from 71% in 2006 to 79% in 2007 and 2009, in the proportion of children reporting that their CV has been able to help.

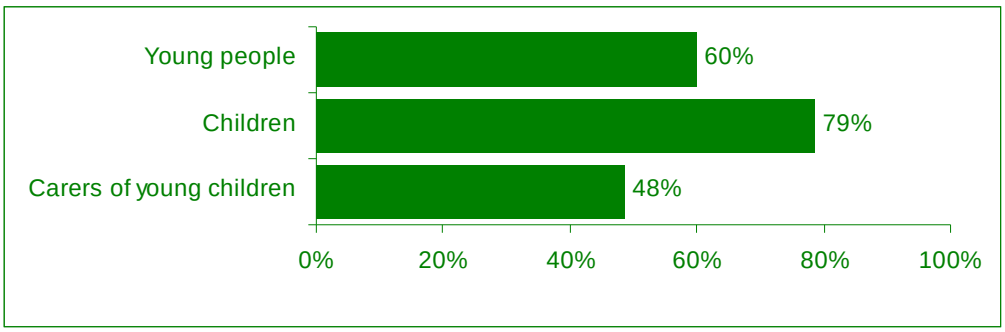

Figure 67. CV has been able to help – young people, children, carers (2009)

Respondents were asked to describe the types of things that their CV has been able to help with. Hundreds of comments were received highlighting the diverse ways in which CVs are able to assist children and young people in care. Some of the comments made by young people and children are:

- ***Change in contact arrangements.***
- ***A lot of things like seeing my family.***
- ***Answering questions and making me feel good.***
- ***Change of school because of bullying.***
- ***Care plan, school, health, nurse, visits, contacting family brothers.***
- ***Controlling my temper. Getting the department to do things.***
- ***Counselling, school help. For my CSO to visit me.***
- ***Issues with last carer and transition to new.***
- ***She helped me stay at a great placement.***
- ***Transition from care plan.***
- ***Wonderful support person. Great advice. Very good at understanding me.***

Examples provided by children included:

- ***Got my teeth fixed.***
- ***He talks to me about teasing at school and helps give me ideas about fixing this.***
- ***Listening to my problems.***
- ***Homework.***
- ***Helped me and my sister get visits with our previous carer.***
- ***My manners and reading.***
- ***Reminding me to floss.***
- ***Playing soccer.***

Numerous carers also commented on the help that the CV has provided. These comments include:

- ***Absolutely amazing. Worth her weight in gold.***
- ***Answering all my questions clearly and honestly.***
- ***Supporting me helps support the child – happy Mummy = happy child.***
- ***Thanks. Children in care need CVs. Keep up the good work. I would like to say that the CV that looks over the children we have is fantastic. It makes us feel that there is someone that is there just for him.***
- ***The CV has been the one constant in the children's lives as far as 'gov visitors etc' go, Dept etc – the one who hasn't changed jobs!!***

However, several carers also alluded to the challenges that they believe CVs face in relation to advocating for children in care. Comments of this nature include:

- ***Need to have more power. It is obvious that some Dept workers have a negative view of CVs.***
- ***Dept doesn't listen to CV.***
- ***Department override CV all the time.***

Out of 10, how helpful has your CV been?

Young people were asked to rate the helpfulness of their CV on a scale of 1 (really unhelpful) to 10 (really helpful). Figure 68 shows that almost two thirds (62.7%) of young people awarded their CV a maximum score of 10. The mean score of CV helpfulness as rated by young people is 9.0 This score is largely consistent with that of 2007 (8.9), but significantly higher than the mean score of 8.8 in 2006.

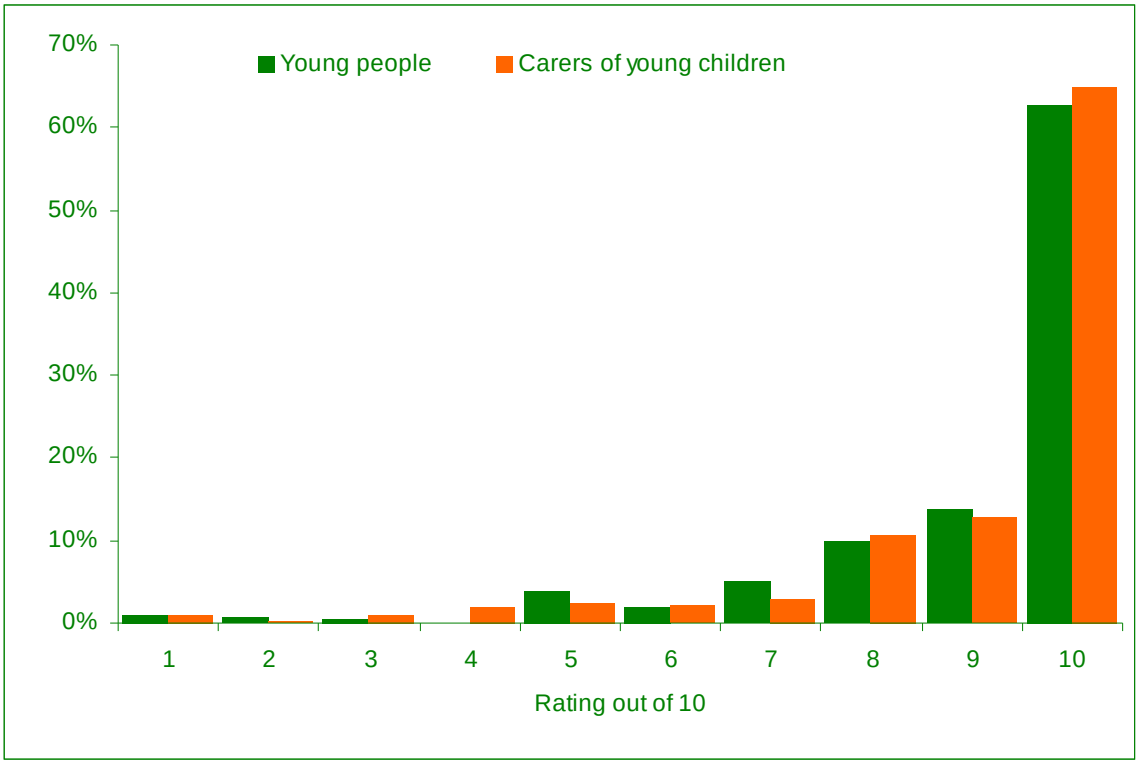

Figure 68. Rating for helpfulness of CV – young people and carers (2009)

Carers on behalf of young children were also asked to rate, out of 10, the helpfulness of their CV. As Figure 68 reveals, 65.0% of carers awarded their CV a maximum score of 10. The overall mean score of CV helpfulness is 9.1. These results are similar to those of 2007 but represent a statistically significant increase on those of 2006 when the mean score was 8.7 and just over half (53.0%) the carers awarded their CV a score of 10.

Summary of findings

- Reports from children, young people and carers indicate that CVs continue to perform an important and valued role in the lives of those in care.
- Most respondents report that the CV listens to them and cares about their best interests. They are able to contact their CV if needed and appear satisfied with the frequency of CV visits. Satisfaction with the frequency of CV visits has increased significantly since 2007.
- Ratings of CV helpfulness remain consistently high. Comments from respondents highlight the numerous ways in which CVs have been able help children and young people in care.
- Commonly listed were assisting with school issues and homework, listening to problems and liaising with the department about medical appointments, care arrangements, contact with family, and transition from care plans.

Discussion

The findings presented in this report provide important insights into children's and young people's experiences of being in care. Their views highlight some strengths and weaknesses of the child protection system as well as evidence of incremental changes since 2006 when the *Views* research commenced.

This section focuses on what the Commission considers to be the most notable of the findings. These findings are grouped under several broad headings:

- subjective wellbeing
- health
- education
- placement history
- impacts of being in care
- having a say
- permissions
- contact with community
- support and advocacy
- leaving care

Drawing on the findings and relevant national and international research, implications for policy and practice are also noted.

Subjective wellbeing

Subjective wellbeing refers to how individuals *feel* about their own wellbeing (Thomas, 2009). It is increasingly recognised by policy makers, practitioners and researchers as an important consideration when assessing the benefits of preventative policy and service initiatives (Thompson & Aked, 2009). Subjective wellbeing is widely understood to be a multidimensional construct comprising a range of indicators. These indicators vary according to the research focus but, in relation to children, they commonly relate to happiness, safety, health, worry, having people who care and experiences at school (Davidson & Cotter, 2006; Nevill, 2009; UNICEF, 2007; Thomas, 2009; Thompson & Aked, 2009). This section of the discussion focuses on the survey findings that reflect these aspects of children's and young people's subjective wellbeing. The exceptions are health and school, the findings of which are covered individually in the sections *Health* and *Education*.

An important finding from the study is that an overwhelming majority of children and young people consider themselves to be happy. Most also reported feeling loved and cared for by someone and safe and happy in their placement. Further evidence of these feelings emerged from children's and young people's comments about their placement. When asked to describe the best thing about their placement, the things most commonly mentioned are relationships with carers (such being loved and looked after) and lifestyle factors (such as being able to do or have things). For these children and young people, simple pleasures such as going fishing, cooking, having pets and being part of an everyday family are clearly important.

Despite feeling safe, happy and loved and cared for, the survey findings revealed that many children and young people reported that they are worried. More than one third of the young people reported worrying most or all of the time and almost half the children reported worrying about things a lot. The survey did not ask respondents to comment on the reasons for their worry. However, the prevalence of worry among this group and the negative impact that worry can have on wellbeing suggest that further investigation of the prevalence and causes of worry is warranted.

In light of the findings on worry, there is a need to:

- ***conduct research that explores the prevalence and causes of worry among children and young people in care***

Health

As noted in the findings, the vast majority of children and young people reported that they are healthy. Likewise, an overwhelming majority of carers indicated that the child in their care is in good health. Despite this, the findings suggest that considerable numbers of children and young people appear to have a variety of unmet mental and physical health needs. Many children and young people reported having mental health issues and a variety of physical health problems such as dental, speech, hearing and respiratory problems, infections, allergies and migraines that they have not yet seen someone about.

Another key finding is the persistently high number of respondents reporting to be taking ADHD medication. Around 16% of young people and 15% of children reported taking medication for ADHD, similar to the proportions in 2008 and 2006. For young children this figure is around 7%. In light of the recently released draft guidelines from the Royal Australian College of Physicians (2009), it is particularly concerning to hear from carers that children as young as 1 year of age are being medicated for ADHD. The draft guidelines advise that a pharmacological intervention it is not appropriate for children less than 6 years of age because of the high risk of misdiagnosis. The guidelines caution that an assessment of ADHD should only be undertaken by specialist paediatricians or child psychiatrists and should involve a comprehensive medical, developmental and psychological assessment taking account of comorbidities, family dynamics and cultural or religious diversity. Furthermore, the guidelines recommend that medication should only be prescribed when symptoms are pervasive across a range of settings and result in significant social, academic or behavioural impairment (Royal Australian College of Physicians, 2009).

Given the prevalence of mental and physical health issues, it is concerning that less than one fifth of young people reported having a health passport and less than half the carers reported that the child in their care has a health passport. As these passports or plans provide a record of each child's or young person's individual health assessments and day-to-day health needs, they are a vital source of information for carers. Without this record, it is possible that children and young people will miss out on their initial and follow up health assessments as well as the necessary specialist referrals.

Researchers in Australia have pinpointed a number of barriers that undermine the implementation of health plans and provision of health care services for children and young people in care. These barriers include the lack of medical history that often accompanies children and young people into care and a tendency to rely on carers who may not be fully informed about the child's medical history and needs. A further barrier is the difficulty that different services encounter in the recording, sharing and transfer of health information, particularly where frequent placement, caseworker and health provider changes are involved (Cashmore at al, 2008; Crawford, 2006). Information sharing among agencies is vital for ensuring that services for children and young people in care are delivered in a timely and holistic way. However, until such time that there are electronic systems in place to facilitate the sharing of health information, achieving a coordinated, multi-agency response to the health needs of children and young people in care will remain a challenge (Nathansen, Lee & Tzioumi, 2009).

Drawing on the findings and related literature, implications for policy and practice are:

- ***ensure that assessment and treatment of ADHD is managed by trained professionals***
- ***continue to improve departmental compliance with policy requirements to provide each child and young person in care with an individual health passport***
- ***continue to develop and implement systems that facilitate interagency information sharing and collaboration on health related matters***

Education

Few would argue that education is critical to the academic and socio-emotional progress and recovery of children and young people in care (Cashmore et al., 2008). School, in particular, can be an *anchor* for children whose lives have been uprooted (Fram & Altshuler, 2009) while happiness at school is widely recognised as being a key indicator of children's subjective wellbeing (Nevill, 2009; UNICEF, 2007).

However, the survey findings, like those of previous studies, confirm that many children and young people in care find school immensely challenging (Bruskas, 2008; Fernandez, 2008; Fram & Altshuler, 2009; Stein & Dixon, 2006). As noted earlier, around one third of children and young people report

experiencing a range of problems at school including bullying, difficulties with school work, problems with their own behavior, and problems with teachers and more than one quarter of young people indicated that they have repeated a year at school at least once. Disciplinary absences from school also appear to be commonplace with four in ten reporting to have been suspended at some time and almost one in ten having been formally excluded (expelled). Furthermore, many children and young people appear to have experienced considerable instability in their schooling, with four in ten reporting to have attended more than three primary schools. Of these, more than one in ten reported having attended at least six schools.

While the reasons for these experiences are beyond the scope of this study, research has shown that certain factors can reduce the susceptibility of children in care to problems at school. According to Havalchack et al. (2009), these factors include feeling safe in care, receiving additional supports and experiencing placement and caseworker stability. Stein and Dixon (2006) also emphasise the importance of placement stability along with positive encouragement from carers and teachers. In contrast, they stress that low carer expectations and low valuing of education along with the negative attitudes of teachers only impede educational success. In relation to young children, Cashmore et al. (2008) suggest that exposure to high quality early childhood programs is not only essential to their learning and development, it provides a caring and consistent environment in which their health and wellbeing can be closely monitored.

A key initiative in Queensland designed to address the educational disadvantage so often experienced by children and young people in care are Education Support Plans (ESPs). Each child and young person in care is not only entitled to such a plan, there is an expectation that they will be involved in its development. Given the importance of this initiative, it is disappointing that more than one in four young people in the study report that they are either unaware of having a plan, or do not yet have a plan. Notwithstanding this, it is important to acknowledge the significant increase over the years (from 28.9% in 2006 to 56.0% in 2009) in the proportion of young people reporting having an ESP. This finding suggests that efforts to increase the uptake or awareness of ESPs are succeeding.

In light of the findings and related literature, the implications for policy and practice are:

- ***increase efforts to minimise the number of placements and school changes children in care experience***
- ***promote awareness among carers and teachers of the importance of education for children and young people in care and the need to encourage success at school***
- ***prioritise access to quality child care and early education programs, such as kindergarten and prep, for young children in care***
- ***continue to improve departmental compliance with policy requirements to provide each child and young person in care with an individual education plan***

Placement history

Placement stability is integral to children's and young people's short and long term wellbeing (Carlson, Sampson & Sroufe, 2003; CCYPCG, 2006b; JCICS, 2005; Lawrence, Carlson & Egeland, 2006; Wulczyn, Kogan & Harden, 2003). The findings of this survey reveal that despite being happy in their current placements, a considerable proportion of children and young people do not have this vital sense of stability with around one fifth of young people worrying about moving placements in the near future. This is consistent with the increasing numbers of young people reporting that they have experienced numerous placement changes. Compounding this, almost one in five children and young people surveyed reported experiencing failed reunifications.

Although respondents who have been in care for longer periods are over-represented in the sample, the fact that there are still moderately high numbers of children experiencing placement instability and failed reunifications indicates the need for serious and ongoing attention to these matters.

Data currently available from the department do not fully reflect the experiences of instability identified by the children and young people who took part in this survey for several reasons. Firstly, failed reunifications, which are a source of instability for a substantial number of children in this sample, are not reported by the department. Secondly, placements are only reported by a period of continuous care rather than per child. The result of these two factors is that a child who has experienced three placements and two unsuccessful reunifications would be reported three times as having a single

placement. The child's failed reunifications would not be reported at all. Such reporting is quite inconsistent with the child's actual experiences of stability.

Experiences of children and young people in this research suggest that it is important to:

- ***acknowledge the impacts of failed reunifications on children's and young people's experiences of stability***
- ***recognise the cumulative effects of separate periods of care on children's and young people's wellbeing***
- ***create and regularly report measures of placement stability that more accurately reflect children's and young people's lived experiences including counting placement moves and failed reunifications across the child's lifetime and not just the most recent period of time in care***

Impacts of being in care

The findings of this study point to some very positive aspects of children's and young people's foster care experiences. Respondents are overwhelmingly positive about their foster carers with the vast majority reporting that their carer listens to them, is nice to them and treats them well. In addition almost all children and young people reported feeling loved and cared for and safe in their current placements and, on average, young people rated their placements 8.8 out of 10, with the majority giving a score of 10 out of 10. These findings are encouraging given the important role that a warm and nurturing foster placement has in helping children and young people to recover from trauma, maltreatment and disrupted attachments (Dozier, et al., 2001; Schofield, 2002; Riggs et al., 2009).

At the same time, children and young people identified a variety of challenges that their peers outside of the foster care system generally do not have to face. Being away from and missing family is a concern for many with almost half of the children and young people participating in the survey reporting that they do not get to see their family as much as they would like. Comments suggested that children and young people miss not only their parents but also siblings and extended family. In addition, most have to do things like go to meetings and see people that they don't want to at least some of the time and missing out on things as a result and issues with permissions are common to many children and young people. Around one fifth of young people reported that they are made to feel different all, or most of the time because they are in care.

The difficulties and challenges described by children and young people in this study serve as a reminder of the importance of working with families to reduce the need for children and young people to be taken into care. While foster carers and caseworkers can help children and young people deal with the difficulty of being separated from their family and can help them negotiate the challenging aspects of the child protection system including meetings and permissions, the only way to avoid these issues altogether is by providing support to help families stay together. Of course, foster care will always remain an important and necessary intervention for some children and young people and it is necessary to provide appropriate supports to both children and young people and carers to deal with the challenges described by the respondents in this study.

Children's and young people's views suggest some implications for policy and practice including:

- ***provide support for families, including prevention and early intervention services, to allow children and young people to remain at home safely wherever possible***
- ***support children and young people to draw on the many positive aspects of foster care to deal with past instances of trauma and current difficulties associated with foster care***

Having a say

The notion that children do or should have a say is widespread and formally recognised. Under the *United Nations Convention on the Rights of the Child*, children's and young people's views are to be given "due weight" and under the *Child Protection Act 1999* children and young people are to "have the opportunity to take part in making decisions that affect their lives." Young people entering care are provided with a publication entitled *My Journey in Care* which states, "you are allowed to have a say in the decisions about your life – like where you are going to live" (Department of Child Safety: 15). The message delivered to children and young people is that participation in decision making is a right.

The findings of the survey provide some insight into how children and young people in care interpret this right. While the vast majority of children and young people report being listened to most or all of the time, only slightly over half report having a say most or all of the time. Even as the proportion of young people who report that they are listened to has grown in recent years, the proportion who report having a say has declined. Clearly, for children and young people in care, having a say involves more than being listened to.

The department's interpretation of this right is outlined in the *Children and Young People's Participation Strategy 2008 – 2011*. The strategy describes four approaches to participation that vary by the degree of power and responsibility afforded to children and young people. At the lower end, children and young people provide information into the process and decisions are made and implemented exclusively by adults. This approach is referred to as 'consultation' and contrasts with other forms of participation where children and young people have direct influence over outcomes, whether by "steering" a process ultimately determined by adults or by making decisions autonomously.

There is an apparent mismatch between these two understandings of participation. Children and young people draw a distinction between being listened to and having a say where the department does not. The result is that children and young people who are told that they "are allowed to have a say" may have expectations about their involvement in decision making that are not fulfilled. The resulting frustration is evident in both the content and tone of young people's comments about unresolved issues and may go some way to explaining why the majority of young people lack confidence that the department will follow through on promises.

To avoid this sense of frustration, it is necessary for children and young people and the department to develop a shared understanding of the right to participate in decision making. In doing so, it may be necessary to change the way children's and young peoples rights are explained, for example, it may be beneficial to be more explicit about the different ways children and young people can contribute to decisions and to articulate more fully the extent to which children and young people can expect to be involved in decision making. Crucially, children and young people must properly understand their role in making any given decision and know how much scope there is for negotiation before the decision making process begins.

Implications for policy and practice arising from the findings include:

- ***further explore how children and young people understand their right to participate in decision making***
- ***articulate a more nuanced message about the right to participate to ensure children's and young people's expectations align with the forms of participation outlined in the department's Children and Young People's Participation Strategy 2008 – 2011***
- ***clearly explain to children and young people how much input they will have in any given decision before the decision making process commences***

Permissions

A major issue for respondents in this study is that of permissions. Almost half of young people reported that permission requirements are unreasonable, around a third reported that permission is never, or not very often granted in time and a fifth indicated that they miss out on doing things most, or all of the time. In addition, the restrictiveness of the department's rules and administrative delays were both frequently raised when young people were asked about how the system could be changed. Carers were also concerned about permissions with a third of the carers of young children indicating that they believe permission requirements are unreasonable. Both young people and carers frequently made comments in favour of giving more decision making authority to carers.

Respondents' comments suggest a level of confusion around permission requirements that may exacerbate feelings of dissatisfaction. Some carers specifically commented that they were unsure about which decisions required permission and which did not. Others complained about the impost of seeking permission for routine activities such as haircuts and low-risk sporting activities that in fact do not require departmental or parental permission. Similarly, young people frequently cited missing out on sleepovers when the department's policy is that young people are able to spend up to two nights away without departmental or parental permission.

At the same time, carers and young people expressed frustration at a range of decisions that do genuinely require departmental or parental permission. Carers most commonly complained about decisions relating to routine medical procedures including immunisations and blood tests, while young people wanted to be able to participate in sporting activities like horse-riding and motorbike-riding considered high-risk by the department. Both carers and young people frequently commented that taking holidays outside of Queensland was unnecessarily difficult.

The findings suggest that satisfaction with permissions could be improved in two ways. Firstly and most simply, it may be beneficial to increase awareness of the rules around permissions. Information about permissions is already freely available in the *Carer Handbook*, however, given the apparent confusion, it may be beneficial to promote these rules more actively.

In addition, there may be some benefit in relaxing rules around some of the activities identified by carers and young people. In particular, given the low risk and the Queensland Government's active promotion of immunisations, it would seem reasonable to allow carers to have children and young people immunised without specifically seeking permission. Likewise, it would seem reasonable to allow carers to give permission for school camps and other sporting and educational activities that may involve an element of risk but are considered unexceptional by community standards.

These types of changes would require some curtailment of parental rights and should therefore not be undertaken lightly. However, if children's and young people's interests are to be the paramount consideration, some change might be warranted.

In light of the findings it may be beneficial to consider:

- ***actively promoting rules around permissions to reduce confusion and uncertainty among children, young people and carers***
- ***exploring options for giving carers more authority to approve routine activities***

Contact with community

The proportion of Aboriginal and/or Torres Strait Islander young people who reported being in touch with their community improved significantly since the last survey conducted in 2007. Overall, most Aboriginal and/or Torres Strait Islander young people feel in touch with their community, however, rates are significantly higher for young people living with a carer who shares their cultural background.

Young people's comments also highlighted a wide variation in the level of community involvement that Aboriginal and/or Torres Strait Islander young people desired. On the one hand, a number of young people specifically commented that they wanted to learn more about their culture and language and to be more involved, while at the opposite extreme, a number of young people stated that they were not at all interested in learning about or being involved in their Aboriginal and/or Torres Strait Islander community. Some young people acknowledged some Aboriginal and/or Torres Strait Islander heritage but chose not to identify as Aboriginal and/or Torres Strait Islander. It is important to recognise the intensely personal nature of cultural identity and support children and young people to engage in their culture to the extent and in the ways that they choose to.

Implications for policy and practice include:

- ***continue placing Aboriginal and Torres Strait Islander children and young people with carers who share their cultural background wherever possible***
- ***provide a diverse range of opportunities for Aboriginal and Torres Strait Islander children and young people to connect with their culture and community***
- ***support children and young people to engage with their Aboriginal and/or Torres Strait Islander culture and community to the extent and in the ways they choose to***

Support and advocacy

Removing children and young people from their family is the most serious intervention that a government can undertake (Cashmore et al., 2008). Once this has happened it is essential that children and young people know who they can contact, or have someone to turn to, when they need support.

Findings from the study indicate that the majority of children and young people do know who to contact if they need help. Furthermore, there is evidence of growing satisfaction among respondents in relation to the support provided by CSOs. There appear to have been notable improvements in the contactability of CSOs and increases in how often CSOs visit. CSOs are increasingly seen by respondents as being nice, helpful people who listen and care about what is best for them. CSOs were acknowledged for helping in a variety of ways ranging from resolving problems at school and helping with behavioural issues to finding, or facilitating contact with, family members.

Findings such as these highlight the valued and important role that CSOs can play in the lives of children and young people in care as well as the complex and demanding nature of their work. It is unfortunate, therefore, that a re-occurring theme throughout the open-ended survey responses was lack of continuity of CSOs. Young people and carers, in particular, indicated that frequent changes of CSOs are both disappointing and frustrating, particularly when CSOs have established a positive relationship with the child or young person and have a thorough understanding of that child's or young person's unique history. Young people and carers also referred to CSOs as being overworked, having unmanageable caseloads and insufficient time to listen to, or get to know, children and young people.

While recent initiatives in Queensland to improve recruitment, training and retention of CSOs must be acknowledged and commended, it is important that such efforts keep pace with the growing numbers of children and young people who are entering care each year. As Cashmore et al. (2008, p. 9) caution, *no system for promoting children's wellbeing, reducing children's vulnerability and protecting those who are abused or neglected can succeed without attracting, retaining and developing the knowledge and skills of the workforce.*

Also evident from children's and young people's responses is the important support and advocacy role of the Commission's CVs. For an overwhelming majority, the CV is someone who listens to them, cares about their best interests and is helpful. Comments from respondents highlight the types of assistance that CVs provide including helping with school issues and homework, listening to problems and liaising with the department about medical appointments, care arrangements, contact with family, and transition from care plans.

Policy or practice implications stemming from the findings and related literature are:

- ***acknowledge the important role that CSOs and Community Visitors can play in supporting and advocating for children and young people in care***
- ***continue efforts in the areas of recruitment, training and retention of CSOs***
- ***ensure that CSOs are adequately resourced and have manageable caseloads***

Leaving care

The importance of thorough planning to assist young people in their transition to independence is now widely recognised by governments around the world. Careful planning can be effective in mitigating the educational underachievement, unemployment, homelessness, involvement in criminal activity, ongoing mental health problems, and reliance on government welfare so often experienced by young people once they have left care (Bruskas, 2008; Cashmore & Paxman, 1996; McDowell, 2009; Fowler et al., 2009; Mendes, 2009; Schneider, 2007; Stein & Dixon, 2006; Tweddle, 2007). In Australia, however, the absence of a coordinated, national approach to leaving care plans and post care entitlements means that efforts to respond to the needs of care leavers have been inconsistent.

Although in Queensland planning for leaving care is required to commence at around the time a young person turns 15 years of age, the study findings point to a substantial shortfall between policy and practice in this area. Of the 16 to 18 year olds who participated, around 30% reported that no one has spoken to them about what will happen when they turn 18 and less than one third reported having a leaving care plan. The absence of such a plan is particularly concerning given the range of supports that these young people acknowledged they will need when they leave care. As discussed earlier, these supports include financial assistance, help with living arrangements, life skills, finding employment, accessing training and education programs, and getting information on health services.

A number of findings from the study highlight the strong connection that a young person can develop with their foster family and the sense of support they derive from them. Not only was staying in touch with the foster family after care considered by young people to be the most beneficial type of post-care assistance, most indicated that they would prefer to remain with their foster family after they turn 18.

Alongside research that demonstrates numerous benefits for young people when they are able to remain with their foster care family, including completion of school, participation in tertiary education, higher earnings, and delayed parenting (Cashmore & Paxman, 2006; Courtney et al., 2007) these findings underscore the need for flexibility in terms of the age at which young people must leave care. While Cashmore and Paxman (2006) acknowledge that not all carers are able or willing to accommodate young people beyond 18 and not all young people wish to continue living with the foster family, they point out that if expectations were changed and support to foster carers extended, many carers would be in a position to accommodate young people until they were equipped to leave.

Drawing on the survey findings and literature in the area (Cashmore & Paxman, 2006; Courtney et al., 2007; Mendes, 2009; Stein & Dixon, 2006; Tweddle, 2007), policy and practice implications for leaving care centre on the following system considerations and practical supports.

System considerations:

- ***develop national standards on the nature and extent of government supports provided to young people transitioning from care***
- ***achieve consistency in relation to the duration of entitlements – in line with the majority of Australian jurisdictions***
- ***adopt a flexible leaving care system that allows for carer entitlements to be extended to enable young people to remain with the foster family***
- ***ensure that each young person has an individualised and up-to-date leaving care plan and that they have been involved in the development of that plan***
- ***incorporate data on the take up of leaving care plans into departmental performance measures***
- ***evaluate the effectiveness and availability of after care services***
- ***conduct longitudinal research into long-term outcomes for care leavers***

Practical supports:

- ***provide assistance with finding and maintaining stable accommodation***
- ***facilitate access to healthcare services and employment programs***
- ***provide sufficient financial support to cover living costs that recognise the absence of parental support usually available to other young people (similar to the additional Centrelink payment to refugee families)***
- ***explore possibilities for concessions or subsidies to undertake higher education***

Conclusions and future directions

The report has highlighted some key strengths of the child protection system and has drawn attention to areas where improvements have been made. These gains, most notably in relation to ESPs and the perceptions of CSOs, should be commended, particularly given the tight fiscal climate in which they have been achieved.

Notwithstanding these improvements, the survey findings also point to further improvements that need to be made in the best interests of children and young people in care. To this end, the Commission will continue to work closely with government and non-government child protection agencies to achieve better outcomes for those in care, particularly in the aforementioned areas of health, education, stability, involvement in decisions, and leaving care. The Commission hopes to see evidence of continued improvements when the survey is next conducted.

To increase awareness of the views of children and young people in care in Queensland, the Commission will disseminate the research findings through a range of mechanisms including publications in scholarly journals and presentations at conferences and forums attended by child protection policy-makers, researchers, practitioners and students. A young person's edition of the report will also be distributed by CVs to all children and young people in care so that they can see that their views have the capacity to inform and influence the systems that care for them.

Further and more in-depth analyses of survey data will be undertaken to shed light on factors that promote positive outcomes for children and young people in care. Of particular interest are the interactions between respondent characteristics such as age at commencement of care, cultural background and placement history and a range of subjective measures such as health, worry, happiness in placement, difficulties at school, and involvement in decisions. Insights gained from such analyses will continue to inform the Commission's monitoring and Community Visitor functions and contribute to the growing evidence base on the determinants of wellbeing for children and young people in care.

At a broader level, the Commission will continue to play an active role in helping to shape the future direction of out-of-home care in Australia. Along with other key stakeholders, the Commission is contributing feedback to the development of National Standards for Out of Home Care. The standards comprise part of the federal government's National Framework for Protecting Australia's Children 2009-2020. The Commission has also commenced a second audit of the Queensland Government's Indigenous Child Placement Principle with the audit report to be published in 2010 – 2011. The audit is seeking input from Aboriginal and Torres Strait Islander young people on the cultural outcomes that are important to them when placed in care and the extent to which these outcomes are being delivered. Underpinning the Commission's advice in relation to both these initiatives is the view that children's and young people's perspectives are essential if policies and programs are to respond effectively to their needs.

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Appendix

The best thing about living here – comments from young people

The best thing about living here – comments from children

Changes or improvements to placement – comments from young people

Changes or improvements to the system – comments from young people

Things that no-one is listening to you about – comments from young people

Things that no-one is listening to you about – comments from children

What is the best thing about living here? (young people)

Lifestyle and opportunities

Outings, holidays and adventure activities, games

- Being able to do things.
- Bikes, go camping.
- Camping and fishing.
- Camping on holidays.
- Do stuff.
- DVDs, pizza night.
- Get to go fishing.
- Get to go on heaps of holidays with the other kids.
- Get to go out.
- Get to hang out in the house and do things when she wants eg. show, kitchen, eat, painting, music.
- Go on holidays.
- Go out and do stuff.
- Going on outings like McDonalds, movies, family, shopping.
- Going out to places.
- Going places that never been before.
- Going places.
- Going to theme parks and going out to places.
- Grandma letting us play soccer and taking us to clubs.
- Having passes to all the theme parks and we go out all the time.
- Heaps of play and treats and watch movies and love going to prayers.
- Heaps of things to do.
- Help building. Build cubby house.
- I get to do what I want which is my music.
- I get to play games. Because I get to do things.
- I have a car I am building my carers gave me.
- I like swimming, boxing, trampoline.
- I like when my carer takes me fishing at the beach.
- Motorbikes.
- Motorbikes.
- Nice to play on the swing.
- Pig chasing.
- Pigging.
- Playing football.
- Playing my sports.
- Playing soccer.
- Playing with carer's daughter, littlest pet shop.
- Playing.
- Riding horses, riding motor bikes, learning to drive a car.
- Riding motor bikes, Motorcross and I'm getting two of them.
- Riding motorbike.
- Running with kids outside and going on holidays.
- She takes us shopping.
- Swimming.
- Swimming.
- They take us places.
- They take us to many different places we haven't been to.
- TV and shopping and swimming and netball and softball.
- TV.
- We get lots of special treats and go to the theme parks.
- We get scooters.
- We get to do a lot of things that a lot of other kids in care don't get to do!
- We get to do dancing and do a lot.
- We get to go camping.
- We get to help *** in the shed.
- We get to stay up on Saturdays and we go out.
- We go away on holiday.
- We go camping at *** sometimes if we don't have babies.
- We go on a lot of holidays.
- We go out every weekend, swimming, beach, movies, play at pool.
- We go places – Cowboys football. Rollingstone.
- We go to lots of theme parks.
- We go to the coast often.
- We got to get to places like Port Douglas.
- Went on a trip to Vanuatu as quickly as going into this placement.
- Wet 'n Wild every week. Theme park passes.
- When carer takes us out for dinner.
- You get to do things that you haven't done before. Being treated by respite carers to go the movies with their child.
- You get to go fishing and play whatever you want to play
- You get to play with kids.

An additional **78** responses are included under “Multiple themes”

Space, environment, amenity, location

- Acreage.
- Beach over the road.
- Being able to have my own space.
- Big room. Big backyard.
- Central to everything, park central to shops.
- Close to school. I know everybody.
- Close to shopping centre.
- Close to the beach.
- Close to town.
- Close to work.
- Fire place, big screen TV. Own bedroom, lots of space.
- Freedom of choice.
- Good house. Good food.
- Got my own room. Personal things.
- Having my own room.
- Having my own room.
- Having own bedroom.
- I am the only one in this placement.
- I get to be by myself.
- I have my own room and a big bed.
- I have personal space.
- I'm in church again and there is only one child there.
- It is a lovely place and I would do anything.
- It's near school and we have a park next door.
- It's peaceful.
- It's peaceful.
- It's quiet.
- Like the street, the neighbours.
- Live near the beach.
- Live on six acres and have room to ride my bike.
- Living on a farm and seeing cows and sheep born and being able to feed them.
- Lot of space.
- Lots of space to ride my bike.
- Mum giving me my own room.
- My carers are building me a granny flat.
- My own room.
- My own room.
- No neighbours to worry about.
- Pool. Close to friend's places.
- Privacy. Open space.
- Same suburb as prior to care.
- That no one is allowed in your room.
- The backyard.
- The beach is close. I like to swim in the pool.
- The country smell.
- The country.
- The house is neat and the children are well behaved.

What is the best thing about living here? (young people)

- The parks around.
- The railway line out the back.
- The tree in the front yard.
- There is enough room for me to play and it's close to town.
- We are right beside the river. I can go fishing. Lots of area to play.
- We get our own place.
- You can do things other kids living in town can not do.

An additional **68** responses are included under “Multiple themes”

Possessions or luxuries
- A pool.
- Access to computer and internet.
- Big TV.
- Computer, Xbox 360 and Wii.
- Food Pool, Tv. Lots of toys.
- Get lots of toys for birthdays or Christmas.
- Get more things.
- Get nice toys and clothes.
- Getting an iPod.
- Getting stuff.
- Got a new bike.
- Having a playstation.
- Having heaps of dolls.
- Heaps of presents. Get pocket money.
- Heaps of things. Treats, good clothes and toys.
- I get lots of stuff.
- I get lots of toys.
- I get money.
- I get nice things.
- I get the stuff I want.
- I got my own TV.
- I sometimes get what I want.
- Lots of Lego games and toys.
- Lots of things, all my belongings that I wouldn't have if I was living with my mum
- Motorbikes.
- My computer.
- Playing the Nintendo.
- Playing Xbox and watching TV.
- PlayStation.
- PlayStation. Pool table.
- Pocket money.
- Pool table.
- Pool, air con, TV.
- Pool, air con.
- Pool.
- Sometimes we get take out.
- Swimming pool.
- The best thing is that we get to play the Wii or Play Station.
- The computer.
- The new car, new things in the house, presents for me.
- The PlayStation 3.
- The pool, air con.
- The pool.
- The pool.
- They buy me lots of things.
- Trampoline. PlayStation2. Pool table.
- TV, movies, computer, internet.
- We get to have a DS. We get water.
- We got a big TV.
- We have a pool and a boat.
- Wii and big TV and PlayStation2.

An additional **62** responses are included under “Multiple themes”

Food, cooking eating
- Food.
- Food.
- Food.
- Food.
- Getting the best dinners and best dessert – like stewed apple and custard.
- Getting to cook my dinner. That's it.
- Good food.
- Good food.
- I get to cook with Mum.
- Like the meals.
- That I get fed well.
- The food.
- They bring McDonalds home on Saturdays.
- We get lollies.
- We get to eat what ever we want.

An additional **78** responses are included under “Multiple themes”

Pets
- Animals.
- Dogs, animals, ***.
- Dogs.
- Dogs: *** and ***.
- Get to have *** (pet).
- Get to have *** (pet).
- Got a dog here.
- I'm allowed to have pets.
- Playing with dogs. Talking with carer.
- Puppy listens to me.

An additional **41** responses are included under “Multiple themes”

Personal autonomy, taking responsibility, personal improvement
- A lot of freedom.
- Achieved and learnt more about life and responsibilities.
- Being able to watch my TV shows.
- Can do what I want.
- Don't really know, get to look after little kids.
- Feel free to experiment and explore.
- Freedom – do what I want, when I want, how I want.
- Freedom I have here.
- Freedom I have to myself.
- Freedom to do what I want.
- Freedom.
- Freedom.
- Freedom.
- Freedom.
- Get to do things that I like to do.
- Get to do what he wants generally.
- Getting on track.
- Going to Church. Being a leader.
- Got a job working with ***.
- I cook dinner, I am a good cook.
- I don't have a bed time.
- I get to be myself.
- I get to do my own thing and don't worry about getting into trouble.
- I get to go on the quad to do the cows.
- I have freedom!!
- I have freedom.
- I like being a kid.
- Nothing to get in trouble for. Not in trouble.

An additional **20** responses are included under “Multiple themes”

Fun
- Enjoying it.
- Fun.
- Having fun.
- It is fun here.
- It's fun and it's good.
- It's fun.
- It's fun.
- It's fun.
- It's fun.
- It's fun.
- Laughter.
- Lots of fun.
- The best thing about living here would have to be that it is fun and it's great living here.

What is the best thing about living here? (young people)

- You get to have fun.

An additional **29** responses are included under “Multiple themes”

Educational

- Doing school work.
- Going to a good school.
- Having a bright education which I really do need.
- I get a good education.
- I go to *** High. I am happy with my school at the moment.
- School.
- The school is really nice.
- You don't have to go to school.

An additional **22** responses are included under “Multiple themes”

Carer

Love, support, care understanding

- *** and *** treat me like I'm their real child.
- *** cares about me.
- *** is very nice, and she cares and she helps us when we get stuck on something. Out of my first carer and ***, I'd say *** is the best.
- A loving and caring family.
- Because if I wasn't here today I would be with some mean other carers. And plus I love it here.
- Being able to talk to carer if I have problems.
- Being in a great loving and caring family.
- Being loved and cared for.
- Being loved by my mum (carer), dad (carer) and sister (foster sister).
- Being spoilt and the love.
- Being spoilt. Being encouraged.
- Being supported.
- Being with somebody that understands me.
- Care about you.
- Carer spoils me.
- Carers that love me.
- Everyone helps me.
- Everyone is supportive and caring.
- Feeling that somebody actually cares for you. You are treated like they are actually my parents.
- Get cared for.
- Get looked after properly.
- Get looked after well.
- Get spoilt.
- Get spoilt; healthy spoilt. When *** goes overseas he gets us something.
- Get what I want in a matter of time and I am well love(d).
- Good care.
- Happy and loving care and kind.
- Happy and loving care. Kindly.
- Happy. Kindly loving care.
- Having a wonderful day with the carers and spending time with them.
- I am loved!
- I can talk to *** about anything.
- I feel cared for and loved.
- I get cared for and I can smile.
- I get loved for who I am.
- I get loved.
- I get new things that I always wanted.
- I get spoiled.
- I get spoilt.
- I get spoilt.
- I get spolt rotten.
- I get treated like I'm a real daughter.
- I get treated well. *** loves, cares about me.
- I have a family that loves and cares for me.
- I have people who care about me. People who love me.
- I know my mum (carer) loves me.
- I know that I have all the support I need.
- I know that Nan and Grandpa and every one else loves me so much.
- It is all the love I get and things.
- It's a good positive household, we all get along.
- It's good because I don't have to live with people I don't know. I get treated perfectly.
- It's the best and helped me with lots of things.
- I've lived there for long time. I love my foster parents sister and brother.
- Kindly and happy.
- Knowing that you have someone that cares for you.
- Listen to me, care about me, love me.
- Lots of kisses and hugs. Spoiled rotten. Love it.
- Love, caring, family.
- Love.
- Love.
- My carer is more of a friend than a parental unit.
- My carer is nice
- My carers treat me like I'm their real daughter and they love me and care for me really well.
- My Nan looks after me and keeps my diabetes under control.
- Nan gives me everything.
- Nan looks after me.
- Our carers care for us all and love us.
- People care about me.
- She takes care of me and wants the best for me, whatever my decisions are.
- So many great things. Loved by carer. Carer always there for me.
- Sometimes when I ask for things sometimes my mum and dad (foster carers) give it to me.
- Spoiled.
- Supportive family. Opportunity to grow.
- That *** listens to me and cares.
- That I feel loved.
- That I get good caring.
- That I get LOVE and CARE and that I get to be happy all the time.
- That I get loved here.
- That I have someone to go to.
- That I know they care about me. And treat us really well!!
- That I'm loved.
- That I'm spoilt.
- That I'm trusted.
- That they look after me properly.
- The best thing about living here is being loved and understood.
- The best thing about living here is that I am loved and respected.
- The best thing is they love me.
- The carers support, love and care that they show.
- The hugs I get from my carer.
- The let me have birthday parties and they let my friends sleep over.
- The love and the care.
- The love and the fact that I'm equal and wanted.
- The people who live here care about us and love us. If we have a problem we tell them they sort it out.

What is the best thing about living here? (young people)

- The way I'm treated and how much I'm cared for.
- They always listen and get where I am coming from because of their young age.
- They are all kind to me.
- They are clean, kind, and the best carer I've settled into.
- They are funny, sweet, loving, caring and nice. Changed my life totally around.
- They are good to me. They are my favourite Uncle and Aunty. I am loved by them.
- They are so nice and caring they are like my real mum and dad.
- They care for me.
- They care for my health. They are nice and they are always doing what's best for me.
- They give me good care.
- They listen to me.
- They listen to me.
- They love me and I get spoilt.
- They love me.
- They love me.
- They spoil me.
- They're my favourite Uncle and Aunty in the whole thing. There are good to me. I feel loved.
- Treated as a real child.
- Treated nice.
- We all love each other.
- We are loved and cared for.
- We get loved. Some other people with different carers don't.
- We get spoiled all the time.
- We get spoiled.
- We love altogether
- We understand each other and get along pretty well!
- Well cared of.
- Well looked after.
- We're loved and cared for.
- When I have being loved and cared (for).
- You are loved all the time.

An additional **94** responses are included under “Multiple themes”

Fair treatment and respect

- *** and *** (carers) treat me well.
- Because we all ways get treated the same way.
- Being listened to. Respect my wishes. Honesty.
- Being treated with respect.
- Don't really get in trouble for what you do.
- Equal attention.
- Everyone gets treated equally and fairly and they listen.
- Everyone is equal here and everyone is treated fairly.
- Everyone is treated equal there just like real parents.
- Everyone is treated equally.
- Everyone is treated the same.
- Everyone treats me well.
- Get treated fairly.
- Get treated good.
- Get treated well and not get in trouble for the things I do around the house even if it is the right thing.
- Get treated well.
- Get treated well.
- Get treated well.
- Getting along with people around me and knowing (about) them.
- Getting treated very well and looked after properly.
- Good rules.
- Having people who listen and respect my feelings.
- How I'm treated; I'm treated really good.
- I always get treated the same way as everyone.
- I am happy and are getting treated well.
- I feel happy where I'm staying.
- I get respect.
- I get treated fair.
- I get treated good.
- I get treated the same.
- I get treated the way I treat others. I'm respected and gain my own trust.
- I get treated well.
- I get treated with respect and treated the same way as the others.
- I get treated with respect.
- I get treated with respect.
- I'm always treated with respect.
- I'm happy most of the time.
- I'm treated well and listened to.
- Knowing and getting along well with everyone.
- Nice respectful caring.
- Not getting hit.
- Playing fair.
- Respect.
- Respect.
- That carers are friendly and treat me well.
- That I'm treated the same as the other kids.
- The best thing about were I live is that everyone is treated equally and with the same love.
- They respect me. They be nice to (me).
- Treat me well and give me a life.
- Treat me well.
- Treated very well and always looked after.
- Treated well.
- Treated well.
- Treated with respect.
- We are treated excellently.
- We get treated with the same respect.
- You do not get smacked.
- You get paid when you do chores and get disciplined when you're naughty and not do right thing.
- You get treated fairly and my carer listens to us.

An additional **38** responses are included under “Multiple themes”

Nice/good people

- *** (carer).
- *** and *** (carers).
- A wonderful lady.
- Aunty ***, Uncle ***.
- Aunty is nice. She give us what we want.
- Because I am living with ****
- Being with my carer.
- Being with people that you know.
- Everyone is happy.
- Everyone is very nice.
- Foster carer (mum)
- Get on with *** (carer).
- Good.
- Grandma.
- I have good mum and dad.
- Kind carers and just a nice place to stay.
- Laid back carer.
- Living with *** because he is like my father.
- Living with ***.
- Mum ***.
- Mum and Dad (foster parents).
- Mum and Dad.
- My carers. Get to go away. Get treats.
- My foster carers.
- People.
- Really friendly people.
- She's nice (carer).
- The carers are nice.
- The carers.
- The parents.
- The people I live with.

What is the best thing about living here? (young people)

- The people.
- The people.
- They're nice. I really like it here.

An additional **53** responses are included under "Multiple themes"

Protection/ safety
- Always safe.
- Being safe.
- Big safe.
- Feel safe and well cared for.
- Feel safe and well protected.
- Feeling safe.
- Having someone to look after us.
- I don't have to live in fear.
- I feel safe.
- I feel safe.
- I feel safe.
- I feel secure and safe. Haven't needed to move around.
- I love it. It is very safe.
- I'm safe.
- It's safe.
- No alcohol or fighting like at home.
- No arguing.
- Safe place to come to. Mum reminds us to keep safe.
- Safe.
- Safety.
- Security.
- That I am safe.
- That I'm not living with my Mum.
- The support that I get knowing that I am safe.
- Very safe and healthy in here.
- We all feel safe in care.

An additional **30** responses are included under "Multiple themes"

Family

Family life / being part of a normal family
- *** is like my Aunty and she loves me and treats me like part of the family.
- Being family.
- Being here since I was three months old, this is my family.
- Being part of a family.
- Being part of a family.
- Family.
- Family.
- Feel like I am their real children.
- Feel part of family.
- Feels like family. Happy here.
- Feels like she belongs. Feels like a family.
- Having a caring family.
- Having a family that actually cares for you and loves you.
- Having family.
- I feel comfortable and normal.
- I get to have a good family.
- I get treated as if I were in the family and I'm accepted.
- I get treated like I am part of the family.
- I have a second family.
- I like being apart of the family and cared for.
- I like living with my family and I miss my family. I best love this house.
- I live with my whole family.
- I love being in a family that is happy and get along with everyone.
- It feels like a normal family. Like not actually being in care.
- It's a proper family environment.
- It's fair and like a proper family. It's a real family!
- It's my family.
- I've got a mum and dad and family that really loves me.
- Just a normal household.
- Like a family.
- Likes this family.
- My family.
- My family.
- Nan and me do things together and like the same TV shows.
- Not living with real parents.
- The best thing is that you feel just like an ordinary person.
- The opportunity to be a part of a family unit.
- They treat you like family.
- This is my family.
- We're in a family environment.

An additional **32** responses are included under "Multiple themes"

Being placed in relative care
- Because I'm living with a relative it makes it better. My friend is in care and her foster carer gave up on her.
- Because I'm with family.
- Being with family (grandparent).
- Being with family.
- Being with family.
- Being with my family.
- Being with my family.
- Family.
- Family.
- Family.
- Family.
- Family.
- Get to be with family.
- Here with part of my family.
- I am living with my family.
- I am really happy that I living with my Aunty ***.
- I am with my grandparents.
- I get to be with family members instead of being with strangers.
- I live with family and they are really nice.
- I live with my family.
- I live with my grandmother and she raised me and my sister.
- I love living with my grandmother.
- I'm living with my aunty and I don't like my uncle ***.
- I'm still living with relatives.
- I'm with my family.
- Living with family.
- Living with family.
- Living with family.
- My family.
- My grandparents (carers) give me good opportunity in life.
- Surrounded by my family and the people who love me.
- That I have my family.
- The best thing would be being with the family and love.
- We are surrounded by family we love.
- Well that we are with family and we love it for living with family is the best thing.

An additional **22** responses are included under "Multiple themes"

Maintaining contact with biological family
- Being with family.
- Close to everyone. Get to see everyone: brothers and sisters.
- Close to family.
- Close to Mum.
- Get to see Mum and brothers sometimes.
- Gets to see his family.
- I get support from my Pop.
- I'm not too far from other family.
- My brother can come over.
- Spending more time with my grandparents.

What is the best thing about living here? (young people)

An additional **14** responses are included under “Multiple themes”

Being in care with relatives or siblings

- Being with my brothers and sisters.
- Getting to live with my sisters.
- Having *** here (small uncle).
- I get to be with my little sister ***.
- I've got my brother with me.
- Live with my brother.
- Living with my sister.
- Living with my sister. No bitchiness or trouble here.
- My sister is here now.
- Staying with my sister.
- That my brother and sister are with me.

An additional **12** responses are included under “Multiple themes”

Other

Basic needs met

- A roof over my head and food to eat.
- A roof over my head.
- Bed.
- Get what I want in a matter of time and I am well love(d).
- Getting most stuff we want for granted.
- Home.
- I get every thing we need.
- I get everything I need.
- I get most things I want and need.
- I get my own things I need.
- I get what I want.
- Needs are met.
- Roof over my head.
- Sleeping.
- Umm, not sure. A roof over my head and clothes to wear.
- We are provided with everything we need if the house is clean.

An additional **15** responses are included under “Multiple themes”

Other

- All right.
- Been the longest carer.
- I feel secure and safe. Haven't needed to move around.
- I just like living here.
- Its a better place then the other place that I was with.
- It's very nice.
- Leaving soon.
- Stability. Location (near friends, school, beach, public transport).
- That I'm bored.
- There's a whole bunch of stuff.
- This is the best place I've been to so far.

An additional **5** responses are included under “Multiple themes”

Multiple themes

- *** (puppy). Cared for well.
- *** and *** are really nice and they give a lot of school.
- *** is nice, very nice and we have fun so much.
- *** the dog. *** the cat. Trampoline. Nintendo. DS and TV and dolls.
- Able to have my own room. I get nearly everything I want.
- All the food, love and care. My health is looked after.
- All the nice food and the nice stuff I get.
- All the people and get to play with all the people.
- Animals, school.
- Because I can see my brother and sister every day even when I wake up. I can get what I want.
- Because you can see other family and it's best living with members.
- Being loved and feel really safe and feeling really happy. It's really really fun and I love them heaps they are family to me.
- Being able to go to a private school and getting looked after well and cared for.
- Being listened to and always being with a family.
- Being loved and cared for and being able to visit my friends.
- Being loved. Being able to cook.
- Being part of a family and getting to visit relatives.
- Being safe. Having an animal to play with.
- Being with best carer ever and being with my brother.
- Being with my brothers and grandmother. Being with family.
- Being with my brothers and sisters and the food is nice.
- Being with my sisters. Support from Mum and Dad.
- Better house, grandparents care for us!
- Bicycle, always nice to me, rules are always fair.
- Big playground, house is perfect and have a barbecue. Close to friends and shops.
- Big wide, open spaces. Lots of things to do. Peace and quiet.
- Big yard and friends live near by.
- Brothers and sisters. Big family. Treated well.
- Cared for and everyone loves me. Very safe and nice people.
- Carer pays for overseas holiday trips and to the Gold Coast. Carer pays everything. Feel part of the family, eg. ***'s daughter.
- Carers take us out and lots of other things. Looks after me.
- Close to family and friends, has been able to stay at the same school.
- Close to school. My carer is nice.
- Community and family.
- Computer, foster carer's grandson visits.
- Cuddles. Caring people. Nice people. Mostly let me do anything.
- Don't need to walk far. Close to shops. Computer.
- Everybody is treated equally and all loved. Everything is fair.
- Everybody loves me. The food is yummy.
- Everything – carers and brothers and sisters (carer's family).
- Everything, my horse, life.
- Everything. I'm allowed to go home but I choose to stay! My carer is just brilliant!!
- Everything. This is my family now.
- Family and play sports.
- Feel part of a family. I can be me. Can be more open and express my feeling.
- Feel safe and loved for.
- Feel safe here. Enjoy having my own room.
- Feeling safe and wanted and nothing can hurt you.

What is the best thing about living here? (young people)

- Fishing, being treated as one of the family, 'one of their kids'.
- Five minutes from friends. Help from parents.
- Food and love and care.
- Food and loved heaps.
- Food and Nana.
- Food, DS, water.
- Food, Gameboy, TV.
- Food, people.
- Food, watching TV.
- Food, workers.
- Food. Accommodation.
- Food. Other kids. Seeing ***.
- Food. Outings. Going to Rockpool.
- Football and nan.
- Freedom. Supported.
- Friends and swimming pool, Wii etc
- Friends, and I'm glad I don't have to move again until I'm 18.
- Friends, creek.
- Games and fun.
- Games, TV, riding scooter and bike. Playing with toys.
- Get everything I want and need.
- Get fed properly. Getting cared for properly.
- Get fed. Somewhere to sleep. Unlike some other places, that's all.
- Get good food all the time. Always feel safe here.
- Get good stuff like MP3, bikes, recar, but you have to earn it.
- Get looked after well and have enough freedom to do the things I want.
- Get lots of stuff to do and lots of food.
- Get so much care. Make sure don't go over the line and break the rules.
- Get some money for school. I get woken up for school. I get to see my family.
- Get to do lots of things. Getting things bought for me.
- Get to hangout with my friends, movies, shopping.
- Get to have a pet and mainly everything!
- Getting treated nicely. I have nice things and I like living here.
- Getting everything and being with my close family.
- Getting paid for doing my chores. *** is nice to me.
- Getting treated well and get what we need and we are cared for.
- Go out places. Get cuddles and kisses. Activities.
- Go to parties, vacation care. Carer nice to her: fun – very fun.
- Go to school, play football.
- Going fishing and playing the Wii and living with Nana and Pop.
- Going ice-skating and Gladiator 4.
- Going to farm on weekend. Home pets.
- Going to places, good holidays, get good things.
- Going to special places and being with family.
- Good dogs and the birds and the turtle and the pool
- Good family and good to be able.
- Good food, I can smoke.
- Good holidays. Aunty looks after me.
- Good home. Close to friends.
- Good people and being safe with the people.
- Good. It's nice and she gives me food that I like.
- Got my own space. Get treated with respect.
- Has own bedroom. Loves playing with the toys. Family does a lot of activities together.
- Have a pool and dogs.
- Have a real bed and healthy food, not junk food.
- Have freedom can do what I want. Get help to get to appointments.
- Have my own space. Close to shops – can meet my friends.
- Having a family. People who care.
- Having a great life.
- Having a PlayStation and having a mum.
- Having a wonderful life. Because I am loved and I get to see my birth Mum too.
- Having family around me all the time, and also having access to my horses and other animals, etc (things I like).
- Having friends over to play and I have a dog.
- Having lots of fun, lots of company.
- Having Milo, having snacks cause we get snacks after our lunch and they're yummy. We get money sometimes when we are good.
- Having my brother and sister and Mum and Dad here, and supporting me in everything.
- Having people who care for me. Having my sister here. Everything else, cause I like it here.
- Having somewhere to live and meeting new people. Carer's son and I am now good friends.
- Having two foster brothers. I was only child at home. Foster carers that actually love me.
- Helping me with my reading. I like helping ***, she's nice.
- Horses and food.
- How they care about me. There are so many here to play with. They love me and so do I.
- I am allowed to go to netball and do what I want.
- I am guided into a lovely place and have transformed into a lovely nice young lady.
- I am loved and cared for and I'll always be a part of this family. I feel wanted.
- I am safe and have friends.
- I am with family and I will be able to ride horses.
- I can talk to my carers about anything and they treat me like their own family.
- I feel protected and I am not forced to do stuff and go places I don't want to.
- I feel safe and at home.
- I feel safe. I get treated well.
- I get lots of things and taken everywhere eg the movies and sport and stuff and over friend's house.
- I get my own room. I am loved.
- I get presents. I get to go to town and go swimming.
- I get spoilt and I like living with my nana and Uncle ***.
- I get spoilt and my carer trusts me.
- I get to go to my friends house and my mum never say no.
- I get to have fruit. I have permission to do stuff like help.
- I get to live with my relatives and it is safe.
- I get to play Atari. I have my own desk to do my homework.
- I get to play my PlayStation2 any time.

What is the best thing about living here? (young people)

- I get to play with the other girls here. I get your favourite food sometimes.
- I get to see my parents. My carers listen to me.
- I get treated good and I am loved and safe.
- I get treated like a real child, not just a kid in care.
- I get treated well and fed right.
- I get what ever I like. I got a big room.
- I go with every healthy meal. I go horse riding.
- I have friends, I'm close to more things and I am happy here.
- I like being in this family. I am treated well. Food is good.
- I like it here. I like the school. I like to see my friends.
- I like it, dogs, cats, Ben10 cartoon.
- I like the food and the people here.
- I like the school. I came at the right time time and got to go to Dreamworld and Movieworld.
- I live with my family and it's fun.
- I live with my family who love and respect me.
- I live with my nan and pop but I still see my mum when she visits.
- I love having fun and I think they are nice carers and I love staying here and there like ***
- I love the food and the rules.
- I own a horse and people see my point of view always.
- I really like living here. It's safe and I think I can talk all about my problems.
- I stay at the same school and I get taught how to cook.
- Ice cream & lollies. Mum (carer) is so happy.
- I'm always safe and it has made me a better (person).
- I'm always good and I get ice-cream for dessert. I have good times and it's fun here.
- I'm loved, got all I need to have and I'm treated as an adult.
- I'm with family and close to my school.
- It is fun and and I like *** a lot.
- It is fun. *** helps me with my school work.
- It is really fair. I can do sewing. Nana is going to teach me knitting.
- It's fun and we get treated the same as everybody else in the house.
- Its fun sometimes. Hanging out with *** and family.
- It's fun. I ride my bike.
- It's like a real family, we are all loved like we are her own children.
- It's safe and its fun.
- It's safe, I feel happy here. Get everything I need.
- Kapa Haka (New Zealand dance). Friendly people.
- Kids to play with. Close to friends. Pool.
- Knowing that I'm safe and having fun.
- Like riding horses and playing with puppies. Swimming.
- Listen to me. Got what I want. Very nice people.
- Living with carers' baby. Pocket money.
- Living with my aunty, my mother. She cares for me and loves me and always there for me.
- Lot of space. Good parents.
- Love going to school in Bundaberg and Crossroads. Love having own room. Love having pets.
- Meet new people, do different things.
- Money and food.
- More space. The river. Good carers.
- Mum and Dad don't only give me a roof over my head, they also love me, they listen to me.
- Mum.
- My foster brother *** and our toys.
- My friends and family time.
- My Mum and my Dad and Aunty *** and lovely dinner.
- Nice home. Own bedroom. Nice parents.
- Nice present. Carer buys treats. Have my own room.
- Not having to move again.
- Own living area, closer to friends.
- Play with your friends. Go swimming.
- Playing with ***. ***'s good meals.
- Playing with Lego, playing with mates.
- Playing with my friends and with the pups.
- Playing with my toys, dog and soccer with the ball.
- Playing with Nintendo, PlayStation, Xbox and DS. And the movie, Mummy and Daddy take me out to the movies I haven't seen.
- Pool, safety, air conditioning.
- Safety, honesty, love.
- She feeds us the right food, she treats us fair and explains things to us.
- Stability. Location
- Support, loved, supplies, opportunity
- Take care of me buy me everything most times.
- Take good care of us. Aunty takes me places.
- That everyone is the same treated and that they love us.
- That I can learn about different language and about my background.
- That it's close to my mum and different to other placement. I can talk and am understood.
- The backyard and dogs.
- The bush, food, dam, bike.
- The dogs. Country lifestyle.
- The food and art classes.
- The food and Dad who is awesome and Mum who is okay. The baby who is cute.
- The food and freedom.
- The food and space and drinks.
- The food and the dogs.
- The food, the appreciation and respect.
- The food, the love.
- The food. Presents.
- The house and youth workers (some workers).
- The house is nice and my brother is here with me.
- The Nintendo, Wii. Little cousins that come to play.
- The park, pool, PlayStation in room.
- The people are nice and they treat me good.
- The pool. The animals.
- The view, the eagles and caring.
- The Xbox, the wide screen TV. I get pocket money and carer is nice.
- There is always someone to talk to, because there is a lot of children in the house. They're my family.

What is the best thing about living here? (young people)

- They are fun. They treat me well. I trust them. They make me feel welcome.
- They have fun with me! We play around. Take me on great holidays.
- They listen to me, they let me do stuff that I want, but not stuff that would be bad for me, e.g. late night shopping.
- They painted my bedroom. New bed and they let us play with the dog ***.
- They respect me and I feel safer.
- They take me fishing and actually that was my first time. And football. All because of my carers which is good.
- They treat me well and let me buy stuff like Coke, chocolate, lollies and chips.
- They treat me with respect and they're nice to me. They let my friends sleepover.
- To be around and to get to play with other kids and also know that I'm safe.
- TV in my room. New room with plasma TV.
- TV, laptop, friends.
- Very fun. Picking on my sister.
- We get $5 max of pocket money and having trips overseas.
- We get food and clothes and get loved.
- We get healthy food. Toys.
- We get to see friends and it's really fun here.
- We get treated right and we get to go on holidays.
- We got a Dreamworld pass and it is our grand parents house.
- We have so much fun here. People to talk to.
- We live on acreage and I can ride my bike. We have a big house and a swimming pool.
- Well looked after, pocket money and rewards for good behaviour.
- Well, I get most of the things I want and I get all of the things I need.
- With brothers. Can do lots of things.
- With family, children to play with.
- Yard is good to play in. Now supports me to play sport.
- Yet to have a family that loves me and takes care of me.
- You can voice your opinion and you can always count on being cared for.
- You get to play games and playing the computer.
- Bike, Wii, swimming pool, lots of friends, nice toys, good school and a comfortable bed.
- Carer takes care of me. She is together with her brother & sisters. Food. Get to go places that are fun.
- Cats. Nann she loves. Do lots of things together, like taking you to sports and doing crafts and walks.
- Close to shops, great carers, soccer grounds and friends and family.
- Computer, food, tickles (grandma), scratches (poppy).
- Everything. I like the animals and I like Nanny and Aunty and ***.
- Everything. Having better stuff. Getting fed. Being warm and not being alone.
- Everything. It's peaceful and you can play safely around with no people coming in.
- Everything: workers, clean house, good food.
- Food – loves the food. Go good places like Seaworld. Get to play and carer takes care of her.
- Food is good. Beds are great. Carers look after me well.
- Food, living with other people (brothers and sister), the environment.
- Friends in the area, living with family, play sports.
- Get spoilt. Own room. Like family.
- Get to do sport with my family and play with my brothers and sisters – lots of space.
- Get to have a lot of food. Have my own room. Get to go to places.
- Get to play with my friends down the street. I love getting food and when she cuddles us at night and also when she tucks us in at night.
- Get to sleep in a good bed and get to watch TV. Playing with dogs.
- Going to school. It's fun having friends over. Carers are nice.
- Good school, friends, amenities, good home.
- Great people. Own caravan. Help with travel to work.
- Have a sister, dogs, playing on trampoline, pool, everything's better now.
- Having fun being cared for and loved. And they treat me like a mum does.
- Helping carer ***. Swimming pool. Having own bedroom.
- I always get treat fairly and get money for tuckshop mostly each week.
- I feel safe and I am treated really well. I get healthy food all the time!
- I get pets. I get love. TV.
- I get to do fun things and my carers are really supportive.
- I get to see my Nan and Pop and my dog, my bird and have fun.
- I get to see my oldest brother, play games. I get pocket money.
- I get treated properly and with respect I get clothes and food on the table.
- I get treated well. I eat healthy food and I live with a wonderful family.
- I got a mobile phone, individuality, privacy, own room, respect.
- I have *** and *** to care about me, we have a dog and a basketball hoop, a spa, a Wii, a plasma screen, and DVD player and I have Lego and a basketball.
- I have more friends. There's more to do. My carers look after me.
- I love my grandparents, they respect me, and I feel safe.
- I love the people. Going out all the time. I love the rooms and ***, ***, ***.
- It's fair, it has good house rules, there's a lot of things to do here. We all get along with each other, and they do care.
- I've got lots of assets, a big house, I go to a good school. Little brother is good as I have someone to hang with.

What is the best thing about living here? (young people)

- Like the bike, the chickens, like the bells, the school bus, my bed and trampoline.
- Living on a farm with animals. Fun here.
- Lots of good food, animals, outings.
- Lots of mates live around here. Carer cooks good dinners. Canoeing in creek.
- Loves the meals here. Family. Loves the carers. Birthdays are good.
- My own room, pool, dogs.
- Own room, computer, toys. I am listened to.
- People are nice. School, *** and ***, *** and ***.
- People, *** , food, outing. Going Rockpool.
- Play DS. Being cared for. Getting loved. Helping with homework.
- Playing with Lego & Polly Pockets. Playing with my mates. Love school.
- She listens. The food and drinks and travelling (going on holidays).
- She take us out to the shop, buys us toys and she is nice.
- Spa outback. Made new friends. Near a park.
- Summer pool. Horse. Nice parents.
- That I get along with *** really well and I get a bit of freedom, my own space.
- That we get treated well, get heaps of things and go heaps of places.
- The best thing living about here is she always happy and she buy's us things and she provides us what we need.
- The dog and my brother. Good food.
- The food, my bed, Dad, family.
- The land, motor bikes, soccer, and other sports, ride on mower.
- The nice people. The fair rules. Having nice furniture.
- They listen to me and treat me with respect, give me privacy and they spoil me.
- We get to stay up on the weekend...play with the bird...get to have lots of fun.
- We're fed. We also do a lot of activities like sport to do. She treats us like we're her kids.
- Everything, we go to a good school. We go to fun places. We are encouraged. We are looked after and we are taught everyday skills. So, everything.
- Food, carer, playtime, outside, dam.
- Going places. Roof. Food in stomach. Clothes. Being in a family.
- Have toys, have food, safe, loved a lot.
- I get love, I get my proper family, I get food, I get toys.
- I get to have fun, play my DS, watch TV, love nana grandad, play with ***.
- Kids my age, open space, animals, lovely people.
- Live with family, fun, a very nice man, love him.
- My carers. The other young people. The pool and spa. The pets.
- My whole family even dog and cats. Mum's (carer) cooking. Dad – he's funny sometimes.
- Nice care, nice food, nice toys, nice bed.
- Own bedroom, play lots of sports. Carers takes to see family. Carer does fun things with me.
- Safe and fun here, living with other kids, having pets
- That I live with my proper sister and that the carers are really really nice and I feel safe and that we look after other little children.
- The best thing living here is talking to my aunt and uncle. My family are nice to us and fun too.
- The other girl and Nana and the pool and being safe.
- Working, going school, playing, eating, desserts.
- They give me food, joined me up for football, put me in school and taught me a couple of things like cooking and they control my anger.

What is the best thing about living here? (children)

Lifestyle and opportunities

Outings, holidays, physical activities and games

- ***, computer.
- About *** (CSO) playing games with her.
- Because we go to Dreamworld.
- Being able to play football.
- Camping with Nanny and Poppy and going fishing.
- Can go places. Parks, circus, the Worlds, sport.
- Carer takes me everywhere, like monorail.
- Doing cool things with carer (male).
- Doing puzzles. Playing with everyone.
- Fishing.
- Football. PlayStation. Soccer.
- Gardening, swings, drawing, trampoline, dolls, TV.
- Get to go for bike rides and stay up late.
- Get to play games.
- Get to play my DS.
- Get to play with all the Transformers.
- Get to ride my Ben10 bike.
- Girls Brigade. Organ.
- Go in the pool sometimes.
- Go out and watching TV.
- Go shopping.
- Going in the pool.
- Going into sandpit and the pool.
- Going on drives.
- Going on holidays.
- Going on the trampoline, swing set, Wii, soccer ball.
- Going out for dinner.
- Going out to beaches. Going to Southbank.
- Going out to different places.
- Going out to places like Yamba.
- Going places eg. Wet and Wild, circus.
- Going places like Seaworld, Movieworld and Wet 'n' Wild.
- Going swimming.
- Going to Dreamworld tomorrow.
- Going to swimming lessons and I might be doing ballet.
- Going to the park.
- Going to the park.
- Going to the park.
- Going to the shops.
- Going to the shops; playing with toys, going to Wet and Wild, getting passes to go lots of days.

What is the best thing about living here? (children)

- Going to theme parks. Tomorrow we are going to Dreamworld.
- Gym. Jeep before it got broke.
- I am allowed to play outside if I want and I can listen to music like High School Musical.
- I am going to get a motorbike.
- I get to go on my scooter.
- I get to go places.
- I get to go to places like Dreamworld and Seaworld.
- I get to play PlayStation 2 and 3.
- I get to play the ???
- I get to play.
- I like playing on the trampoline.
- I like playing.
- I like staying here and playing games.
- I like to play Tiggy on the Shaplen.
- I like to play with my bike.
- I love drawing pictures and doing craft things.
- Is that we get to go places.
- Kicking the ball in the yard.
- Listening to my radio.
- Lots of games.
- Lots of things to play with.
- Lots to do: board games, movies, PlayStation, dancing, musical instruments.
- Motorbikes, going places.
- Mum takes us places.
- Music.
- My racing computer game. Going in the truck with foster dad.
- My red bike. Playing on trampoline.
- Nintendo Wii, PlayStation, my Leapster, Nintendo DS.
- Painting.
- Piano, play games.
- Play footy.
- Play outside on bike.
- Play with toys.
- Play with toys.
- Playing games. Jumping on trampoline.
- Playing in garden, climbing trees.
- Playing in room (dolls).
- Playing in the play room.
- Playing in the sandpit and going swimming.
- Playing Ninja Turtles.
- Playing on my bike.
- Playing on swings and running around, feeding the animals.
- Playing on the gocarts.
- Playing on the roller play equipment.
- Playing on the swing.
- Playing PlayStation.
- Playing puzzles and painting.
- Playing space invaders on my computer.
- Playing the computer.
- Playing with cards. Going out to places and going to Dreamworld.
- Playing with Grandma.
- Playing with my toys and watching TV.
- Playing with my toys.
- Playing with my toys. Doing drawing.
- Playing with teddies.
- Playing with toys.
- Playing with toys.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing.
- Playing. Watching movies. Playing games.
- PlayStation, computer, watching TV, playing with toys.
- PlayStation, Xbox.
- PlayStation.
- PlayStation.
- PlayStation.
- Riding my bike.
- Riding my horse.
- Riding our bikes and playing with my toys.
- Seeing movies.
- Swimming and bike riding and scooter.
- Swimming pool and playing games.
- Swimming, dancing, singing, hula hooping, playing.
- Swimming, playing Wii, PlayStation
- Swimming.
- Swimming.
- Swimming in the pool.
- Swings and monkey bars, slide.
- Swings.
- That we are always going places. Fraser Island and camping at other places.
- That we go out to special places.
- That we have a pool, the park and puddles.
- The park.
- The PlayStation 2.
- The pool.
- The pool.
- The pool.
- The trampoline.
- The Xbox.
- Trampoline, swings, TV and PlayStation and games.
- Trampoline, Xbox.
- Trampoline.
- Trampoline.
- Trampoline. Austar.
- Trampoline. Going uptown.
- TV.
- TV.
- Watch Dora on DVD. Playing with toys and doing puzzles. Swimming once a week, shopping is fun.
- Watching TV.
- Watching TV.
- We do lots of fun things: fishing, swimming, beach.
- We get to go out to the movies, the beach and go bowling on the holidays.
- We have a pool.
- We have a pool.
- We play a lot.
- Well I get to ride my bike to school.
- Wii. I get Spiderman being with family (Nanny).
- Xbox.
- You get to go out sometimes.
- You get to watch TV.

An additional **95** responses are included under “Multiple themes”

Possessions and luxuries

- *** gave me a toy.
- Beauty treatment.
- Because I have a warm bed with electric blanket.
- Because there are lots of toys.
- Chocolates.
- Easter eggs.
- Easter eggs.
- Get lollies from Grannie.
- Get nice stuff. Carers buy me nice clothes.
- Getting toys.
- Got heaps of toys.
- Has lots of toys and paint.
- Have toys.
- Having a cubby house.
- Having a Playstation.
- Having lots of toys.
- Heaps and heaps of treats.
- I get enough toys.
- I get nice clothes and toys and digital camera for my birthday.
- I got heaps of toys in my bedroom.

What is the best thing about living here? (children)

- I have birthdays and get toys.
- I have heaps of toys.
- I have lots of things to play with.
- I like my toys.
- I like to have things out of the toy box.
- Lots of toys.
- Lots of toys.
- My footy.
- My toy room.
- Nan buys me lots of clothes and toys.
- Nanny and Mummy buy me games.
- New books.
- On my birthday I get whatever I want.
- Play with my dolls.
- Play with my toys. Read my books. Sleeping in my bed.
- Playing with my (toy) horse.
- Playing with my dollies.
- Plenty of toys.
- Plenty of toys.
- Pocket money and watching movies.
- The best thing about living here is nice clothes and nice toys.
- Toys and stuff.
- Toys.
- Toys.
- Treats.
- We get things. Would like to live with Mum.
- We have things to play with.
- When I get my birthday presents.

An additional **56** responses are included under “Multiple themes”

Food, cooking and eating

- *** always lets me have a second dinner/snack when I ask her.
- *** cooking.
- *** gives healthy food.
- Best dinners cooked and best breakfast and best food.
- Breakfast – noodles, corn flakes.
- Dinner.
- Eating.
- Food.
- Food.
- Get chocolates.
- Get to eat healthy food.
- Good food for dinner.
- Good food. Swimming pool.
- Having breakfast: we get Weetbix and toast.
- I like vegetables for tea.
- Mummy's food.
- Nan makes supper and noodles.
- The best thing is that I get healthy food.
- The food.
- The food.
- The food. My favourite is homemade sausage rolls!.
- We have iceblocks.
- Yummy breakfast and fruit.

An additional **56** responses are included under “Multiple themes”

Space, environment, amenity and location

Big backyard.
Big yard.

- Getting own room soon.
- Got a new lounge.
- Having showers.
- I get a good view.
- I got a bedroom.
- I have my own desk and beautiful butterflies over there.
- I have my own pool.
- I have my own room.
- I have my own room.
- I like living here because we have a nice house.
- I like playing outside.
- I like the way how the dining room is clean and I like the way how the kitchen is tidy.
- It has a nice garden that I can play in.
- It's a beautiful house to live in here.
- Like playing outside in the yard.
- More space to play.
- More space to play.
- My bedroom.
- My new room.
- Our room, mine and ***.
- Own bedroom. Likes living with his Nana.
- Playing in the yard.
- Playing inside and outside.
- Playing outside.
- Playing outside.
- That we live in *** (place name)
- We have a best home.
- We have a big back yard and a tree to climb up but it has big itchetty grubs.
- We have a nice house, a nice bedroom and a nice backyard.
- When we get to play out the front here.

An additional **36** responses are included under “Multiple themes”

Other children and friends

- Get to go and stay over at your friend's place.
- Having *** and *** playing here.
- Having good friends here.
- Having people visiting.
- Having two friends to play with.
- I get heaps of friends and at my other school I had only four friends.
- I get people to play with.
- I get to play with ***.
- I got lots of friends.
- I have one foster sister.
- I like playing with *** (carer's child).
- I like playing with my friends.
- I like to play with my sister.
- I play with lots of people.
- Like playing with little ***
- Lots of children to play with.
- Loves company of other children and carer.
- My friends.
- Playing with *** (a friend in the neighbourhood).
- Playing with *** is fun.
- Playing with ***.
- Playing with cousins.
- Playing with cousins.
- Playing with friends.
- Playing with my friends.
- Playing with other kids.
- That I get to sleep in the same room as my brother.

An additional **25** responses are included under “Multiple themes”

Pets and animals

- I got my own pet 'Larry the Lobster'.
- I like playing with my dog.
- I like the horses.
- Looking after animals.
- Lots of animals.
- Playing with the cats.
- Playing with the cow.
- There are two dogs and I can play with them.
- There's horses to ride. Have a pony.
- We have a dog and two guinea pigs.
- We have a guard dog.

An additional **36** responses are included under “Multiple themes”

Having fun

- *** joking with me.
- All the fun we have.
- Having fun playing, people.

What is the best thing about living here? (children)

- Having fun with aunty ***.
- Having fun.
- It is fun.
- It is fun.
- It's fun.
- It's fun.
- It's fun.
- It's very fun. Nan and Pop make it fun.
- We have fun; we have fun together.

An additional **11** responses are included under “Multiple themes”

Personal autonomy or acknowledged as a good person

- Best thing is when I'm good. I be nice to each other.
- I get to do "the finger", it makes 'Mum' and 'Dad' laugh, it means I'm 'boss'.
- If I am good I get a reward.
- More privileges
- On Friday afternoons we get to do whatever we want as long as we ask.

An additional **4** responses are included under “Multiple themes”

Educational

- Going to school and getting dropped off.
- Going to school.
- Going to school.
- That I learn school work at this place. It's nice.
- We get to go to school and make stuff.

An additional **2** responses are included under “Multiple themes”

Carers’ characteristics

Love, support, care, understanding, help and spoiling

- *** and Nan. When I have a bad night, they are always there for me and cuddle me.
- ***, *** and *** love me.
- All the love I get in this home.
- Because my carer (Mum) loves me. I'm very special.
- Being looked after.
- Being loved by Mum and Dad.
- Being with *** and ***.
- Cuddling Mum.
- Everybody likes me here.
- Everyone is there for me when I want to talk to someone. They always care for me.
- Everyone takes care of me.
- Getting loved. Knowing people care about you.
- Going to bed and kissing Mummy goodnight.
- Grandma looks after me.
- I am loved by my carer.
- I feel love(d).
- I get spoilt by Mum and Dad.
- I have nice parents they are loving me (foster parents).
- I love Granddad because he is nice and warm.
- I love Grannie (carer)
- I love my mum and dad (carers).
- I love my Poppy very much and like living with him.
- Like my carer.
- Looks after me and loves me.
- Love my carers.
- Love my family.
- Love, care, happiness.
- Loved here.
- Loving my mum, Dad, ***, ***, ***, ***.
- Me love my carer all day.
- Mum looking after us.
- Mumma cares for me.
- Mummy's cuddles.
- My Nan helps me with things a lot.
- Nan looks after me.
- People care about me and listen to me.
- That I get cared for.
- That I get help.
- That my carers like me and listen to me.
- That my mum (*** my carer) loves.
- They care about us and they love us.
- They care for us.
- They look after me.
- They love me and take care of me.
- Understanding carers.
- We get cared for really well. We have a really good carer.
- When I have a nightmare I can wake my mum up when I need to.
- When I'm upset Nanny helps me right away.

An additional **52** responses are included under “Multiple themes”

Carer is nice or good

- *** (carer) nice.
- *** (carer).
- *** is nice to me.
- ***'s a good carer.
- Cause *** is kind to me and she's nice.
- Grandma.
- Grandmother lives here.
- It is great to live here. It is great to live here because of my mum and dad (the carers).
- Mum and Dad.
- Mum and friends are good to me.
- Mum is good.
- Mum is my best Mum and she takes care of me very nicely.
- Mummy and Daddy (carers).
- Mummy, I like it here (carer is 'Mummy').
- My carer ***.
- My grandma and brothers are really nice to me.
- Nana and Poppa are nice to me and I am comfortable here.
- Nanny and Poppy.
- The people.
- That they are so nice to me.
- They are very nice people.
- With Nan.

An additional **23** responses are included under “Multiple themes”

Provide protection and safety

- Because it's very safe.
- Being safe is the best thing.
- Being safe.
- I feel safe here.
- I'm safe.
- It's safe.
- Safe.
- Safe.
- That I'm safe and nobody can hurt me.

An additional **11** responses are included under “Multiple themes”

Fair treatment and respect

- Get treated nice.
- Good treatment.
- I like living with Aunty because she treats me really well.
- Mum and Dad and most other people here respect me.
- We get treated good.

An additional **8** responses are included under “Multiple themes”

What is the best thing about living here? (children)

No abuse or violence, or removed from a bad place
- No yelling or screaming.
- We don't get sent to bed.

An additional **5** responses are included under “Multiple themes”

Family

Maintaining contact with biological family
- Being with and seeing family.
- Being with brother and sister.
- Being with my brothers.
- Being with my sister and cousin.
- Carer gives the child contact with older brother (sleep over) as they wanted to be together over Easter.
- Get to see cousins and my grandma.
- I can talk to my mum on the phone.
- I get to play at my visit with my mum.
- Is that my cousin lives close by and near to the shops.
- Like living in your community. Go everywhere with carers. See your family all time.
- Living with my two sisters and 2 year old brother ***.
- That my brother is here.

An additional **13** responses are included under “Multiple themes”

Being placed in relative care
- Being with my Nana and brother and sisters.
- Being with Nanny and Grampy.
- Being with nanny and grandad.
- I live with my Grandma and Grandad.
- I live with Nana and Grandad and *** and ***.
- Living with Aunty ***.
- Living with Grandma and on a farm.
- Living with Nan.
- My family.
- Staying home/in community.
- That Nan looks after us.

An additional **6** responses are included under “Multiple themes”

Family life and being part of a normal family
- Being with my family.
- I like living here with my mum.
- Living with Aunty *** & Uncle ***.
- Part of a family.
- That I have a home.

An additional **11** responses are included under “Multiple themes”

Being able to contribute
- Building fences.
- Helping Poppy.
- Is I can help.

An additional **7** responses are included under “Multiple themes”

Other

Basic needs met
- Looked after good.
- That the carer looks after me.

An additional **14** responses are included under “Multiple themes”

Other
- I get to sit on their laps.
- I want to go home.
- If we had a really really really nice foster carer.
- Learning from the fire officer.
- Sleep in.
- Sleeping
- There's nothing to do here.

An additional **4** responses are included under “Multiple themes”

Multiple responses
- *** always helps me (carer's daughter) and *** (carer) loving me.
- *** always takes us out and she is loving and caring.
- *** and uncle *** look after me.
- *** gives us clothes and dinner and treats.
- *** takes care of us. Going to the beach in the caravan.
- Because its safe. Because I feel happy and I feel good living here.
- Because my uncle bought me a motorbike. I get heaps of toys.
- Because we get care and very good vegetables and rain water.
- Because we get pocket money and soon we will go on holidays.
- Being loved, having pets.
- Being with my brother.
- Being with my brother.
- Being with my Gran and sister.
- Camping. Good so I get treats.
- Carer takes care of him. Does fun stuff.
- Colouring – art, crabs, animals outside, riding the bike.
- Cooking. Rollerblading.
- Cubby house, Foxtel. ***
- Eating, having a bed.
- Eating, sleeping playing with cats and a dog. Dress them up, with me.
- Enjoy playing, the cats, television.
- Everything: Mummy and Daddy and *** and *** and *** All the things.
- Family treats me well and gives me good food.
- Feeding the animals. It's good when I get treats.
- Food is good and riding bikes.
- Football, karate and Mum.
- Get lots of toys, go camping and play soccer, football and AFL.
- Get to help Nanny and go out with Poppy.
- Gets listened to and cared for and treated well. Treated with respect.
- Getting a shed, we going to get a cubby house. Got a new puppy.
- Getting clothes, toys, going to parties.
- Go swimming and have parties and have party food. Auntie is nice to me and gets nice party food for my birthday.
- Going for a swim. Sometimes I'm a bit bored because my sister doesn't play with me.
- Going for drives and working.
- Going to Movie World. Having my school work 'cause I want a good education.
- Good food and MONEY!!!
- Good food everyday and they love us.

What is the best thing about living here? (children)

- Got lots of new clothes, had a big birthday party. Nan loves us.
- Have heaps of toys and everything I want. Get heaps and heaps of kisses and love.
- Having chickens. Playing outside.
- Having fun. Loves his grandparents.
- Having pets. Mum and Dad (foster).
- Having pocket money and being looked after.
- Heaps of toys. Having my own bedroom.
- Holidays. Room to play.
- House is getting new. Good food.
- I am safe. I like it here.
- I get cared for and not moving from place to place and *** loves me.
- I get to eat good food. I get looked after well. I am kept warm when I am cold.
- I got lots of chocolates at Easter. I love my carer.
- I have a good family here and my sister plays with me.
- I have a loving home and feel safe.
- I like my bedroom, books.
- I like playing outside on the swing. And I get to see my dad.
- I like swimming. I like ***. I love ***.
- I like this house. When I go outside I ride a bike and scooters.
- I like to play with my DS and skipping and talking with ***. Lots of swimming and stuff.
- I live on a farm and grandma and grandad love me and my family.
- It's fun. Grandma is a good cook.
- I've got a cat. That I get more toys.
- I've got guinea pigs. Got a loving family.
- Like the food. Like lots of things in the house.
- Like the movies, nice dinners, going to bed early.
- Likes staying with Grandma and her horse.
- Living with mummy and uncle and they buy me things.
- Living with my brothers. Cuddles from carers. Seeing my sister.
- Lots of food. Toys.
- Lots of games, bubble bath.
- Love, care, food.
- Making yard clean, swimming, chores, go to beach, fishing.
- Mum and Dad (foster parents) and the cat.
- My carer is very nice and she is helpful.
- My family and my love.
- My friends and lots of toys.
- Nan cooks nice food and sometimes we get surprises.
- Nana's so nice. Nice, nice clean house. I love Nanny.
- New thongs, cupboard, clothes, playing outside.
- Nice bedroom. Nice mum and dad.
- No one steals stuffs, no one throws stuff (shoes) and no one smacks us and we have no trouble here.
- Play computer games. Living with my brothers.
- Play with DS and PlayStation. I and other foster child like having nice dinners.
- Play with toys and having people over to play.
- Playing babies with other young person.
- Playing games and having a nice carer.
- Playing with motorbike. We get things.
- Playing with my carer's son. And playing cricket with Uncle.
- Playing with my toys and Nan loves me.
- Playing with toys. Sometimes we play Ninjas on the trampoline.
- Playing, school.
- Playing. Likes the house.
- PlayStation, new TV, new lights.
- Pool and my sister is nice.
- Pool, go dancing, live with family.
- Seeing new kids. I don't know.
- She makes our dinner and she buys us clothes and new toys.
- Swimming in pool. Getting hugs and kisses. Getting to draw what I want.
- That it has a trampoline. Carer cooks lovely dinners.
- That my nana is keeping us safe.
- That they really like me and they are fun to play with.
- That they take care of me and they give me lots of food.
- The best thing about living here is I can ride a horse and there are other kids.
- The best thing about living here is we are allowed to have takeaways and have pets.
- The best thing is that we have been here for a year and I'm still with my sister.
- The carer is nice and the garden has play stuff for me to use.
- The food is nice and its close to the beach.
- The plants, the swimming pool, the house.
- The rules are fair. We get spoilt sometimes.
- They feed me and give me new things.
- They have a pool and a dog.
- They love me and look after me.
- Toys and my PlayStation.
- Toys, camps, beach, going out for dinner.
- Treats, chocolates & toys.
- Watching movies. Playing with toys. Good food.
- Watching TV. *** with the family, for family time.
- Watching TV. Get spoilt.
- We are all respected and treated very well. My carers support me a lot, and go to the end of the world for me.
- We are allow to play, play with the dog and swim in the pool.
- We get pizza on Tuesday night and on Friday we get a movie night.
- We get to go to the park, kick a soccer ball around. We have nice dinners.
- We get to play. Me and *** got a puppy.
- We go to church.
- We have a lot of room to play. I am spoiled by Grandma.
- We have a pool. Lots of Xbox games. Food is good.
- We have good foster parents, horses, and we love each other.
- We have Lego to play with.
- We have pets outside. My nan and dad love me.
- Wet 'n' Wild and Mummy.
- We've got a nice carer and lots of space to run around (but some of the rules are a bit strict).

What is the best thing about living here? (children)

- When *** comes over with ***. I love playing games at parties.
- Xbox, TV, pool, family.
- You can have fun, playing around and get dirty sometimes.
- *** is nice to me. I'm with my brothers. The dogs.
- A lot of toys and have two beds. Don't have to get hurt. Nana and ***** loving me.
- All my toys, Ma and Pa taking me to the beach, my brother being here.
- Aunty *** and Aunty *** being nice to me and look after me nicely and don't be rude to me.
- Because they are nice to me and they buy us stuff and the are giving us food.
- Being with family. Buy me new stuff. Nice food.
- Cats, food, love, happiness.
- Chocolates. Watching TV. Carers.
- Food. Where I sleep. Clothes.
- Foster carers love me. Keep me healthy, take me nice places like cruises and New Zealand.
- Get lots of things. Lots of things to do. Carers care about me.
- Get to go out to places eg. games. Feel part of the family, carer loves me.
- Get to go places. Be healthy. Like playing with dogs. My own room.
- Get to play with cousins. Be with family. Bushwalking with Nanna.
- Go out to *** shopping and visit family and pocket money.
- Going to my brothers house. Get to go to my friends house. Play with Lego.
- Having fun, lots of toys, no physical discipline.
- Having nice food and lollies. Having nice clothes. Going on holidays.
- Horses, dogs, cows. Nice people. Own bedroom to myself.
- Horses, people and motorbike.
- I am safe, loved and respected.
- I am safe. I am happy. I get treated the same.
- I can do my own thing like my Sony or be in my bedroom.
- I don't get smacked. We get to do lots of stuff. It's very fair.
- I get food, I get treated well and I get taken to school well.
- I get play with ***, play with DS and watch TV. I do half my jobs.
- It's fun. There are lot's of children, chickens, dogs and friends and a bird.
- It's nice. They're nice. I like it. I get what I want.
- Jetskiing. Cared for. Pets. Loved.
- Keeps us healthy. They buy stuff for us. Uncle *** takes us to football. The back yard is clean.
- Like playing on the trampoline and like keeping my own room tidy.
- Like playing with *** and toys, especially the piano.
- Living with family. Getting spoilt rotten. Having a roof over my head. Getting loved.
- Love, safety & food
- Loved and cared for. Get things that she wants. Likes the food. Likes her new bed.
- Loves the food. Game boy. Very nice carers.
- My parents (carers), my dog ***, having my own room.
- My room, my toys, my puppy.
- Nice people and lovely family. Give me anything I need.
- Playing on the hammock. Play with the other children. The food.
- Playing with baby ***, shopping, Mum and Dad.
- Playing with brother and the Xbox. Mum makes good meals that taste nice.
- Playing with my own toys, going out to the shops, helping Mummy.
- Space, animals, freedom.
- That I get lots of treats. That I get looked after so I am safe.
- Toys. Pets. Going on holidays.
- Watch movies, clean my room, playing with the cat.
- We do special things together. I have nice lunch and my own room.
- We go places. We have best food and I don't live with Dad.
- We have good food, and we get to go auntie ***'s house and it's fun there.
- Austar. Comfy room, nice food, clothes.
- Food, shelter, happiness, fun.
- Get to eat some junk food. Have other children. Have toys. Makes things with cardboard.
- Going out to dinner. Anything that concerns food, my *** and *** (carer).
- Having animals, food, clothes. Going to shops, going on trips/holidays and we have a pool to swim!
- I get toys. Looked after properly. Do fun things. Feel loved.
- I like getting treats. I do some things with ***. Making the sand pit and my garden.
- Loves outside, carer breeds dogs, will help feed. Lots of family activities.
- More people and more fun. Likes food. Lots things to do.
- Pets. Carers and their son. Xbox and games consoles. Healthy lifestyle.
- Toys I get, pets, food I eat, back garden.
- Trampoline, dogs, sister, chocolate, Aunty and Uncle.
- We always get food, clothes, shoes and we have a good house conditions plus rules that are safe.
- We have a big yard, I have my own room and I have a telly. I help Mum and she helps me.
- I've got a new guinea pig. Got a lovely family and all six kids are together. I've got lovely grandparents.
- That I got clothes. I got a loving grandma and uncle. I've got a room to sleep in and dinner and a dog. We get to hop in the pool in summer.

What would you most like to see changed or improved to make your placement better? (young people)

Management of household

Improved relationships within the household

- *** not be BITCH!!
- *** to be good.
- Attitude of other kids at house.
- Boys not bullying me and that.
- Carer listens.
- For *** to stop whinging.
- For everyone to be happy.
- I don't get on with one of the other girls here. I want her to move.
- Me and ***, well all of us girls to get on better.
- My brother being nicer to everybody
- My sister stop having hissy fits.
- My sister to grow up.
- No arguing.
- No fighting
- Not sure. Grandad not working at the moment. So Grandma does not yell as much.
- People get along.
- People not being mean.
- Stop fighting with the other kids.
- That *** would get rid of her attitude.
- The other children not teasing me.
- Young person living here not to be mean to me.

An additional **21** responses are included under “Multiple themes”

Household membership

- ***, ***, ***
- Another boy in the house.
- Another child.
- Another foster girl around my age.
- Another girl my age living here.
- For *** to be moved. She is my sister.
- For brothers to move out (3 of them).
- For other young people to leave.
- Having a big sister.
- If *** could leave.
- Less kids.
- Less kids.
- More boys. Too many girls here.
- More kids (no other's here but me).
- Nice kids.
- No. I'd like another kid here my age.
- Not too many kids.
- Other 2 children going.
- Other young people get put if they're the same needs as me.
- Some friends here would be good.
- Someone leaving.
- Someone my own age would be nice.
- To get another girl resident living here.

An additional **13** responses are included under “Multiple themes”

Better behaviour, rules, discipline or cleanliness

- *** behaviour.
- Bedtime.
- Better rules, no yelling.
- Flexible groundings.
- Getting told to go back to bed if I get up early.
- I want to stay up until 8:40 not 8:30pm.
- If my carer was less strict.
- If the girls pull their weight and respect the rules.
- Less yelling.
- Like to have no rules.
- My oldest brother not steal my stuff.
- Not so many jobs around house.
- Not so strict.
- Punishments.
- Rules.
- Staying up later.
- The grounding rules.
- The rules.
- The rules. Need less rules. Safe respectful and responsible.

An additional **12** responses are included under “Multiple themes”

Material goods or services

Personal possessions or luxuries

- $1,000,000!
- A better TV.
- A billion dollar house.
- A motorbike.
- A new bike.
- A new motor bike.
- A Playstation.
- A pool.
- A Wii. Better TV.
- A zoo and a motorcross track in my backyard.
- Another swimming pool.
- Austar.
- Be less clothes.
- Bigger motor bikes.
- Buying me smokes.
- Computer.
- Computer. More food.
- Driving cars.
- Everything is good but need TV.
- Football field out front.
- Get a laptop – wouldn't really make it better; I just want one.
- Get a Wii.
- Get more Playstation games.
- Get my "P" Plates.
- Get things.
- Getting a car.
- Getting more money.
- Getting pocket money. Not having to eat vegetables.
- Good books.
- Good presents.
- Having a motor bike.
- Having a pool.
- Having my DS in my room.
- I get my bike from Mum's.
- I really want a laptop.
- I want a PS3.
- I want an iPhone.
- I want karaoke machine.
- I want to have a new computer.
- I'd like to have a big spa, can you send one over.
- If I had my own laptop.
- Inground pool.
- Internet.
- Laptop for school, more clothes money.
- LCD in my room.
- Less junk food.
- Like a TV and DVD player in bedroom.
- Like big plasma and other kids have.
- Lollies.
- Mobile phone back.
- Money, toys, house and computer.
- More credit on mobile phone.
- More flowers.
- More money and food.
- More money.
- More money.
- More money.
- More money.
- More pocket money.
- More swimming pools.
- More toys.
- More yummy food.
- Motorbike.
- My own garden.
- My own TV in my bedroom.

What would you most like to see changed or improved to make your placement better? (young people)

- Nothing – except a computer from Child Safety.
- Plasma TV, DSI. web slider, laptop for me.
- Plasma TV, Laptop, Motorbike, DSI.
- Pool for the hot days.
- PS2. A decent CD player.
- Sports Foxtel. Eating arrangements, veggies every nite.
- To get me a computer.
- To ride scooters to school.
- Trampoline.
- TV in my room.
- Wii.
- Xbox 5.
- Yard toys. Swings and climbing toys.
- Yes – want energy drinks.

An additional **8** responses are included under "Multiple themes"

Household items
- A playground.
- Air conditioner (too hot).
- Dishwasher.

An additional **2** responses are included under "Multiple themes"

Changes to premises

Larger house, yard or bedroom
- A bigger bed.
- A bigger house.
- A bigger room.
- Backyard bigger.
- Bigger back yard.
- Bigger house – more bedroom.
- Bigger house.
- Bigger house.
- Bigger house.
- Bigger house/unit with a reasonable backyard.
- Bigger room for me.
- Make the home bigger.
- New house.
- Nicer house, some backyard.
- Room.
- To have a bigger house to look after little babies.
- To live in a two storey house.

An additional **4** responses are included under "Multiple themes"

Own room or more privacy
- Get my own room.
- Have my own room.
- Have own bedroom.
- Having my own room.
- If I had my own room.
- More bedrooms/space.
- More privacy.
- More space for my own bedroom.
- My own quite room to relax and paint.
- My own room.
- My own room.
- To have my own room.
- Want my own room.
- Would like own bedroom

An additional **5** responses are included under "Multiple themes"

Renovations, repairs or re-arrangements
- Computer working.
- Fix my bike.
- Holes in walls to be fixed.
- House renovation.
- House renovation.
- Paint job on this house and maybe a fence.

An additional **4** responses are included under "Multiple themes"

Relationship with birth family

More contact
- Brother staying a bit more.
- Go to Aunty ***.
- If my brother comes over more.
- More visits with Mum.
- More visits with my niece, brother and sister.
- Mum being here.
- My sister.
- See Mum and Dad and brothers and sisters more.
- See my mum and little sister more.
- See my mum everyday.
- Seeing *** (brother).
- Seeing ***.
- Start seeing my brothers again.
- To get to know my real father.
- To see Mum more often.
- To see my dad and mum every year.
- Wants to see Mum on Fridays.

An additional **7** responses are included under "Multiple themes"

Reunification
- Go back to my grandmother.
- Go home.
- Go home.
- Going home.
- Going to live with Mum.
- Going to live with Mum.
- I want to go home.
- I what to living with Mum and family.
- Just me and Mum.
- Live in house with Mum and Dad and brother.
- Live with my mum.
- Living with Mum.
- Living with my mum.
- Moving back home.
- Send me to live with Dad.
- To go back to my mum.
- To try and get us back with Mum.
- Want to live with Dad.
- Would just like to go back home.

An additional **5** responses are included under "Multiple themes"

Opportunities and activities

Activities, games, adventures, outings, family time
- At least around 2 hours on the Playstation.
- Do more stuff outside the house, go movies.
- Do more things together as a family.
- Go different places.
- Go out more.
- Going out places on the holidays with the family.
- I want to go to Movieworld.
- I would want to work more.
- More computer time.
- More family time.
- More game time.
- More playing time.
- Mum and Dad to play more games with us.
- Nothing more have heaps of more dance competitions.
- Seeing more movies at home.
- To play World of Warcraft.

An additional **5** responses are included under "Multiple themes"

What would you most like to see changed or improved to make your placement better? (young people)

Social or friends
- Being allowed to see friends.
- Bigger social life.
- Everyone play with me.
- See my mates.
- Seeing my friend ***.

An additional **6** responses are included under “Multiple themes”

Having pets or more pets
Another puppy.
Dog.
Get a new dog.
Have another cat and a bird.
Having a kittens.
I want a pet reptile but the carers don't.
To have a dog.

School
- School.

An additional **2** responses are included under “Multiple themes”

Treated differently

More respect or fairer treatment
- Fairness.
- Make stuff fair – like if someone gets to go out, the other gets to out too, even if grounded.
- That she would treat her kids the same way as she treated us.
- Treated the same way.

An additional **14** responses are included under “Multiple themes”

More autonomy
- Allowed to do stuff.
- Leave.
- Maybe more freedom to go out by myself, like travel by train etc.
- More freedom.
- More freedom. Like.
- More say on what we get to do.
- Moving out.
- To get what I want.

An additional **7** responses are included under “Multiple themes”

Other

Care arrangement
- Being in my carer's guardianship.
- By being in another placement.
- Getting guardianship.
- Guardianship to my carers.
- Live closer to Toowoomba.
- Love to live in Albora HC.
- Move houses.
- Mum and Dad getting guardianship of us.
- My grandmother having guardianship of me.
- The same care.
- To stay here.
- Wants to go back to previous carer.
- Wants to go back to previous carers.

An additional **5** responses are included under “Multiple themes”

Changes to self
- Behaviour.
- Control anger.
- I stop having tantrums.
- Learning to read and being able to do hard homework.
- Me behaving myself at school.
- My actions.
- My attitude.
- My behaviour – its getting better.
- My behaviour.
- My behaviour.

An additional response is included under “Multiple themes”

More support, understanding, action or resources from Department
- CSO to visit more often.
- DOCS should be more involved.
- I want the Department to help the carers more.
- More help from CSO.
- More support for my grandmother.

An additional **6** responses are included under “Multiple themes”

Other
- Build another park.
- I wish the next door neighbours would move out because they have parties every night.
- I'd like to own the motel and I could be boss.
- Like to be grade 5 student leader at school.
- Me be a superstar.
- Not doing too many jobs.
- Nothing because I want to leave.
- Nothing could make it better.
- People would stop coming to see me because I'm happy.
- Please make it snow.
- Tablets. Would like them changed.
- To find out who my father is.
- Would like a haircut.

An additional **6** responses are included under “Multiple themes”

Multiple responses

- *** and *** needs and that would help the whole household. And *** (dog) not to fart because he clears the room.
- *** stops picking at me. *** to stop swearing at me (other foster children).
- Allowed to go to friends place.
- Allowed to sleepover friends place.
- Another boy my age in care too so I have someone to play with.
- Another girl my age and culture living here.
- Clean up a little and buy toys for the little ones so the big ones can watch TV and little ones play with toys.
- Communication.
- Find a house for my sisters and me and Aunty ***.
- For my little brother to live here.
- Get a job.
- Get rid of ***.
- Have yelled at and feeling safe.
- Having *** (sister) live with us as well.
- Having a chef and waiter. Put some bedrooms upstairs, to the next to each other. Another pool – for a clean swim.
- His room. Nor enough space.
- I don't want to see bad things again (remember)

What would you most like to see changed or improved to make your placement better? (young people)

and feel they'll happen in the future.
- I keep banging my head on the bunk bed. I would like a normal single bed.
- I want to change my bedroom to another room and make my bedroom teenage style.
- I would like a door on my wardrobe and also a double bed.
- I'd like to have more privileges i.e. have a phone.
- If *** contact can be slowed down.
- If I was trusted more.
- If they would let me stay with *** or have weekends at least.
- Kids not going through my stuff.
- Leaving placement, more family contact.
- Like to live with Mum and Grandad.
- Like to see *** (child of carer) change.
- Me and my sisters and Aunty.
- Money, toys, and attitude, house.
- More myself time.
- More time with carer and own room.
- More time with them.
- More turn at the Xbox 360.
- More! Sugar! Sugar land.
- Mum not being so bossy and the girls leaving me alone.
- My bed is uncomfortable. I used to have a good one but now carer's daughter has it.
- My brother and sister come to live here too.
- My sister to not touch my stuff.
- My stuff treated with respect.
- Nobody pick on me.
- Not really. Just more freedom. Seeing friends outside of school.
- Nothing.
- One boy does not like me here.
- Pack your bags you're going home.
- Pay Mum and Dad mileage for driving us to school to Toowoomba and back about 160 km a day so I can go to special school.
- People living here.
- People need to respect their elders.
- School and being happier with family.
- Sleeping at my mum's and living with my mum.
- The boys stop hitting.
- The kids to actually listen to Mum.
- The rules and discipline, changed to make it fairer.
- To be left alone. I don't like talking to anyone. I've done it for 3 years and I'm only upset for repeating myself.
- To have ***(brother) room moved away from mine.
- To have all of my family.
- To stop being teased.
- Understanding.
- Want to be listened to.
- Would like my brother *** here.
- Yes – maybe a different carer that's not a healthy food freak and is not very strict.
- Yes better computer.
- Better food. More games. Better computer. See mates.
- The twins not going in my room.
- Have my own room and mobile phone and not get into fights with the kids that live here.

What would you most like to see changed or improved to make the system better for kids? (young people)

Decision making and communication processes of the Department

Issues with permissions

- A bit of freedom for kids to do what they want.
- Approvals should be done faster and better.
- Bed times
- Being able to sleepover more than two nights with family, and carer allowed to sign permission forms.
- Carers not to be so strict.
- Carers to be able to sign forms.
- Change the permission forms to parent/carer, not parent/guardian. Then it will get signed faster.
- Do what they want.
- Easy approval for excursions. My mum (foster) to sign. Be able to drive cars and motor bikes on our farm, and ride horses.
- Faster approval to go interstate.
- Forget about the rules.
- Forms get signed by CSO quickly as I want to go on camp and not miss out on things.
- Get permission slips signed quicker.
- Go over people's house.
- Go over to our friends' house for sleepovers.
- Go to far places where your other families stay.
- Go to more places.
- Go to sleepovers without CSO permission.
- Have sleepovers.
- I would sign all of the paperwork and forms.
- I wouldn't like any other kid to go to my last carer because I had to go to bed at 7.30 and get up at 6 am and the carer was on a diet so I had to be too.
- I'm not allowed to ride motor bikes because I am in care. It's not fair.
- Kids allowed to do more things.
- Kids can go more places with friends if they're over 12 or in high school. Kids don't need to ask the department about every little thing that you want to do.
- Kids get to do more things.
- Kids should be able to go and do what they want.
- Less red tape.
- Let children do the things they want, ie, go to Sugarworld.
- Let kids decide on things like ear piercing.
- Let me go on school excursions, especially expensive ones ie. $360.

What would you most like to see changed or improved to make the system better for kids? (young people)

- Let me go out and do what I want.
- Let me go where I want to go when I visit my dad.
- Let them do fun things like motorbike riding and get their ears pierced.
- Let them do more things.
- Let them do what they want to do to keep them happy.
- Let them have more time to communicate with their friends, like sleepovers.
- Let us do what we want to do.
- Letting carer sign things such as camp, dental, medical.
- Letting the carers sign forms, without the child being a permanent kid in care!
- Make it less complicated and do things on time.
- Making their lives better. I would like to visit other children in care/not in care. Going to sleepovers at children's homes who are in care, not in care.
- More freedom to do what I want in life.
- More freedom.
- More freedom.
- More TV time.
- No paper work.
- Not as many rules about what we can do.
- Not so many restrictions. Sometimes I can't do things I want (eg. sleep at a friends house longer than 48 hrs).
- Not to be so strict on young people who are almost adults.
- Parties, sleepovers.
- Permission stuff pretty crap.
- Permission to do stuff.
- Permission to do things.
- Permission.
- Quicker response from CSO for approval to do things.
- Respond quicker to questions about permission to do things.
- Sign own forms as a carer.
- Sign papers and permission on the spot!
- Stay over people's house more than 48 hours.
- That we could go to countries and states without having to ask.
- The safety issues like being able to do more activities, like motorbike riding etc.
- They get to do what they want. Horseriding club. Owning a horse.
- They make it easier for us to talk to people.
- To have permission about things ASAP not six-seven months later.
- To let us have more sleepovers and do what we want more, and go to late night at Australia Fair.
- To not be so strict on what activities kids can do.
- Unsupervised visits for 14-18.
- Well we can go anywhere.
- What the kids want to do.
- Would like more freedom.

An additional **21** responses are included under “Lots of things”

Listen to children and young people more

- Being able to speak their mind and know that they will be listened to.
- CSO to listen more.
- For adults to listen.
- Hear their say.
- Listen and interpret, and see our point of view, not just as children, but as a person.
- Listen more to the kids.
- Listen to kids more.
- Listen to me.
- Listen to us more.
- Listen to us more.
- Listen to what kids want.
- Listen to what we are saying.
- Listening to kids.
- Make Child Safety listen better to kids.
- Pay more attention to kids.
- People listen to us more and understand. Just 'cause we are fostered doesn't make us poor or not wanted.
- People to listen.
- The department needs to listen more to the kids.
- The department to hear what kids have to say. Believe the little kids.
- To take in our opinion and listen to us. Just because CSO went to uni etc. doesn't mean that they know every child inside out.

An additional **24** responses are included under “Lots of things”

Greater input by children and young people in decisions about them

- A choice in where we get placed.
- For the department to actually take in the children's choices.
- Give kids more say.
- Give them the choice in what they have to do.
- Kids have more choice/authority.
- Kids that were of a mature age should have a say about what is going on.
- Leave the decision of going home entirely up to the kids. Don't give the parents as much say in that. Make sure that if a younger sibling is in care that the older, mature siblings have a say in what happens to them, eg. going home.
- Let the children make more of their own decisions to what they want to happen or be done!
- Let the kids have the decisions, not the department.
- Let the older kids have a lot more say in what they do.
- Let them have their own opinion and make DOCS actually listen.
- Let them have their say for what they want.
- Let them speak out.
- Let us have more say.
- More say in decisions made for me.
- More say in what happens.
- That all kids older than seven could have their own say and that the department could do what they say.
- To give kids more of a say because we're not dumb, we know what we're saying.
- To let children be able to make their own choices.
- We need more of a say.
- When they have meetings about me I want to be involved. I want my opinions to be considered.
- Younger kids should have the decision like older kids in care.

An additional **10** responses are included under “Lots of things”

What would you most like to see changed or improved to make the system better for kids? (young people)

Keep all parties informed about what is going on

- Advise the children of things that are important to them or their family.
- Carer kept more informed. Carer should be able to attend FGM [Family Group Meeting] and let carer know outcome.
- Get more information than given.
- Give me info about family.
- Give more information to kids about what is going to happen in their life.
- More info on what is happening from CSOs.
- More information as time progresses in care particularly re. reunification.
- Need to tell us what is going on.
- Nothing really but CSO should tell us more.
- Relationship between department and young children could be better and easier for some kids to understand what's happening.
- Talk to kids.
- Talk to me about decisions before they are made.
- Talk to the kids more.
- Tell kids about the decision made by the department.
- Tell them exactly what's happening.
- That we get told more.
- The way that you are taken away from your parents and not told what's happening.

An additional **6** responses are included under “Lots of things”

Follow through on decisions / promises

- For the department to keep their word when they say they'll do something.
- Make things happen; keep promises.
- People do what they said.
- The department should do what they say they going to do.

An additional **7** responses are included under “Lots of things”

Explain decisions

- Explain more facts to the kids and don't lie.
- Explain things more.
- Talk to the person and explain things better.
- Talk to us more; explain to us what is happening.
- Tell them what is going on and why it is happening and how it has happened.
- Try to explain things to kids better.

An additional **3** responses are included under “Lots of things”

Return phone calls and improve availability / contactability

- When kids want to ring up and talk to their CSO they should be able to get them right away instead of them calling them back later.

An additional **4** responses are included under “Lots of things”

More support, understanding and resources from the Department

Money, resources and possessions

- Buy me a new bike.
- Computer and Internet.
- Computers for kids in care for school work.
- Every few months/year kids in care get given a voucher/money.
- Free laptops.
- Get a new bed.
- Get children, when they get to high school, a laptop for school work.
- Get more funner stuff.
- Get more games.
- Get my own room.
- Give the children $100 when the carers get paid.
- Have more outings and stuff.
- Have more stuff for kids.
- I'd like the department to provide more money for activities.
- Laptops.
- Make a bank for kids.
- Mobile phone.
- Money, toys, equiptment, cars faster and cooler, and better seats and more room, more time more games.
- More child care activities.
- More financial support.
- More fun stuff to play around with.
- More fun things for children.
- More games for the Xbox.
- More money, toys, equipment, cars faster and cooler, better seats, more room, more time and more games.
- More money.
- More money.
- More pets for kids.
- More time spent fishing or with friends.
- Take kids to theme parks.
- Take them out most of the time.
- That a kid leaves a place that they have a scrapbook with pictures photos and school things.
- Their own room.
- Transport for sports.

An additional **18** responses are included under “Lots of things”

Planned activities for young people in care

- A fun group.
- Day out, fun day for all the kids.
- Department get together so us kids know who and how CSOs are going.
- For kids in foster care to spend more time together.
- Good holiday programs.
- Make friends with other kids in care.
- Make it better by going to excursions with other kids in care.
- Maybe have a day in the year where activities are made for everyone to attend with family?
- More activeties. More camping. Cultural knowledge.
- More activities where they can go to parks to meet other kids in care, like days out together.
- More children's activities so I can meet more kids in care.
- Something for other children to get together. Share their story with other people. To go on camps as well.

An additional **2** responses are included under “Lots of things”

What would you most like to see changed or improved to make the system better for kids? (young people)

Support and understanding for young people
- Kids should be able to get more support through the Department of Child Safety.
- More help with maths support at school.
- More help.
- More support.
- The department to help with problems we have.

An additional **7** responses are included under “Lots of things”

Treat children and young people in care more like 'normal kids'
- Everyone treated the same.
- Getting the same things as other kids.
- Make them feel like everyone else.
- That we are allowed to do the same things as everyone else.
- Treat them like real kids; give them a life.
- Treated like part of the family.

An additional **5** responses are included under “Lots of things”

Support for carers
- Better pay for carers because they put up with us.
- Carers paid more.
- More money for carer.

An additional **6** responses are included under “Lots of things”

Changes to relationship with birth family

More contact
- Can see their parents more often and they can contact their parents: for example, phone number, etc.
- Get to see parents and family more often.
- Go and see Mum, Mum and Dad.
- I wanna see my family and see who my dad is, and step cousins and brothers and sisters.
- If they are not allowed to talk to their parents they should be allowed to.
- Kids see their mum whenever they want to.
- Kids want to spend time with their family.
- Let them be with family if they want to, such as sleepovers or unsupervised.
- More consistent family contact with all family members.
- More contact with family.
- More contact with other family members eg. Grandma. I don't want anything to do with my mum if she is going to ruin my life;I just don't know how to tell her.
- More family visits from our sisters and bros.
- More family visits! Like now.
- More family visits.
- More opportunity to go back home.
- More visits with Mum.
- More visits with our parents.
- Need more time for visits with family and for them to be better organised.
- Nothing but for my half brother come over.
- See family more.
- See family more.
- See family more.
- See Mum and Dad more.
- See my mum more.
- See their family more of it.
- See their mum every two days.
- See your dad or mum twice a week.
- That contact with family would be better and easier.
- That my Mum rang every time and showed up to visitation.
- They get to see the dad more often, or whichever parent they don't see often.
- To be allowed to see family more.
- To get them to see their family.
- To have contact with Mum but people say no, which makes me upset and sad.
- To see Mum more.
- To see their family if they're in care.
- To see their parent more often.
- Visit Mum often.
- Visit mums more often, and dads.
- Want to see Mum.

An additional **10** responses are included under “Lots of things”

Reunification
- Being with their family.
- For kids to be happy and go back to their mums.
- For kids to live together in a family.
- Go back home forever.
- Go back to Dad's.
- Go back to grandma.
- Go back to parents.
- Go home.
- Going back home to my family more quicker.
- Help me live at Mum's quicker.
- I want all the foster children to be back with their parents.
- I would like to see kids put back with their mother if she improves her behaviour and treats her kids with respect.
- Let me go to Mum's house to live.
- Let them go home.
- Return to family.
- That both parents be given a chance straight away for permissions and reunification. My mum only ever got a chance, but now my dad is starting to.
- That you only stay in foster care, then go home.
- To live with my parents.
- To see their mums change and they go home.
- Trying to live with families.

An additional **6** responses are included under “Lots of things”

CSO Issues

More contact with CSO
- CSO needs to come every two weeks.
- CSO see children more and talk to them about things.
- CV should come every two/three weeks.
- I think that more visits should happen.
- More contact from the department.
- More interaction between children and case worker.
- More one-on-one time.
- My CSO to talk to me.
- People visit more often.
- See CSO more often.
- See CSO more often.
- The case workers visiting their kids more often.
- To see CSO more please.
- To see CSOs more often.

An additional **18** responses are included under “Lots of things”

What would you most like to see changed or improved to make the system better for kids? (young people)

More or better CSOs

- A new CSO.
- Allow/try to get more case workers so when children have case officers they are able to have a bit more time with them.
- Be more caring staff at dept.
- Better workers like ***.
- Case worker needs to be more organised.
- For CSOs to grow a brain and listen to the kids. They're d***heads!
- For them not to be so slack. CSO has too many kids to look after so they can not do much.
- Get rid of the retards that work at the department.
- Hire better people in dept offices.
- More CSOs.
- More workers.
- Some case workers would get off their butts & do something. I've had a few case workers like that and it aggravates me.
- Support workers should have more knowledge about disabilities.
- They need to have more people in the Office. My last CSO was overworked, and she quit the job.
- To have people in the department that have common sense and can think for themselves.
- Work with each child equally. Some kids get better service than other kids. The other kid never gets her CSO coming to see her and ringing her all the time. When she does well at sports, her CSO sends an email or phones. I have that CSO.

An additional **11** responses are included under "Lots of things"

Greater stability/ permanency of CSO

- CSOs not changing as often. Kids stop caring and start to disrespect CSOs when they change as often as I change underwear.
- Have CSOs that stay full time.
- Have the same CSO, not change all the time.
- Not have CSOs change all the time.
- Stop changing CSOs, so they know us.
- When kid comes into care, they get the same CSO. *** is awsome.

An additional **6** responses are included under "Lots of things"

Other issues with Department practices

Quicker action by Department/ CSO

- Be quicker with DOCS decisons.
- CSO responding time.
- Department could organise things a bit faster.
- Department do things faster.
- Department to work faster.
- Faster decisions.
- Faster reacting when a child wants something they own to be delivered to them.
- I wish the department would be more prompt with their decisions and replying to requests.
- Make things happen first [fast]
- Quicker answers.
- Speed things up.
- That they get what they ask for when they want it from the department.
- The DOCS to organise things for children faster.
- They get things done faster.
- They should get quicker at stuff.
- Things to be done on time.

An additional **11** responses are included under "Lots of things"

No Departmental involvement and/or more autonomy for carers

- Get rid of Child Safety people and we do whatever we want.
- If you don't want to see department-related people we should have the choice to say so.
- Leave kids alone.
- Leave them alone. Give them a chance and not pressured.
- No rules.
- Stay out of my life!
- Stop take children off their parents would be the go.

An additional **6** responses are included under "Lots of things"

Other

- Actually care! Don't treat us like a job.
- Child Safety care organisations.
- For the department to wake up to themselves and be there for ALL THE CHILDREN!!
- Give parents a second chance.
- Inspect the house first and then check up on the person weekly when they first go into care.
- No residentials that aren't nice places for kids.
- Not be so harsh (dept).
- People that came to pick us up and drop us off.
- Possibly having the department actually care about the kids' concerns instead of ignoring them and forgetting about them completely.
- Relate better to me!
- Tell the parents where the children are moved to.
- That kids are not removed in the middle of the night and taken away.
- The department having more funding to help kids more.
- To make sure kids know the people they are going to.

An additional **14** responses are included under "Lots of things"

Foster care issues

More/better foster care and foster carers

- Carers that care about looking after their children
- From what I've heard and seen check out the carers.
- Get more parents to foster children who really want them.
- Have foster carers that don't abuse kids. This has not happened to me but kids that have been to *** and *** place have. *** used to live with them.
- Let them have better placements.
- Make more improvements in placements and kids.
- Make them better carers.

What would you most like to see changed or improved to make the system better for kids? (young people)

- More foster care homes and more help.
- More foster parents so more kids can be placed in houses.
- Prefer to live in foster care placements not group home.
- That carers are nice to foster kids.
- To get *** and *** out of being foster parents.
- To make sure carers are good.

An additional **3** responses are included under “Lots of things”

Prevent kids from having to go into foster care

- Adults get their act together and not have drugs and care for their kids. Adults should treat their kids better. Don't be mean to your child.
- For parents to treasure their children, not harm them.
- Help stop child abuse.
- I think that if kids want to live with their relatives if they would like to.
- Make sure carer is a family member.
- More care by friends rather than foster care.
- Not having foster care; only for people who really need it.
- Number of children going to each carer.
- Parents looking after them.
- Support me with my family more.
- To have their parents be nice to them so they don't need to be in foster care.

An additional **3** responses are included under “Lots of things”

Increase placement stability

- Have the same CSO and meet the team leader.
- Have the same CSO.

An additional **2** responses are included under “Lots of things”

Other

To be adopted

- I want to get adopted.
- Let them be adopted.
- Stay at carers.
- To be adopted by my carer.
- When child not going home to be adopted by carers.

To live with siblings

- Reckon they shouldn't split brothers and sisters when they come into the system.
- Younger brother to live with me and my two brothers.

An additional **1** response is included under “Lots of things”

Other

- *** stay away from me so I can live my life and be happy.
- All carers have to be nice like my carer.
- At school teasing.
- Be happy and get a lot of love from your carer.
- Be nice to one another.
- Been to dentist.
- Being nice to them.
- Better funding for CREATE. Think young people in care should have better connection with CREATE; they will learn about 'in care' issues, can talk to someone who cares, and they do it all in a fun way. With CREATE groups I feel like I'm talking to people who have the same experiences as me; they actually know what 'in care' means.
- Better lives.
- Buy good cars like Porsches for CSOs so children can comment on them.
- Children feeling more safe than they do!!!
- Don't be very harsh on them.
- Everyone must be very nice and accept anything.
- For everyone to be cared the same.
- Get more Aboriginal people into care because they have no food.
- Go fishing every weekend.
- Go to TAFE.
- Going out to park some little times.
- Have fun.
- Have my brother less angry.
- Having no violence.
- I have people that love you and care for you, like Uncle ***, are really nice.
- I think it is really important for children in care to have a good relationship with carers and family members.
- I want to leave.
- I would like to see my personal belongings back from my previous carer; Ph: ***.
- If everybody was nice.
- If the kids are good, take them to good places as a treat.
- If they are unhappy they should be able to go to respite or somewhere else for the day.
- If you try and work hard and feel like they are your parents it is better.
- Just my behaviour. My attitude.
- Kids playtime. Hehehe.
- Kids should always have sunscreen and hats even in foster homes.
- Kindly and loving.
- Kindly and loving.
- Kindly.
- Less school. More play.
- Less schools and less houses to live in.
- Less support visit.
- Let the kids blend in with foster families without too much of any problems.
- Love.
- Make sure teasing doesn't happen.
- Make sure they don't go back to their parents.
- Making more friends.
- More activities for kids
- More activities for kids.
- More fun for them like going to places they've never been before.
- More happiness.
- More Helplines.
- More parties.
- More playing.
- More publicity.
- More respect for the kids.
- More respite carers.
- Most people would say to change the rules but I wouldn't.
- No hitting.
- No life.
- No name calling from the boys who live with me.
- People getting treated better.
- People happy.
- People not to be mean and kids not to be bullied around by big kids or adults.
- People stop annoying everyone with surveys and questions.
- Private schooling.
- Send them to a good place with a roof over their head and food on the table.

What would you most like to see changed or improved to make the system better for kids? (young people)

- The parents can be the kids slaves.
- They should not take us from school, but if they do they should let us get stuff from our parents.
- To have a better look out for the kids and the carers, NOT LIKE s*** *** or ***.
- To have other kids to play with the same age as you.
- To live in a good caravan when I get older. Kids like me should have a good caravan when we get older.
- To make it better for other kids (not me), their Mums need to talk to them and listen.
- To make the parents have a say.
- To meet a famous person.

An additional **13** responses are included under “Lots of things”

Lots of things

- A lot of things: CSOs more listening to kids, and not moving children from carer to carer, more stability in the child life.
- All kids should be bought a motorbike.
- Allowed to sleepover. More money for families with more than one child.
- Ask what they want and send them to better places.
- Attitude, swearing, bedtimes, more DVDs, a decent DVD player.
- Be more strict. Stop lying or letting kids down.
- Being fair, treated with respect and explaining why things happen.
- Being more organised. Contact visit being cancelled because CSO is on holidays and no other staff available.
- Better discipline rules for kids in foster care. Kids in court cases should be listened to more and have more of a say.
- Bigger house, have our own rooms. Always can to go to Aunty ***.
- By not being lied to, and listening to us more closely and thinking about what we say!
- CSO checking up on the kids. Things happen faster like permission to do things.
- CSO should listen more and spend some time with kids.
- CSO to be allocated quickly and stay with the kid.
- CSO to visit and to return phone calls.
- CSO visit, listen to me.
- CSOs fast tracking kids home. Warnings it affects children.
- CSOs to be more honest and visit kids more often.
- DCS not being so bossy. In care too long and see their mum.
- Department listening a bit more and giving more quicker responses.
- Department to listen and visit more often.
- Do the same things 'normal' kids can do, eg. ride motor bikes.
- Dog.
- Don't lie to kids because they know, and don't pretend to care if you really don't.
- Explain to parents when they take kids away. Don't sign things if it's not fair.
- For case worker to take responsibility for us and listen.
- For CSO to listen to people and not judge them.
- For kids to have a better chance at life, like more workers, more homeless shelters.
- For them to be nicer. Do what they say for kids. Do not lie to the kids.
- Get help for carers for things. Travel, clothes for work, more money for kids.
- Get more carers and treat the carers with respect. Get things quicker.
- Getting everything from Child Safety and to help the carer.
- Gettings calls from DChS and on time. Being kept informed by DChS, without having to chase them.
- Give them more visits with their parents. Help them get their own rooms. Make sure carers are nice for the children.
- Go back to mum and not lied to by Child Safety.
- Having a pool at foster carers home. See Mum & Dad more often. Choice in CSO allocated.
- Help to get mums jobs so we can go home.
- I don't have anything; wanted to change just my carer to sleepover.
- I want to go to ***. Sleepover at ***. Visit my dad.
- I would give free toys, free clothes, free hobbies, free activities and a good fair education for all foster kids.
- I would like to see them go ahead with things they plan and not just drop it without notice. And better planning and action on transitions from care.
- If siblings can't live together they should still have contact with each other. Try and keep the CSOs the same.
- Increased contact between children and CSOs/DOCS. Time frames met e.g. DOCS getting back to you. Transition from care should start earlier so you are fully prepared for your future when you leave care. MORE SUPPORT FOR CARERS.
- Just getting thing done and listen to what's best.
- Kids should say what they want and not be told at the last minute. You can't trust the dept.
- Leave the kids that don't want anything to do with the department alone and start supporting parents.
- Less change. Don't change CSOs so many times.
- Less meetings, less outside intrusions, not having to ask for permission for everything.
- Let me go to my friends, and when I ask for thing to be done it means NOW and not in two years, and buy me smokes.
- Listen to her and involve her in decisions.
- Listen to kids more and do things quicker.
- Listen to kids more and let them have their own say.
- Listen to, don't judge us because we come from a

What would you most like to see changed or improved to make the system better for kids? (young people)

bad background; give us respect and be honest.
- Listen very carefuly. Spend more time with children.
- Lose the word 'will'. More money for carers.
- More camps to be paid for. A big camp for all kids in care, and more CARERS!
- More contact from CSOs. More action from the department regarding permissions for requests.
- More help and talking to me when I came into care.
- More listening by each CSO and better understanding.
- More opportunities to have choices. Better communication between department and young person.
- More visitors and more details from them. Clothes and personal stuff I need.
- More visits with the caseworker. Change some rules so foster kids treated the same as other kids.
- My handwriting. That foster care was never mentioned. I want to be an *** not my real name.
- Nice CSOs. Same CSO.
- Not tell us what to do. Relate better. Communicate.
- Not to be intimidating. Making placements less traumatic. Ask me what I – no one ever has except carer.
- Nothing. Everything is clear for me now. Would just have liked to be told why I was taken in the first place.
- Own pets even in youth workers' houses.
- People listening. Transition plans done. Questions answered ASAP instead of months.
- People stop picking on me. Want to go home.
- See parents. A lot of CSOs not good. CSO should be coming out to the house. CSO to read history on the children before coming to meet the children
- Should ask children what they really need. Stop using the word "foster". Asked for years to bring Nana up from Sydney.
- Sleep over with friends for more than 48hrs. See my family whenever I want.
- Sports, more caring, putting siblings together.
- Stop taking so long to pay things, eg. TAFE fees. More information when entering care. More contact with CSO, eg. monthly.
- Support for children in care and financial support for those who need.
- Take in to account how the kids feel. And look closely at how the family runs together, how happy or sad they are and actually listen.
- Take less time to do things. Listen to kids more.
- Talk to parents more. Don't believe little kids over parents.
- Talk to the kids before making decision because they will get scared because they don't know what is happening.
- The Children's Services did what they say, and the CSOs didn't change as much.
- The department listen to children and be faster with requests made by children and young people.
- The department to listen to the kids more often. Ask what they would like to improve or change.
- The department would listen, and the CSOs were more educated and had more experience. (You can't learn how to fully understand and know how to take care of children by reading books!).
- The regional manager to stop being so stingy and stop acting like the money for normal stuff is coming out of his own pocket. Child Safety Queensland has a budget of over $110 million from what I have been told, so why is it such a battle to get things we need, eg. Learners, uniforms, enrolment fees, etc. This just isn't fair on the kids in care because we practically have to beg for things that normal kids get in the blink of an eye. Also the time that it takes to approve requests is unacceptable. We shouldn't have to miss out while they take their time. The last problem is that when one case worker is away, or the Manager, they don't have a system in place to fill the spot while they are on leave. This is unacceptable because sometimes it even brings things to a complete stand-still.
- They make things easier. They should at least make CSO come once a month.
- They need to understand us. They need to have more workers who have been in the position we have. I feel we are 'just their job'.
- Things to do. Chocolate smokes.
- To be treated as a normal child. Feel different, for instance can't see Mum or Dad. Feel isolated. Know they are out there.
- To go and see kids more often then they do. And listen and ring to see if you're okay.
- To help them and listen to them.
- To live with my mum and have a pool.
- Too many rules which don't make sense. Freedom from dept.
- Try to get with family.
- Visit and listen to kids more.
- When I ask for something I can get it. Pocket money.
- Work more with family. More workers so things happen more quickly.
- Workers ie CSOs allocated need to focus on needs of kids in care. Leave kids that are happy alone. Kick out lazy CSOs. Show more respect for views of kids in care. Time frame to address issues is too lengthy.
- Would like to see Mum and Dad, and more CSO workers to come out and visit and return my calls and not have over nine CSO in under two years.

Is there anything that you would really like to have happen that no one is listening to you about? (young people)

Family and friends

Reunifications

- Be with mum.
- Go back home.
- Go back to Mum and Dad.
- Go back to Mum.
- Go back to Mum.
- Go back to Mum.
- Go back to my mum.
- Go back to my mum.
- Go back to my parent.
- Go back to my parents quicker.
- Go home, but they won't listen or let me – it's like lock me in a prison or tower.
- Go home.
- Go home.
- Go home.
- Go home.
- Go home.
- Go home.
- Go home.
- Go to my mum.
- Going back to home to family.
- Going back to my dad (maybe).
- Going bact to Mum.
- Going home now.
- Going home.
- Going home?
- I want to go home to Mum.
- I want to go home.
- I would have preferred to go home at 16 but no one listened.
- I would like to go back to live with Mum.
- I would of like to go back to Mum earlier than 18.
- Listening but not happening. (Going to live with Mum).
- Live [with] Mum.
- Live back with Mum.
- Living with Mum.
- Living with my dad.
- Really want to live with Mum.
- Return to Mum.
- To go back to my Mum.
- To live with my mum.
- To live with my mum.
- To live with my parents.
- Want to go home.
- Want to return to Mum.
- Want to return to Mum.

An additional **5** responses are included under “Multiple themes”

Contact with birth parents

- Case worker take us to see our father (all of us).
- Contact with Dad.
- Contact with Mum more often.
- CSO to take us all to see our dad.
- Extra time with Mum.
- Finding my dad.
- Finding my father.
- Going to my mum's.
- Going to see Mum again.
- I want to see my mum more.
- I would like to see my mum.
- More time with Mum.
- More time with Mum.
- My mum is not listening. I would like to sleepovers with my mum.
- See Mum more.
- See Mum.
- Seeing my mum.
- Seeing my mum.
- Sleep over to start with parents soon.
- That mum comes with ***.
- To see Mum more often.
- To see my Dad.
- To see my dad.
- Visit Dad more most of the time.
- Visit my dad.
- Visits with mum.
- Want to see Dad.
- Want to see my mum.
- Want to see my mum.
- Wants to see Pa over Christmas but upset as he has dreams at night. On last visit Dad took him to M+ movie, blood, sex, killing, vomited in the toilet at the movies, ambulance almost called. *** wanted to see a kid's movie.

An additional **5** responses are included under “Multiple themes”

Contact with other family members

- Contact with my sisters.
- Get my grandmother's phone number.
- Get my son back.
- Go to ***.
- Going to *** and see my step family and my real family.
- Have a family get together.
- I want longer visits and more often.
- I want to see my brothers.
- I would like to see my brother in ***.
- More visits.
- Not allowed to go and sleep at Nanny and Poppy's house.
- See my brother and sister.
- See my brothers.
- See my real family.
- See relatives more often.
- Seeing my brother.
- Seeing my family.
- Sleep at Nan's more.
- Sleepover with little sister.
- To have sleepovers with my mum.
- Visits with sis.

An additional **10** responses are included under “Multiple themes”

Issues with friends/want to see friends more

- A big sleepover party!
- Friends don't listen sometimes.
- Have a friend over.
- Having friends over, sleepovers.
- Kids teasing.
- More time with friends, sleepovers.
- Relationship.
- Seeing friends at houses.
- Sleepovers.
- To see *** more often.

An additional **4** responses are included under “Multiple themes”

Material Assistance

Provision of money or resources

- A new motorbike.
- A PS3.
- A TV.
- Bigger motorbike.
- Buying me smoking.
- Can't get a mobile phone.
- Computer.
- Get a kitten.
- Get a motorbike.
- Getting computer.
- Have a DS.
- Have a spa and kitchen and a pool in my room.
- Having a house or pony or cat or rell.
- I can't get a phone.
- I need a laptop.
- I need a laptop.
- I want a big bed.
- I want a motorbike.
- I want my door lock fixed.
- Laptop.
- Laptop/shoes.
- Moblie phone.
- Money for needs.
- Motorbike chain.

Is there anything that you would really like to have happen that no one is listening to you about? (young people)

- My dog.
- My TV.
- New phone, laptop.
- Paddock basher to drive on property.
- Want a puppy.
- Wants a mobile phone.
- We want a car.
- Xbox in bedroom.

An additional **7** responses are included under "Multiple themes"

Medical/therapeutic attention
- Braces for teeth.
- Braces.
- Braces.
- Braces.
- Counselling.
- Getting my ears tested.
- I need braces for my teeth.
- I want braces.
- My speech therapy not happening.
- Tonsils.

Issues with care arrangements

Would like to live elsewhere
- Bigger house/unit with reasonable sized backyard.
- Get a bigger backyard.
- Go back to *** and ***.
- Go back to ***.
- I want to move out of care with my girlfriend.
- I want to move.
- I've been asking since last year. When am I getting out of the motel.
- Live with a member of my family.
- Move placement.
- Moving back to previous carer.
- Not being at boarding school.
- Stay with Aunty *** and Uncle *** in ***.
- To live on my own.
- Want to go back to previous carer.

An additional **2** responses are included under "Multiple themes"

Want to live with siblings
- For my brothers to live with us.
- Getting sister to live with me.
- I want my little brother to live with us.
- I want my sisters to live with me.
- Live with my brother and sister.
- Live with my sister.
- My bros coming back.
- My sister being transferred to me.
- The department won't listen about my brother and sister living with me.

An additional response is included under "Multiple themes"

Want carer to have guardianship
- Birth certificate with my carer's name on.
- Changing surname.
- Guardianship – Mum has too much control.
- Guardianship.
- I want to liver here but I don't want to be in foster care.
- LTG (Long Term Guardianship) to carers.

Conflict in household
- *** want to leave.
- Arguments.
- Grounding.
- Teasing from older boy at placement.
- Yelling.

Don't want changes to current care arrangements
- Not going back to Mum's because I'm scared.
- Not to live [with] Dad.
- Really want to stay here and not ever have to live with my father.
- Wanting to stay at this placement.

An additional response is included under "Multiple themes"

Permission and resources to participate in activities

Holidays, going places
- Holidays with carers.
- I want to holiday wherever Zac Efron lives.
- Me going to ***.
- Want to go out of state without having to ask the department.
- Wants to go on a holiday overseas

An additional **8** responses are included under "Multiple themes"

Sports
- Do more sports.
- Doing gymnastics.
- Go jet skiing. Ride a quad.
- Horse riding.
- Motorbike riding.
- Out of school sport.
- Sport (soccer).

An additional **2** responses are included under "Multiple themes"

Change appearance
- Asking for permission is stupid e.g. [getting] hair dyed. Got to ask for everything.
- Freedom on piercing.
- I want to get a tattoo.
- My belly button piercing.
- Wants body piercing.

An additional response is included under "Multiple themes"

Other/ not specified
- Driving car.
- Driving lessons.
- I would like to do more fun activities.
- Less restrictions.
- More responsibility over ratings over games and movies.
- To go to court.
- Wants to go to Underwater World.

An additional **2** responses are included under "Multiple themes"

Other

Issues with schooling
- Apprenticeship.
- Change schools.
- Moving school.
- My school mates annoy me.
- Not to be kept down a grade.

An additional **5** responses are included under "Multiple themes"

Other
- A new CSO but I haven't asked.
- Australian citizenship.

Is there anything that you would really like to have happen that no one is listening to you about? (young people)

- Be listened to.
- Changing some carers.
- Department never does anything.
- DNA.
- For my younger brothers and sisters to be placed together.
- Guns! Get rid of it. Not at this house. *** and *** do not have a gun.
- Have a party for ***.
- I don't need the department.
- I have a new CSO and this was the only thing.
- I think carer should get paid more.
- Leave me with carer and visit once a year.
- Less department involvement in decisions in long term placements.
- More help.
- More money for CREATE.
- Mother's visit to school not welcome by me.
- My family to be happy.
- My mum – some people listen to me.
- Not being slack and actually do their job properly.
- Not to be naughty.
- Stop people coming.
- To have more fun.
- To tell me the right answers.

An additional **3** responses are included under "Multiple themes"

Multiple themes

- Belly button peirced. A rip stick.
- Computer for schoolwork.
- Computer, horseriding, ice-skating.
- Except when they tell me I'm going back to Mum and it doesn't happen.
- Family excursions on holidays.
- Go back to my house and see the animals, and my room and get some more toys.
- Go back to Non's.
- Go see family in NSW.
- Go to *** and go to movies with mates.
- Go to *** for holiday with family.
- Go to Townsville to see my family.
- Going to Canada as an exchange student.
- I need more clothes and I want to live with my mum.
- I want to live with my dad and my brother to live with me.
- Laptop to learn more. Drivers license.
- Only a couple of people listen. Make sure my brothers and sisters dont go home.
- Ring my mum when I want and see my friends.
- School and family contact.
- See Mum and live with her.
- See my dad – live with him.
- See my mum and sisters and brothers at Southbank.
- To change accommodation. I want to live somewhere that I can have friends to. I live in a motel room now.
- To see Mum and Dad also *** and ***.
- Visit family in Darwin, Sydney and Tasmania.
- Want my Christmas presents from Mum.
- Wants to play soccer but teacher won't let her.
- Was not invited or allowed to attend my brother and sister's case plan.

Is there anything that you would really like to have happen that no one is listening to you about? (children)

Family and friends

Contact with birth parents

- Asked to see my mum more.
- Dad: like to see.
- For children to make decision about access with mums and dad.
- For Mum to arrangements when she is unable to pick child up from school.
- Going to my mum's to have a sleepover.
- Going to visit my mum.
- Have more visits arranged.
- Having sleepovers with my parents.
- How to get along at my Mum's with everyone.
- I want more ? And I want to see my mum and dad.
- I want Mum to stop asking for extra visits and asking to talk on the phone.
- I want to go to Mum's house more.
- I would like to visit my mum and dad every single day!
- Just the visits with the mother.
- See Mother more.
- See Mum more often.
- Seeing Dad.
- Seeing Mum.
- Spend time with my mum every day.
- Visit Dad in good.
- Visit with the mother. Jail visit can upset in this area.
- Want to talk to Mum.
- Want to talk to my mum privately.

An additional **2** responses are included under "Multiple themes"

Contact with other family members

- Didn't want to see step grandmother.
- Dont want little sister *** to go and have sleep-overs at home anytime.
- Don't want little sister *** to go home for sleepovers on Wednesday or any day.
- I don't want my sister to go home without me.
- I want my "sister" (cousin) to come home from hospital.
- I want to ring my other mummy. I don't get to ring her, but I get to ring my Grandma ***.
- I want to see my brother more.
- I want to stay with my brother and sister.
- I want to visit my brother but I can't because he lives far away.
- Talking on phone to sister.
- To see *** – from previous carer.
- Visit my old foster carers.
- Want to see my two (half) siblings.
- Would like to go to see Nanna more often.
- Would like to see my nan.

Is there anything that you would really like to have happen that no one is listening to you about? (children)

An additional **5** responses are included under “Multiple themes”

Reunification
- Be with Mum.
- Go back to Mum.
- Go home to Mum.
- Go to home.
- Going home.
- Going back to live with Mum but it isn't possible at the moment.
- Going back to Mum's house.
- Going home with Mum.
- Going home.
- Going home.
- I want my family back together.
- I want to go home.
- I would like to live with my mummy.
- Live with Mum and Dad again.
- Live with my family but my mother.
- Live with my mum and dad.
- Living with Mummy.
- Want to go home in June.

An additional response is included under “Multiple themes”

Peers and friends
- A girl at school don't believe anything I say.
- Go to my friends house.
- One of my friends at school doesn't listen to me.
- Phoning my friends.
- Play with ***, friend.

An additional **5** responses are included under “Multiple themes”

Material possessions

Computer or computer games
- A game I want.
- Can I please have a Ninetendo?
- Get an Xbox.
- More playstation games.
- My DS. I want more games.
- Want computer.
- Want laptop.

An additional response is included under “Multiple themes”

Food
- A big, big shop with lots of chocolate and lollies.
- I want bubble gum.
- I want more junk food.
- More ice cream. When I want more ice cream no one listens.
- More McDonalds.
- When we want chocolate.

Vehicles
- A new car.
- A ship.
- Get a new motorbike.
- Get a new moto.

An additional response is included under “Multiple themes”

Pets
- A new horse.
- Another puppy.
- I want another cat.

Other or not specified
- Like a guitar.
- Medical payment.
- Money birthday.
- Skateboard.
- Would like a lot more toys.

An additional **2** responses are included under “Multiple themes”

Participation on activities

Sports
- Drive a go cart.
- I want to go to my dancing group.
- I want to ride the 4 wheeler.
- I'd like to do gymnastics.
- Not allowed to swim in the pool as it is too cold.
- Play soccer near Woolworths.
- Swimming at the pool.
- Swimming.
- Want to ride horse.
- Wants to play sport

Holidays
- Go on a holiday.
- Go to New Zealand for a month.
- Going camping.
- Holidays.

An additional response is included under “Multiple themes”

Other or not specified
- Colouring in.
- Do more fun stuff.
- Excursions.
- Go to Brothers League Club for lunch.
- Going to the park.
- Going to the park.
- More birthday parties.
- Play more playstation.
- Play more.
- To save the world.

An additional **2** responses are included under “Multiple themes”

Issues with care arrangements

Want different carer or to live somewhere else
- Foster carers don't listen when I tell them someone is hurt.
- Going back to *** and *** because they give us porridge for breakfast and these people don't know how to play hide and go seek.
- Havent told anyone – Want to go to another placement because other kids are mean to me.
- I want to go to **** (place name) where my aunt and cousins are.
- Live in a castle.
- That *** (carer) wasn't mean.
- The CSO does not listen to me on where I want to live.
- Want to live somewhere else, with older young people in placement, as carer yelled and feel scared.

An additional **2** responses are included under “Multiple themes”

Changes to household membership
- I really want *** to stop being annoying.
- I would like to be alone sometimes in my room.
- Its not fair when the other kids cause a fight and I'm not able to say what happened and I get into trouble too.
- My own bedroom.
- That we are allowed to walk by ourselves to school.
- When I don't want to go to my room.

Is there anything that you would really like to have happen that no one is listening to you about? (children)

Permanency or guardianship for carer

- I want to know who I am going to be living with.
- I will like to have the name of my carer.
- I worry that *** will get taken away.
- I'd like to live with Nanna forever.
- Stay here forever.
- Want Mum to be my real mum all the time and live with her for ever.

Other

School

- I would like to go to a different school.
- Mum (carer) telling me I have to go to school.
- School sometimes.
- Show and tell for school.
- When I want to make something in my classroom my teacher does not listen.

An additional **6** responses are included under “Multiple themes”

Changes to self

- Being sad.
- Help him not to swear.
- My secrets.
- Not getting in trouble.
- Patience.

Other

- A cow flew over the moon.
- CSO to visit.
- More visits CSO.
- People don't believe me that I am Aboriginal.
- People try to involve me with bad stuff but the only people that listens to me are mostly just my friends.
- See a weather reporter.
- ***.
- They listening to me all the time about my harm.
- To stop Dad bashing Mum.
- When people talk to other people they dont listen: Wait turn.

Multiple themes

- Confused with school and children tackling.
- I need a new DS. See Mum.
- I really want to go on holidays to Grafton NSW with my brother.
- I want more friends. I have one friend, told teacher.
- Like if someone punches me in the knee at school.
- Like to go to Seaworld again at school.
- Like to live with my nan and sister.
- No one is listen when I say I want to live with Nana.
- Own house and car.
- People call me names at school.
- See my family.
- Sometimes they don't listen when I tell them a bully hurts me.
- To go shopping.
- Want to live with Dad. Want my brother *** to come and stay for holidays.

Notes

Notes

Notes

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commission for
children and young people
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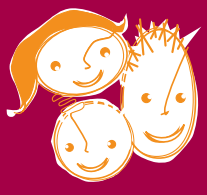
CCYPCG 09-488 JAN

Views of Young People in Residential Care

Queensland 2009

Child Guardian



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- officers of the Commission who designed the study, analysed the data and prepared the report.

Abbreviations

ADD	attention-deficit disorder
ADHD	attention-deficit hyperactivity disorder
ASD	autism spectrum disorder
ATSI	Aboriginal and/or Torres Strait Islander
CCYPCG	Commission for Children and Young People and Child Guardian
CMC	Crime and Misconduct Commission (Queensland)
CSO	Child Safety Officer
CV	Community Visitor
DChS	Department of Child Safety (Queensland) (renamed *Department of Communities (Child Safety)* in March 2009)
DETA	Department of Education, Training and the Arts (Queensland) (renamed *Department of Education and Training* in March 2009)
ESP	Education Support Plan
RACP	Royal Australasian College of Physicians
SD	standard deviation

commission for
children and young people
and child guardian

June 2009

Dear Minister

I am pleased to present you with the Commission's report *Views of Young People in Residential Care, Queensland, 2009*. This report details the Commission for Children and Young People and Child Guardian's latest survey of the views and experiences of young people in residential care.

This survey recognises that young people have important views which are valid and can be used by decision-makers, practitioners and researchers to improve the interventions and support provided to young people in the child protection and residential care systems.

Yours sincerely

Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

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Foreword

It is my pleasure to present the *Views of Young People in Residential Care, Queensland, 2009*. This report details the findings of the Commission's second survey of young people in residential care.

It is significant and timely that the release of this report coincides with the tenth anniversary of the 1999 Commission of Inquiry into the Abuse of Children in Queensland Institutions (the Forde Inquiry), a landmark public inquiry in Queensland that revealed the vulnerability of children and young people in residential facilities and youth detention centres to abuse and neglect. This inquiry was followed in 2003 by the Crime and Misconduct Commission's (CMC's) Inquiry into Abuse of Children in Foster Care, which exposed systemic abuse and neglect of children in foster care.

These inquiries have had a profound impact on Queensland's child protection and youth justice systems over the last decade and their influence continues to be felt today. Indeed, much of the impetus for the research presented in this report can be traced back to these inquiries. These inquiries made wide-ranging recommendations to improve independent systemic monitoring of the rights and wellbeing of children and young people in foster care, residential facilities and youth detention centres. They also identified the need for more effective mechanisms for children and young people in these systems to communicate their needs and experiences and to raise complaints about the services provided to them. In response to the findings and recommendations of these inquiries, the Commission's monitoring functions in relation to the child protection and youth justice systems were expanded and strengthened. An integral component of the Commission's systemic monitoring activities since 2006 has been the *Views of Children and Young People* surveys, incorporating the *Views of Young People in Residential Care* survey.

The *Views* surveys, as they have come to be known, explore the perceptions and experiences of children and young people in foster and kinship care, residential care and youth detention and monitor changes in these over time. Alongside other monitoring and performance data, the Commission believes that the views of children and young people, as expressed through these surveys, provide a critical perspective on the effectiveness of Queensland's child protection, residential care and youth justice systems. The survey findings presented in this report point to aspects of the child protection and residential care systems that are working well and to areas where improvements could and should be made in the interests of providing alternative care systems that genuinely meet the needs of young people, promote their current and future wellbeing, and uphold their legislated rights. For example, young people in residential facilities overwhelmingly reported that they feel safe and well treated and are satisfied with the support and advocacy provided by their Community Visitors. This is heartening, particularly in view of the earlier findings of the Forde and CMC inquiries. On the other hand, the

survey reveals that a significant minority of young people in residential care experience considerable instability and insecurity in their care arrangements, have unmet health and education support needs, and do not feel involved in important decisions related to their lives in care. Encouragingly, the survey findings reveal that progress is being made in some areas. For instance, over the past year there has been an increase in the proportion of young people who feel that they have a say in what happens to them.

The Commission will continue to work closely with the Department of Communities and other government and non-government agencies responsible for administering the child protection and residential care systems so that all children and young people in these systems can enjoy the kinds of positive life circumstances envisaged a decade ago when the reform of these systems was set in train by the Forde Inquiry.

I want to thank very much the young people who participated in the survey for their trust and courage in sharing with us their experiences and perceptions of life in residential care – for some, for a second time. I also appreciate the role that staff and carers in residential facilities played in making the survey possible by accommodating longer than usual visits and helping young people complete and return the questionnaires relating to the Community Visitors.

I encourage you to read this report and be challenged by what young people have to tell us about their lives in care and their views about what we can do better.

Elizabeth Fraser
Commissioner for Children and Young People and Child Guardian

Messages from the findings

The study

- This report presents the findings of the second *Views of Young People in Residential Care* survey. The survey captures the views, experiences and self-identified needs of young people living in Queensland's residential care facilities, providing a critical perspective on the health and effectiveness of the state's child protection and residential care systems.
- The survey was first conducted in 2007 and repeated in 2008. It forms part of the *Views of Children and Young People* survey series, a suite of research conducted by the Commission on a regular basis with children and young people in foster and kinship care, residential care and youth detention. The *Views* surveys contribute to knowledge about the needs and circumstances of children and young people in alternative care and youth detention, assist the Commission in monitoring the safety and wellbeing of these children and young people, and promote their social inclusion and participation.
- The residential care survey is made up of two self-report questionnaires. Community Visitors (CVs) administer the main questionnaire about young people's experiences of their care and accommodation. Residential care workers administer the second questionnaire about young people's satisfaction with their CV.

Respondents' characteristics

- A total of 221 young people responded to the main questionnaire, including 169 young people in the care of the Department of Child Safety (DChS). This represents 34% of the population of young people in the care of the department who were living in residential facilities at the time of the survey.
- Respondents came from all geographical regions of Queensland. They have a mean age of 15 years and almost two-thirds are male. Aboriginal and/or Torres Strait Islander young people make up just under a third of the sample. Comparison with available data on the Queensland residential care population suggests that the sample is representative.
- The survey highlights the relatively short-term and unstable nature of residential care for the majority. The median length of time respondents reported living in their current situation is 4 months and 85% have been there for less than 12 months. Respondents reported living in 2 different residential facilities on average while living in residential care for a total of 8 months on average. One in four reported having lived in 3 or more facilities. Just under half do not know where they will be going after their current accommodation concludes, and one in three is worried that they will have to move to another place in the next few months.
- The survey highlights the significant overlap between the residential care and child protection systems, with four out of five respondents reporting that they are currently in the care of DChS.
- Over three-quarters of those with a history of DChS care reported being in foster care previously. Reinforcing the emerging picture of unstable accommodation and care experienced by young people in this population, the median number of foster placements young people report, in addition to their placements in residential facilities, is 3. This is while reporting a median total of 3 years in DChS care. One in three reported having 6 or more foster placements.

Education, health and disability

- Consistent with the 2007 survey findings, one in five respondents reported having a health problem of concern to them, and one in four of these has not been able to see someone about the problem. In addition, one in three respondents reported having a health problem – other than attention-deficit hyperactivity disorder (ADHD) – for which they currently take medication. The most common reasons given for taking medication are anxiety/depression and asthma.
- As in 2007, one in five young people (21%) reported taking medication for ADHD. This implies a rate of medical diagnosis of ADHD in the residential care population at least two times that of ADHD prevalence in the Australian childhood population, underscoring the mental health and educational challenges faced by this cohort.

- Consistent with survey findings in 2007, one in four respondents (26%) reported having a disability, and 9% of these young people indicated that they have unmet support needs in relation to their disability. The most commonly reported disabilities are intellectual or learning disabilities, autism spectrum disorder (ASD) and ADHD.
- The survey findings reflect observations in the Australian and international research concerning the early disengagement of young people in alternative care from formal education. Almost half (44%) of respondents aged 16 years and over do not attend school, and of these two-thirds are not involved in any other training or education. For the sample as a whole, those in the care of DChS who are not attending school are more likely, however, to be engaged in other forms of training or education.
- The survey reveals instability in schooling for many respondents, with just under a third reporting 5 or more primary schools and a fifth reporting 4 or more secondary schools.
- The survey reinforces the observation made elsewhere that young people in alternative care commonly experience problems at school. One in three reported repeating at least one year of school and over half the sample (57%) reported being excluded from school at least once. Three in ten indicated that they currently have a problem at school that they have not been able to get help with.
- Respondents who have a problem at school that they have not been able to get help with are significantly more likely to report that they have a health problem of concern to them. This finding suggests the importance of a holistic response to the educational problems of young people in care.
- Just under half (45%) of those in DChS care who attend school reported having an Education Support Plan (ESP). This is only half the proportion of children and young people in DChS care who have ESPs or have these in development (90%) (DChS, 2009). One in two of those with an ESP regards it as helpful, suggesting that this initiative is going some way towards meeting the needs of this group.

Satisfaction with current living situation

- Consistent with observations reported for 2007, the survey found that a majority of respondents are reasonably happy with most aspects of their care and accommodation in residential facilities:
  - at least nine out of ten said that they feel safe and well treated, have workers who care about what is best for them all or most of the time, and get along with their workers all or most of the time, and
  - at least four out of five said they feel that their workers listen to or understand them all or most of the time, they have someone to talk to if they are worried about something, the premises are sufficiently clean, they have enough personal space and privacy, their belongings are treated with respect, and the rules and discipline in the facility are reasonable enough.
- Despite the generally positive view most respondents have of many aspects of their care, the survey reveals that almost half (44%) do not feel that they are better off since coming into their current living situation and almost half (47%) do not believe that things have improved for them in the last 12 months.
- As in 2007, the three areas that respondents least commonly expressed satisfaction with are:
  - having sufficient contact with their family
  - having a say in what happens to them, and
  - being able to do the same sorts of things that their peers outside the residential care system can do.

- This last item is reflected in young people's views about what they would most like to see improved in their current living situation. The most commonly desired improvement, expressed by at least one in four young people, is to have more flexible rules governing their behaviour and activities, enabling them greater independence and the option of doing what "normal" young people can do. This is often expressed in relation to participation in social activities, such as going out with friends or having "sleepovers".
- Multiple regression analysis confirms the importance of this issue to young people's sense of happiness in residential care. Being able to do what other young people can do is found to be a significant predictor of young people's happiness with their current living situation. Other significant predictors are having sufficient privacy and believing that things have improved for them in the preceding 12 months.
- Young people's satisfaction with their current living situation is found to vary significantly according to their age group and their DChS care status. Against a wide range of measures:
  - younger respondents tend to be less satisfied than older respondents, and
  - respondents in the care of DChS tend to be less satisfied than those not in the department's care.

The child protection system

- Overall, the survey found strong consistency in young people's views and experiences of the child protection system between the two years of the survey. As observed in 2007, young people in residential care have mixed feelings and experiences of the child protection system.
- The survey highlights that the experience of being in DChS care is often associated with frustrations for young people:
  - more than one in four feels they have to do things that they don't want to do – such as seeing people and attending meetings – all or most of the time
  - two out of five say that, all or most of the time, they are made to feel different because they are in care, and
  - three out of five say they are not confident that, when the department says they can do something or have something, this will eventuate.
- The survey found that young people in DChS care have varying experiences of being involved in or informed about decisions related to their care. Just under half (44%) do not feel that decisions about them are explained to them all or most of the time, and roughly a third (35%) report that the reason they came into care has not been explained to them. A majority are aware of having a case plan (60%), but less than a third (28%) know what is in their case plan, suggesting a lack of engagement by the majority of young people in this important sphere of decision-making about their care.
- The survey's findings on transition-from-care planning reinforce this impression. Although the department's policy stipulates that transition planning must start before a young person's fifteenth birthday, and that the young person must be centrally involved in this planning process, less than three in four young people aged 16 years or older reported that they have been spoken to about what will happen to their care situation when they turn 18. Less than half are aware of having a leaving care plan, and only one in three can report being involved in the development of that plan. The survey does reveal, however, a statistically significant increase from 2007 in the proportion of young people reporting that they have been spoken to about what will happen to their care situation when they turn 18.
- Young people's responses to questions about their Child Safety Officer (CSO) suggest that a majority have a reasonably positive relationship with their CSO. At least two out of three know the name of their CSO, feel that they can contact them all or most of the time if they need to, and feel that their CSO listens to them and cares about what is best for them all or most of the time. However, almost half (44%) would like to see their CSO more often.

- Factors that are found to contribute positively to young people's perception of their CSO as helpful are:
  - having a CSO who is contactable all or most of the time when needed
  - feeling confident in the department to follow through on promises, and
  - feeling that a CSO cares about their best interests all or most of the time.

  Dissatisfaction with the amount of contact young people have with their CSO is found to undermine their sense of the CSO's helpfulness.
- Against several measures, female respondents show a lower level of satisfaction with their experiences in the child protection system. Female respondents in DChS care also register a lower mean happiness score in relation to their current living situation than males in DChS care.

The *Young People's Views of their Community Visitor* survey

- A total of 146 young people in residential care responded to the CV satisfaction questionnaire. Comparison with available data on the residential care population suggests that the sample is broadly representative of this population.
- Respondents expressed a very high degree of satisfaction with their CV:
  - almost without exception, respondents said that their CV is nice, and listens to them and cares about what is best for them all or most of the time
  - more than nine out of ten see their CV monthly and three out of four are satisfied with this amount of contact, and
  - nine out of ten reported that they able to contact their CV all or most of the time when they need to.
- Young people rated the helpfulness of their CV very highly, with more than four in ten giving their CV a perfect score of 10 for helpfulness. One in two indicated that their CV has helped them with something in particular. The most common forms of assistance that young people identified their CV providing are help to:
  - obtain material goods and resources that they need, such as clothes
  - achieve better contact arrangements with their families, and
  - deal with problems that they have with their CSO or the department.
- The survey findings suggest that, from a service user's perspective, CVs are effectively achieving their legislated functions with regard to the residential care system.

Introduction

This report presents the findings of the Commission's second survey of young people in Queensland's residential care facilities. The survey is part of the Commission's *Views of Children and Young People in Care* survey series (the *Views* surveys) – an ongoing body of research capturing the views and experiences of young people in foster and kinship care, residential care and youth detention. The Commission conducts the *Views* surveys because it believes that the views and experiences of children and young people in alternative care and youth detention must be heard and seriously considered in order to continuously improve the effectiveness of Queensland's child protection and youth justice systems.

The purpose of the Views surveys

The *Views* surveys serve at least three important functions. First, they are a means of enabling the participation of children and young people in alternative care and youth detention. The 1989 United Nations Convention on the Rights of the Child, which the Australian Government has ratified and is committed to implementing within its borders, articulates a view of children and young people as having valid views and rights to be heard and to contribute meaningfully to decisions that affect their lives. The *Views* research reflects and models this perspective by providing children and young people with a forum in which to express their views and identify necessary reforms to alternative care and youth justice systems.

The second important function of the *Views* surveys is to contribute to knowledge about the needs and circumstances of children and young people in alternative care and youth detention, and how well these needs are being met. Such an evidence base is essential for dealing with the personal and social disadvantages that often underpin or accompany children and young people's entry into these systems. Through the *Views* surveys, children and young people in alternative care or detention can provide information about their personal backgrounds and indicate the type and extent of problems they have for which they have not been able to get assistance. They can also provide an invaluable perspective on the helpfulness and relevance of initiatives developed to meet their needs.

And, finally, the *Views* surveys serve as a mechanism for monitoring the safety and wellbeing of children and young people in alternative care and detention. Recent public inquiries in Queensland[1] have highlighted the enormous vulnerability of children and young people in the care of the state to abuse and/or neglect, and the importance of having effective mechanisms for them to communicate their needs and experiences and raise complaints about the services provided to them in order to reduce their vulnerability to such abuse. Through the Views surveys, children and young people can highlight interventions and practices that either enhance or diminish their safety and wellbeing. They can also raise issues of concern that they feel no one is listening to them about.

The *Views of Young People in Residential Care* survey

The *Views of Young People in Residential Care* survey provides an opportunity for young people in residential care to share their views and experiences of alternative care. It covers five main topics:

- respondents' characteristics
- health, disability and education
- satisfaction with current living situation
- views and experiences of the child protection system, and
- satisfaction with Community Visitors (CVs).

1 Most notably the 1999 Commission of Inquiry into the Abuse of Children in Queensland Institutions and the 2003 Crime and Misconduct Commission Inquiry into Abuse of Children in Foster Care.

In 2007, the Commission conducted its first survey of children and young people in residential care.[2] A total of 94 young people responded to the survey. The survey found that:

- respondents were generally satisfied with most aspects of their care
- young people particularly valued elements of the residential care lifestyle, the support and care they received from residential care workers, being able to have and make friends, and having access to material resources and opportunities not previously available to them, and
- improvements to residential care most desired by young people focused on three broad themes: improved provision of resources; greater independence for young people, including more say in decisions and case planning; and improved management of facilities.

This report presents the findings of the second survey of young people in residential care, conducted in the second half of 2008. A total of 221 young people responded to this survey. Minor modifications were made to the survey instrument in 2008 to improve the validity and reliability of data collected. As a result, not all findings can be compared directly with those of 2007. Wherever possible, such comparison is provided to enable changes and continuities over time in the circumstances and perceptions of young people in residential care to be assessed.

Report structure

The report is divided into four main sections:

Background defines residential care, outlines legislated standards for the provision of residential care in Queensland, explains the role of CVs in the child safety and residential care systems, and selectively overviews research on the needs of children and young people in alternative care.

Research design describes the methodology used in the study, the respondents, the development of the survey instruments, the procedures used, and how data have been analysed and presented. It also considers the strengths and limitations of the study's methodology.

Findings summarises young people's responses to the survey. It is divided into five chapters dealing with the survey's main topics. Each chapter starts with a summary highlighting the key messages.

Conclusions and future directions discusses some of the implications of the study's findings for improving Queensland's child safety and residential care systems and for the Commission's future work.

Machinery of Government changes

Since the Machinery of Government changes implemented in March 2009, the Department of Communities has been responsible for both residential care and child protection. However, at the time the data for this report were collected, child protection was administered separately by the former Department of Child Safety (DChS). The language of this report, like the surveys and responses, reflects the structural arrangements that were in place at the time of data collection; however, it should be noted that young people referred to as "in the care of the Department of Child Safety" would now be in the care of the Department of Communities.

2 The findings of the 2007 survey are published in *Views of Young People in Residential Care, Queensland, 2008* and in a "young person–friendly" version, *Your Views ... Residential Care, Queensland, 2008*.

Background

Defining residential care

The term "residential care" is used to refer to various types of alternative care settings. Its meaning has also changed significantly over time. For this reason, it is important to define residential care in the context of this report and the *Views* research.

The most common contemporary use of the term in Australia refers to the care of older children and young people in the custody or guardianship of the state government, living in small- to medium-sized group settings where the care is provided by paid staff, rather than foster or relative carers. This form of placement is often preferred for sibling groups who cannot otherwise be accommodated together, and for young people with higher support needs or challenging behaviours. This conceptualisation of residential care is consistent with the definition currently used by DChS:

> Residential care is care provided in a residential building, not a carer's own home, with support by paid staff to young people. This includes rostered staff models and group homes with live-in carers. Residential care involves small group care primarily for up to six young people aged 12 to 17 years with complex and extreme support needs, though it may also accommodate sibling groups with moderate to high support needs. (DChS, 2008b: 103)

This type of care can be provided as a long-term alternative to a placement in foster or kinship care, but it can also be for the purpose of providing a short- to medium-term program of intensive therapeutic and behaviour support to children and young people who have needs for such intervention after the trauma of abuse (DChS, 2008b).[3]

For the purposes of this report and the *Views* research, residential care is defined more broadly than this: residential care is the care provided to children and young people in what the Commission's legislation terms "visitable sites", with the exclusion of one particular type of visitable site – youth detention centres.[4] Visitable sites include any residence, apart from the homes of foster and relative carers, at which accommodation is provided to children or young people who are in the care of DChS. In addition to that described above, this includes the following forms of care and accommodation:

- *supported independent living facilities* (units or houses, usually), where young people aged 15 to 17 are transitioning from care to independent living; workers or carers do not live on-site but provide support to young people on an external basis
- *individual residential facilities*, where children and young people, usually with very high support needs, are cared for on an individual basis by specialist workers or carers, and
- *any other non-family-based setting that children and young people in the care of the department may be placed in*, including boarding schools, motels and youth shelters.

Visitable sites also include residential facilities that provide accommodation and care to children and young people who are not necessarily in the care of the department. These facilities include:

- *licensed mental health services* (including designated hospital wards), where children or young people may receive short- to medium-term psychiatric care
- *disability respite services*, where children and young people with disabilities may be accommodated, usually on a short-term basis, for the purposes of providing them, or their families or carers, with respite

3 This is a similar definition to that used in a benchmark study of residential care in New South Wales undertaken by the Association of Child Welfare Agencies (Flynn, Ludowici, Scott & Spence, 2005).

4 Visitable sites are referred to in s. 64a of the *Commission for Children and Young People and Child Guardian Act 2000*. They include detention centres, mental health facilities and residential facilities. "Residential facilities" is defined more specifically in Schedule 4 of the Act to include any place at which a child accommodation service is provided by a prescribed department or under funding provided by such a department or by the Commonwealth; under a licence under the *Child Protection Act 1999*; or to children in the custody or guardianship of the department.

- *youth shelters and refuges*, where young people who are homeless or at risk of homelessness can be accommodated on a short- to medium-term basis, and
- *any other publicly funded or supported accommodation for children and young people* – this can include housing and support provided to 15–17-year-olds as part of state or Commonwealth government homelessness programs, such as the Supported Accommodation Assistance Program, and housing and support provided for other specific purposes, such as youth justice programs.

Although the "visitable sites" definition of residential care is broader than that used elsewhere, a majority of children and young people who fit within the defined population (around 60%) are in the custody or guardianship of DChS and are cared for in either small-group or individual residential facilities or in externally-supported independent accommodation. In addition, while the population includes all age groups under 18, the vast majority are aged 10 years or older. For this reason, members of the residential care population and respondents to the survey are referred to throughout this report as "young people", rather than "children and young people".

Standards for residential care in Queensland

A central focus of the *Views of Young People in Residential Care* survey is young people's perception of the quality of care and accommodation provided to them. Also under consideration is the adequacy of specific supports provided to them (for example, disability, educational, health-related, transitioning to independence) and the respecting of their rights to various things, such as privacy and having input into decisions that affect them. To help frame this research focus and identify a benchmark from which to evaluate young people's responses to survey items, it is necessary to understand what legislated rights children and young people in residential care in Queensland have and what standards of care they should be able to expect.

No one set of service user rights and standards of service delivery applies across the spectrum of residential facilities described above. Various pieces of legislation regulate the care and delivery of services to children and young people in different contexts of residential care. The most significant of these is the *Child Protection Act 1999*, which concerns the treatment of children and young people in the child protection system. In addition, the *Mental Health Act 2000* specifies the appropriate care and treatment of people in mental health facilities, and the *Disability Services Act 2006* outlines principles for the delivery of disability services and the rights of people with disabilities receiving such services.

Rights and standards of care under the Child Protection Act 1999

The *Child Protection Act 1999* outlines requirements for the care, support and protection of children and young people in the child protection system. It specifies 11 standards of care that children and young people should be able to expect (s. 122):

- the child's dignity and rights will be respected at all times
- the child's needs for physical care will be met, including adequate food, clothing and shelter
- the child will receive emotional care that allows him or her to experience being cared about and valued and that contributes to the child's positive self-regard
- the child's needs relating to his or her culture and ethnic grouping will be met
- the child's material needs relating to his or her schooling, physical and mental stimulation, recreation and general living will be met
- the child will receive education, training or employment opportunities relevant to the child's age and ability

- the child will receive positive guidance when necessary to help him or her to change inappropriate behaviour (this excludes the use of corporal punishment or punishment that humiliates, frightens or threatens the child in a way that is likely to cause emotional harm)
- the child will receive dental, medical and therapeutic services necessary to meet his or her needs
- the child will be given the opportunity to participate in positive social and recreational activities appropriate to his or her developmental level and age
- the child will be encouraged to maintain family and other significant personal relationships, and
- if the child has a disability – the child will receive care and help appropriate to the child's special needs.

In addition to these standards, the Act specifies a "charter of rights for a child in care" (s. 75) and establishes 11 rights for children and young people in the custody or guardianship of the department (Schedule 1). These are the rights to:

- be provided with a safe and stable living environment
- be placed in care that best meets the child's needs and is most culturally appropriate
- maintain relationships with the child's family and community
- be consulted about, and take part in making, decisions affecting the child's life (having regard to the child's age or ability to understand), particularly decisions about where the child is living, contact with the child's family and the child's health and schooling
- be given information about decisions and plans concerning the child's future and personal history, having regard to the child's age or ability to understand
- privacy, including in relation to the child's personal information
- regular review of the child's care arrangements if the child is under the long-term guardianship of the chief executive
- have access to dental, medical and therapeutic services necessary to meet the child's needs
- have access to education appropriate to the child's age and development
- have access to job training opportunities and help in finding appropriate employment, and
- receive appropriate help with the transition from being a child in care to independence, including, for example, help with housing, access to income support, and training and education.

Rights of children and young people in mental health facilities

The appropriate care and treatment of children and young people in mental health facilities is detailed in the *Mental Health Act 2000*. Although the primary focus of the legislation is meeting the health needs of individuals with mental illnesses, various principles for the treatment of those subject to the Act are articulated (s. 8). These include:

- their ownership of the same basic human rights as other people, including the right to respect for their dignity and human worth, and their right to confidentiality of information about themselves
- that their age-related, gender-related, religious, cultural, language, communication and other special needs should be taken into account, and
- that, as far as practicable, they should be
  - encouraged to take part in making decisions affecting their life, especially decisions about treatment

- provided with the necessary support and information to enable them to exercise their rights under the Act
- helped to achieve maximum physical, social, psychological and emotional potential, quality of life and self-reliance, and
- given the opportunity to continue to participate in the community and maintain supportive relationships

Rights of children and young people in disability respite facilities

The *Disability Services Act 2006* sets out service user rights (ss. 18–19) and service delivery principles (ss. 20–33) for disability services in Queensland. As with the Mental Health Act, the Disability Services Act affirms that people with disabilities have the "same human rights as other members of society" and should be empowered to exercise these. First, it emphasises general rights – rights to:

- respect for their human worth and dignity
- realise their individual capacities for physical, social, emotional, cultural, religious and intellectual development
- live lives free from abuse, neglect or exploitation, and
- participate actively in decisions affecting their lives, including the development of policies, programs and services.

Second, it outlines specific rights that people with disabilities have when using disability services. These include:

- being supported to achieve quality of life in a way that supports their family unit and their full participation in society
- receiving services in a way that results in minimum restriction of their rights and opportunities
- receiving services in a way that respects confidentiality of their personal information
- receiving services in a safe, accessible built environment, appropriate to their needs, and
- being provided with support and access to information to enable them to participate in decisions affecting their lives.

These "disability rights" underpin service delivery principles that are subsequently articulated at length in the Act (ss. 20–33).

Recurrent themes across these pieces of legislation that frame the delivery of residential care services to young people in Queensland are the rights of service users to be treated with dignity and respect, to be involved in decisions that affect their lives, and to receive support to meet their specific needs (emotional, health, educational, developmental, disability, and so on) so that they can ultimately achieve the greatest possible level of independence and quality of life. Collectively, these legislated rights and standards provide a clear rationale for the research focus in the *Views of Young People in Residential Care* survey. They also provide an important reference point for assessing the study's findings.

The role of Community Visitors in the child safety and residential care systems

One focus of the residential care survey is young people's views of their CV. Young people are asked about their frequency of contact with their CV and their perceptions of their CV's qualities, availability and helpfulness. As background to this component of the research, it is important to outline the legislated functions of CVs and what young people in residential care should be able to expect from their CV.

The Community Visitor Program is a core component of the Commission's monitoring activities in relation to the child protection and residential care systems. Under the *Commission for Children and Young People and Child Guardian Act 2000*, CVs are required to visit every child in the custody or guardianship of DChS on a "regular and frequent" basis to monitor their safety and wellbeing. In addition, they are required to conduct regular and frequent site visits of all small-group homes, detention centres, mental health facilities, disability respite and other residential facilities that accommodate children and young people (collectively known as "visitable sites") to assess the safety and wellbeing of these children and young people and the quality of care and accommodation provided. In undertaking their responsibilities, CVs have a range of powers to enter premises and gather information from parties.

The Act specifies the functions of CVs in some detail (ss. 67–68). Their role and responsibilities in visiting children and young people and visitable sites are:

- to develop trusting and supportive relationships with the child or young person
- to advocate on behalf of the child or young person by listening to, giving voice to, and facilitating the resolution of, their concerns and grievances
- to facilitate the child or young person's access to support services that they need
- to assess the adequacy of information given to the child or young person about their rights
- to assess the physical and emotional wellbeing of the child or young person
- to inspect the site and assess its appropriateness for the accommodation of the child or young person or the delivery of services to them, having regard to relevant state and Commonwealth laws, policies and standards (not least of which, the standards of care stipulated in the *Child Protection Act 1999*)
- to observe the treatment of the children, including the extent to which their needs are met by staff of the sites
- to assess the morale of the staff of the sites, and
- to give advice and reports to the Commissioner about anything relating to the CV's functions and powers.

CVs are required to complete a report for the Commissioner after each visit with a child or young person in DChS care and after every site visit. Where serious matters affecting the safety or wellbeing of a child or young person are identified, the Commission is required to take immediate action to protect the child or young person. Other problems may be dealt with at a local level in the first instance (that is, with the service provider or the local service centre of DChS).

Based on this specification of the role and responsibilities of CVs, young people in residential care should be able to expect regular and frequent contact with their CV. They should find their CV attentive to their safety and wellbeing and the quality and adequacy of care being provided to them. They should find their CV caring, trustworthy, supportive, understanding, prepared to listen to them, and willing and able to help them with a range of things, including information about their rights; resolving grievances with service providers or DChS; accessing support and resources that they need; and achieving any other improvements in their living environment that are necessary for their safety or wellbeing.

Needs of young people in care

The *Views of Young People in Residential Care* survey explores various areas in which young people may have problems and need specific support (education, health, disability and leaving care). The focus on these issues reflects known vulnerabilities and risks experienced by this population. To justify this research focus and contextualise the research findings, it is useful to review some of the Australian and international research on the needs of young people in alternative care, specifically their educational, health and leaving care needs.

Education

Australian and international research highlights that children and young people in state care more commonly experience a range of educational challenges and disadvantages resulting from their experiences both before and after entry into care. These disadvantages can have serious, negative effects on their long-term social and economic wellbeing.

Research in Australia and the United Kingdom has found that children and young people in state care are less likely on average than other children to continue their education beyond the minimum school leaving age and are more likely to leave school with lower levels of academic attainment (Biehal, Clayden, Stein & Wade, 1992; Stein, 1994). A recent study involving analysis of administrative data across a number of Australian states and territories (Australian Institute of Health and Welfare, 2007) found that children and young people on custody and guardianship orders were considerably less likely than other children and young people to achieve national benchmarks for reading and numeracy. Indigenous children and young people in care were found to have even lower numeracy and literacy scores than other children and young people in care. In the UK, Biehal et al. (1992) found that poor educational attainment of care leavers was more pronounced among young people leaving residential care than among those leaving foster care.

In addition to poor educational achievement, children and young people in care often experience learning and behavioural difficulties at school. Repeating a grade at school has been identified as a more common experience for children and young people in care. While the rate of repeating a year at school in Australia has been estimated at 5.3% (Stone, 1997), in New South Wales between 10% and 30% of children and young people in care are reported to have repeated a year of school (NSW Community Services Commission, 2000). A Victorian study of children and young people in home-based and residential care found a considerably higher incidence of learning difficulties, behavioural problems and intellectual disabilities in this cohort than for the Victorian childhood population (de Lemos, 1997). Another Victorian study of 497 children and young people in residential care found that nearly 50% of the sample had experienced frequent episodes of truancy and school exclusion (Cavanagh, 1996, cited in CREATE Foundation, 2002). Similarly, it has been observed in the UK that children and young people in care experience school exclusion 10 times more commonly than their peers (Social Exclusion Unit, 1998, cited in Dearden, 2004).

There are various explanations given for the poorer educational engagement and outcomes of children and young people in care. These include traumatic experiences before coming into care, resulting in a range of emotional, behavioural and physical health problems that affect performance at school (Veltman & Browne, 2001). Low expectations of carers and teachers have also been identified as a factor, as has the social stigma of being in state care detracting from children and young people's sense of comfort and social inclusion at school (Stein, 1994). Another factor is the greater level of disruption to schooling commonly experienced by this cohort, some of which has been identified as a direct result of statutory interventions (Biehal et al., 1992; CREATE Foundation, 2002; Delfabbro, Barber & Cooper, 2000). Stein (1994) argues that a prioritisation of welfare over education and the low priority often given to education by child protection caseworkers increase the likelihood of such disruptions.

The NSW Commission for Children and Young People, in its submission to the Special Commission of Inquiry into Child Protection Services in NSW (Cashmore, Scott & Calvert, 2008), outlines various factors identified in Australian research as effective in improving the educational engagement and outcomes of children and young people in alternative care. These include:

- statewide agreements between education and community service departments that are implemented at a local level, resulting in interdisciplinary cooperation to support children and young people at school
- individual education plans for all children and young people in care, with a designated person responsible for overseeing that plan
- continuity in schooling, and
- extra support to children and young people at home and at school by mentors, tutors and support teachers.

Health

Children and young people in state care are more likely to experience a range of health and developmental problems (Nathanson & Tzioumi, 2007). Often these are related to past experiences of abuse or neglect (Chernoff, Coombs-Orme, Risley-Curtiss & Heisler, 1994; Simms, Dubowitz & Szilagyi, 2000; Takayama, Wolfe & Coulter, 1998) and/or to disruptions in their care and development associated with statutory care (Cashmore et al., 2008).

Health problems often include both physical and mental health problems. A NSW study of the health needs of 80 children and young people in care aged 4 to 17 found that the coexistence of multiple physical health problems was common (Nathanson & Tzioumi, 2007). Over half the sample were not up to date with immunisations, 20% had vision problems, 30% had dental problems, 25% failed a hearing test, 21% experienced skin problems and 12% had respiratory and ear infections. Over two-thirds of the under-5-year-olds failed a developmental assessment, and half of this group showed delayed speech development. In addition, behavioural and emotional problems were identified in over half the children and young people assessed, and for 9% of the sample these were regarded as significant mental health problems.

Other Australian research has found that children and young people in care experience significantly poorer mental health outcomes than those who have never been in care, and a significant minority experience complex psychological and behavioural problems (Bromfield & Osborn, 2007). One of the most comprehensive of these studies, undertaken by the University of Newcastle with 347 4–9-year-olds residing in foster and kinship care in NSW, found levels of mental disturbance in the sample rarely seen in non-clinical populations:

> Children in care in NSW present with exceptionally poor mental health, with more than half of boys and girls reported as having clinically significant psychiatric disturbances. The poorer mental health of older children in care is largely explained by older age at entry into care. Children manifest complex psychopathology, characterized by attachment difficulties, relationship insecurity, sexual behaviour, trauma-related anxiety, conduct problems and defiance, and inattention/hyperactivity, as well as uncommon problems such as self-injury and food maintenance behaviours (Tarren-Sweeney & Hazell, 2006: 96).

The authors argue that it is important for medical practitioners "to consider these problems in their entirety, rather than as discrete disorders", and that "providing psychological support for the children and their carers is an essential secondary prevention strategy" (Tarren-Sweeney & Hazell, 2006: 96).

Two common difficulties identified in meeting the health needs of children and young people in care are the lack of medical history that accompanies children and young people when they enter care, and difficulties with the recording and transfer of information about their health status and

needs, particularly where there are frequent changes in placement and in caseworkers (Cashmore et al., 2008). Cashmore and colleagues argue that to address this serious area of disadvantage experienced by children and young people in care, comprehensive health and developmental assessments need to be undertaken when they enter care, with follow-up monitoring of these needs.

Leaving care

Since the mid-1980s, a considerable body of research has emerged in Australia, the UK and North America pointing to the significant challenges facing young people in alternative care transitioning to independent adult life, and their trajectories after leaving care.[5] A consistent finding in this research is that young people in care transition to independence on average more rapidly and at an earlier age than their peers (Stein, 2006). Although most of their peers will have the option of returning home repeatedly in the transition to independence, leaving care is a final event for these young people, without the option of returning in times of difficulty (Stein & Dixon, 2006). In this regard and others, care leavers typically have fewer social and economic supports than their peers in the transition process and often carry the additional handicaps of lower educational attainment and unresolved mental and/or physical health problems. Specific groups of care leavers have been identified as facing additional challenges and disadvantages, including young people from minority ethnic backgrounds and young people with disabilities (Stein, 2006).

Many young people leaving care thus face hardship and trauma in the journey to independence and experience poorer social and economic outcomes. Compared with their peers who have not been in care, young people leaving care have been found to be at considerably greater risk of experiencing homelessness, unemployment, poverty, early parenthood, substance abuse, poor mental and physical health, involvement in crime, imprisonment and juvenile prostitution (Cashmore & Paxman, 1996; Maunders, Liddell, Liddell & Green, 1999; Mendes & Moslehuddin, 2006; Tweddle, 2007).

Although this picture is quite stark, care leavers are a heterogeneous group and some experience far fewer difficulties in the transition to independence than others. Using a resilience framework, Stein (2005, cited in Stein 2006) identifies three different groups of care leavers with varying levels of success in transitioning to independence. The most successful group (the "moving on" group) is characterised by having had more stability and continuity in their lives, including secure attachment relationships. Young people in this group are more likely to have achieved some educational success before leaving care. Their preparation for leaving care is more gradual and planned, and they leave care later, on average, than other care leavers. The "survivors" group is less successful in transitioning from care. They have experienced significant instability and discontinuity in their lives but can benefit from effective after-care supports provided. The "victims" group is the least successful in transitioning from care. This group has experienced the most damaging pre-care family experiences, followed by an often-disrupted care and educational experience. Young people in this group are more likely to have significant social and emotional problems that have not been alleviated during care, and that are unlikely to be easy to overcome with after-care support. Stein's analysis suggests that leaving care programs need to be flexible and broad enough to cater to young people with varying degrees of vulnerability and need (Mendes & Moslehuddin, 2006). It also underscores the importance of creating stable care and educational environments for children and young people who enter care after an experience of abuse or neglect.[6]

5 Useful summaries of the leaving care research include Tweddle (2007), Mendes & Moslehuddin (2006), Stein (2006) and McDowall (2008).

6 In their research with care leavers in Australia, Cashmore and Paxman (2006) found similarly that a sense of security, stability, continuity and social support were strong predictors of better long-term outcomes for young people leaving care.

The importance of providing adequate and appropriate support to care leavers, and ensuring that thorough planning goes into this transition process, is increasingly recognised by governments around the world, with a range of initiatives and policies emerging that are designed to address the needs of care leavers (McDowall, 2008; Tweddle, 2007). There is evidence in Australia and elsewhere, however, of a shortfall between policy and practice in this area (McDowall, 2008; Stein & Dixon, 2006). In 2008, for example, the CREATE Foundation undertook a comprehensive review of policy and legislation in Australian states and territories in relation to supporting young people transitioning from care (McDowall, 2008). Although the report found that much effort had gone into the formulation of legislation and policies to meet the needs of care leavers, formal requirements did not necessarily translate into actions, or into actions that genuinely assisted young people.

This brief review of some of the Australian and international research on the needs and vulnerabilities of children and young people in alternative care provides an important foundation for the study's focus on the quality and adequacy of support that young people in residential care experience with their education, health and transition to independent adult life. It also provides a strong rationale for investigating young people's engagement in and views about the usefulness of government initiatives designed to address these specific needs and vulnerabilities.

Research design

The residential care survey uses a self-report survey method to capture the views and experiences of young people in Queensland's residential care system. The survey is repeated at regular intervals with cross-sections of young people in residential care, using a common set of survey questions. This repeated cross-sectional design allows changes to be monitored over time, such as changes in the proportion of young people who report feeling safe in residential care. To capture young people's views on emerging issues, surveys may be broadened to include questions not asked in previous surveys.

Respondents

Most young people who were in residential care between September and October 2008 were invited to participate in the survey (for the scope of "residential care", see the definition in *Background*). Some groups of young people were excluded from participation in the survey, however, in the interests either of their wellbeing or of generating valid and reliable data. These groups are young people:

- in mental health facilities whose state of mental health at the time of the survey was deemed too vulnerable by their healthcare practitioners to permit safe participation
- who, on account of age or disability, were unable to understand the purpose or content of the survey or provide meaningful responses
- in mental health or disability respite services who are not in the care of the department and have not resided at the facility, or are not likely to reside there, for at least 2 months.[7]

A total of 221 young people completed the *Young People's Views of Residential Care* questionnaire, 169 of whom reported being in the care of DChS. This corresponds to a response rate of 34% for the cohort of the residential care population in DChS care ($N = 503$ at the starting date of the survey). The size of other cohorts of the population is unknown and difficult to estimate with any accuracy because care and accommodation in certain facilities (that is, disability respite centres, acute mental health facilities and youth refuges) tends to be very short term and irregular. For this reason it is not possible to specify a survey response rate for these segments.

The CV Program estimates that young people in the care of DChS make up 60% of the residential care population.[8] On the basis of this estimate, the DChS care cohort is over-represented in the sample obtained, with 79% per cent of respondents indicating they are in DChS care. This over-representation is likely to have resulted from the exclusions specified above, which disproportionately pertain to young people not in DChS care.

The *Young People's Views of their Community Visitor* questionnaire was returned by 146 young people. No information was gathered about whether respondents were in DChS care, so it is not possible to calculate a reliable response rate for this questionnaire.

Instruments

The survey comprises two self-report questionnaires with a mix of fixed-response (quantitative) and open-response (qualitative) questions:

- the *Young People's Views of Residential Care* questionnaire, comprising 86 fixed-response and 61 open-response items, and
- the *Young People's Views of their Community Visitor* questionnaire, comprising 15 fixed-response and 11 open-response items.

7 These two subgroups are children and young people who are primarily cared for by their own families with very short-term visits to residential facilities. The survey instruments and data analyses assume a more stable or continuing participation in the residential care system or at least ongoing involvement in the child protection system.

8 Estimate based on Site Report data, July to November 2008.

These survey instruments were based on those originally developed in 2007, with a number of minor modifications made to improve the quality of data collected. The 2007 instruments were developed in consultation with young people living in residential facilities and children and young people in the care of the department living in other settings, such as foster and kinship care. With necessary permissions from the DChS and the Department of Communities, children and young people were invited to participate in various focus groups held around Queensland. Participants were told about the purpose of the survey and encouraged to talk about what they thought the Commission should know about being in care. Focus group transcripts were collated and analysed to identify key themes and issues for inclusion in the survey.

Children and young people in the child protection system have direct or indirect contact with a range of government agencies, so these agencies were also consulted about the survey content. Agencies consulted include the DChS, the Department of Communities, the Department of Education, Training and the Arts, Disability Services Queensland, the Queensland Department of Housing and the Department of Justice and Attorney-General.

Survey questions were written to take account of the varying literacy and language abilities of young people in alternative care. As far as possible, the survey instruments use everyday language, short sentences and basic punctuation.

The survey questions covered the following topics:

- *Respondents' characteristics* – including demographic characteristics, alternative care history and current living situation.
- *Health, disability and education* – including current health and educational problems and disability support needs, and the extent to which these needs are being met; and participation in initiatives designed to address health and educational disadvantages.
- *Satisfaction with current living situation* – including respondents' sense of safety, stability and happiness; relationships with workers and co-residents; general treatment and living conditions; contact with family and community; sense of having a say and being listened to; what respondents like most about where they are living and what they would most like to see improved or changed.
- *The child protection system* – including experiences of being in DChS care, satisfaction with the department and their Child Safety Officer (CSO); involvement in decision-making, such as the development of case plans and transition from care plans; and awareness of advocacy services.
- *Satisfaction with CV* – respondents' satisfaction with the support and advocacy provided by their CV.

Procedure

Questionnaires for each young person in residential care were distributed to CVs. CVs administered the *Young People's Views of Residential Care* questionnaire during their scheduled monthly visits to residential sites. Young people were told that participation in the survey was voluntary and that they could withdraw from the survey at any time if they wanted to. Young people could elect to have their CV help them complete the questionnaire or to complete it on their own. CVs explained to them that the survey was confidential but that, if they disclosed information indicating that they or someone else had been harmed or were at risk of harm, the CV might not be able to maintain their confidentiality in the interests of ensuring the safety or wellbeing of those involved. Young people who elected to complete the questionnaire themselves were given a reply-paid envelope for returning the questionnaire confidentially to the Commission.

To aid consistency of survey administration across the state, all CVs visiting residential facilities (n = 105) were given a detailed survey administration guide, including explanatory notes for individual questionnaire items to ensure consistency of interpretation. In addition, a training

package was developed to assist CVs with survey administration, including techniques for administering the survey without biasing young people's responses. This training was delivered by Zonal Managers of the CV Program who, together with the research team, provided supervision and support to CVs in their survey administration role.

CVs gave the *Young People's Views of their Community Visitor* questionnaire to young people, together with a reply-paid envelope, to complete on their own or with the assistance of residential care staff. CVs provided residential care staff with survey administration resources to help them conduct the survey as consistently as possible and to avoid inadvertently biasing young people's responses.

The research team reviewed every questionnaire returned to the Commission for possible concerns for respondents' safety or wellbeing. Where respondents indicated that they did not feel safe where they were living or that they were being harmed or were at risk of harm, information about the young person was provided immediately to the CV Program. Where possible, young people's information was used to identify them for purposes of providing follow-up or, in serious cases, for notifying DChS (as the Commission is required to do under s. 20 of the *Commission for Children and Young People and Child Guardian Act 2000*).

Data analysis

In this report, survey data are mostly presented as proportions (percentage of respondents) and in some cases as medians or means (average of respondents) or as frequencies (number of respondents).[9] The margin of error for proportions is approximately $\pm 7\%$ when calculated from the whole sample ($n = 221$). Most graphs in this report have error bars to indicate the margin of error.[10]

Between-group analyses were performed to determine if responses to selected questions differed between the 2007 and 2008 surveys or according to respondent characteristics such as sex, cultural background, age group or DChS care status. Depending on the type of data, these analyses used chi-square, Mann–Whitney U or Kruskal–Wallis statistical tests, with all tests using a 95% confidence level (that is, $p \leq 0.05$). The term "significant" is used in this report to indicate that the difference between two or more groups was sufficiently large that it was unlikely to have occurred by chance.

Multiple regression analysis was used in two cases to explore the influence of a range of predictor variables on respondents' answers to questions – specifically, their happiness in their current living situation, and their perception of their CSO's helpfulness. In the absence of theoretical foundations for hypothesising possible explanatory variables, a selection of predictors that were moderately correlated with these dependent variables (that is, happiness or perceived helpfulness) was included in the multiple regression models. Because of variation in the views and experiences of young people of different ages, cultural backgrounds and sex, these variables were controlled for by being entered in the first step of the regression analysis. The remaining predictors were entered in the second stage. The confidence level for identifying significant predictors was again set at 95%.

Respondents' open-ended comments were analysed using a thematic approach. Young people's comments were reviewed and coded into underlying themes. It must be noted that, while respondents' comments provide a rich insight into problems that may be affecting young people in residential care, they are not necessarily representative of the views of the majority of young people in residential care. Respondents' level of motivation or interest in commenting on a

9 Data were analysed using the Statistical Package for the Social Sciences (SPSS), version 15.

10 Margins of error (95% confidence intervals) were calculated using the Wilson method and software developed by Lowry (2008).

particular issue and their literacy ability are likely to play a role in their completion of open-ended questions. To help with the interpretation of this data, the report first indicates how many respondents gave an answer to each open-ended question, to provide the reader with a sense of the reliability of the data. For example, where a very large proportion of the total sample responded to an item, the likelihood is greater that the breadth of themes relevant to the survey item will have been captured. The report then indicates how many respondents gave an answer associated with each theme, allowing the reader to identify the most common themes. Coding qualitative data can be inexact and subjective, however, so percentages should be regarded only as a rough measure of response frequency.

Strengths and limitations

A primary goal of this research is capturing the subjective experiences, perceptions and needs of young people and identifying changes in these over time. Surveys are the most suitable method for gathering this type of information and undertaking such analyses. The supportive mode of survey administration described, the option of confidential self-completion if desired, and the design of instruments to accommodate the literacy abilities of the cohort further enhance the study's capacity to capture these data. Self-report surveys are also very effective for achieving another research goal – the participation of young people in alternative care. CVs often relay to the Research Team their observation that children and young people enjoy completing the surveys and having a say about their lives in care. Seeing their own words in print, and being given their own copy of the research findings in a "young person–friendly" report format, further engages their interest and conveys to them that what they say matters and makes a difference.

The research team took various steps to address some of the inevitable limitations of self-report surveys. To reduce the impact of recall biases, CVs helped young people wherever possible to complete items collecting factual data, such as the number of placements respondents have had in alternative care, their age at entering care, and the length of their residency in a facility. Where respondents could not recall details accurately, CVs encouraged them to draw on other available sources of information to improve the accuracy of information reported. To reduce the impact of subjective interpretations of survey items by survey administrators and respondents, CVs and residential care staff were given a detailed survey administration guide, which included explanatory notes for individual questions. Another possible limitation of surveys is that they provide respondents with a predetermined set of questions and response options that are designed and analysed by a researcher. Therefore they do not necessarily capture a complete record of a respondent's views and experiences. In recognition of this possible limitation, focus groups were conducted to inform the development of survey questions and a large number of open-response fields were included so that a richer picture of respondents' views and experiences could emerge. Making CVs available as scribes for respondents further enhances the survey's capacity to capture this richness, particularly where respondents' literacy ability may prevent them from conveying their views as fully as they wish.

Other limitations in the study's methodology that should be acknowledged are more specific to the residential care survey. These include the following:

- The survey data may not adequately represent the views and needs of young people who are most dissatisfied with their experience of alternative care. CVs report that this group of young people are particularly difficult to engage in the survey because of their level of disenchantment with the care system and their cynicism about the value of participating in such research.
- The survey data do not adequately represent the views and needs of very young children in residential care and children and young people with disabilities that prevent them from either understanding the survey questions or responding adequately or meaningfully to them. It is difficult to know with any accuracy what proportion of the residential care population falls into these categories; however, CVs report that the prevalence of disabilities such as autism

spectrum disorder (ASD) and severe learning and attention-deficit difficulties are quite significant in the population.

- The survey is not able to explore variability in the views and experiences of young people across the very different contexts of residential care, because of the small number of respondents in certain contexts, such as boarding schools, supported independent living and mental health and disability respite facilities. However, one important contextual difference that is explored in the 2008 survey, because of the larger sample size, is the difference between the experiences of young people in residential care who are in DChS care and those who are not in the care of the department.

Findings

This section of the report presents the findings of the residential care survey. It is divided into chapters, corresponding to the five broad topics covered in the survey. These topics are:

- respondents' characteristics
- health, disability and education
- satisfaction with their current living situation
- views and experiences of the child protection system, and
- satisfaction with their CV.

Each chapter starts with a summary of key messages emerging from the research.

Respondents' characteristics

A total of 221 young people living in residential care responded to the *Views of Young People in Residential Care* questionnaire, including 169 young people in the care of DChS. This represents 34% of the population of young people in the care of the department who were living in residential facilities at the time of the survey. This chapter summarises respondents' demographic characteristics and aspects of their alternative care history and current living situation. Sample data are compared with available population data to assess the representativeness of the sample.

Key messages

- Respondents came from all geographical regions across Queensland. They have a mean age of 15 years and almost two-thirds are male. Aboriginal and/or Torres Strait Islander young people make up just under a third of the sample. Comparison with available data on the residential care population suggests that the sample is representative of this population.
- The survey findings reflect the policy shift in recent decades away from large institutional forms of residential care, with almost a quarter of young people being cared for on an individual basis. Of those living with other young people, the median number of co-residents is 2.
- The survey highlights the relatively short-term and unstable nature of residential care for the majority. The median length of time respondents reported living in their current situation is 4 months and 85% have been there for less than 12 months. Respondents reported living in 2 different residential facilities on average, while living in residential care for a total of 8 months on average. One in four reported having lived in 3 or more facilities. Just under half do not know where they will be going after their current accommodation concludes, and one in three is worried that they will have to move to another place in the next few months.
- The survey highlights the significant overlap between the residential care and child protection systems, with four out of five respondents reporting that they are currently in the care of DChS.
- Over three-quarters of those with a history of being in DChS care reported being in foster care previously. Reinforcing the emerging picture of unstable accommodation and care experienced by young people in this population, the median number of foster placements young people report, in addition to their placements in residential facilities, is 3. This is while reporting a median total of 3 years in DChS care. One in three of these young people reported having 6 or more foster placements.

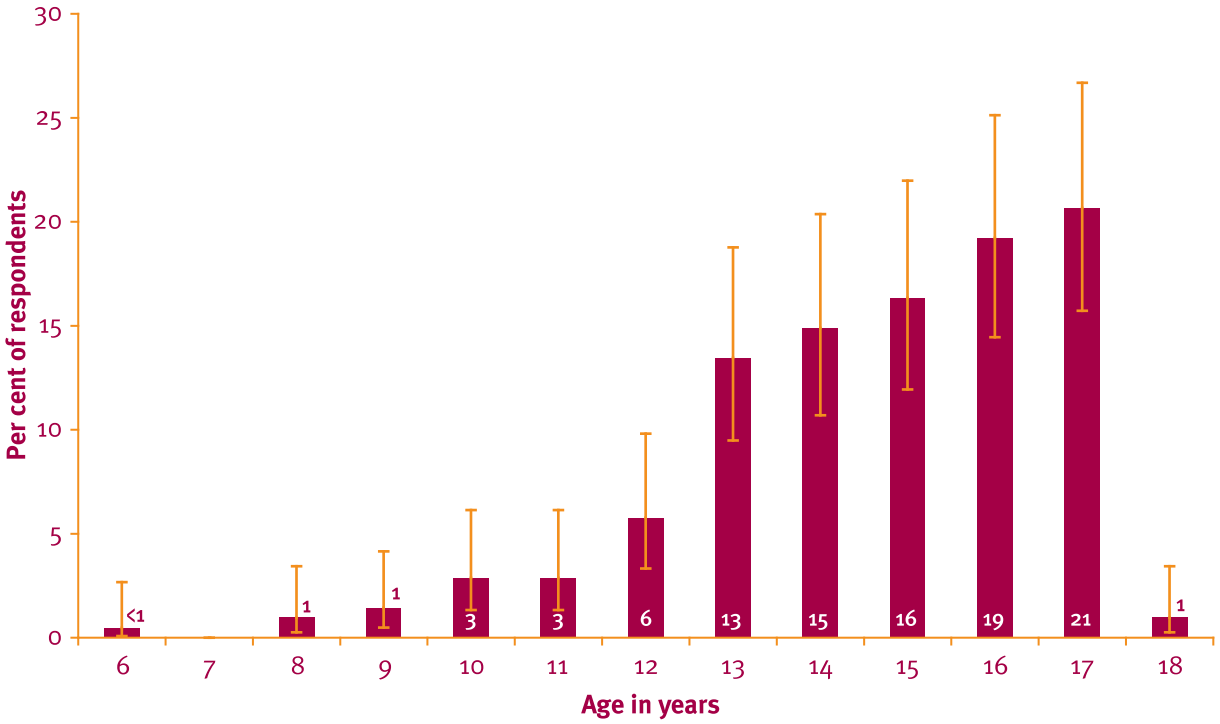
Demographic characteristics

Sex and age

Sixty-two per cent of respondents are male and 38% are female. They range in age from 6 years, 7 months to 18 years, 10 months. The distribution of age is skewed towards the maximum, with the mean age being 15 years, 0 months (median = 15 years, 3 months) (see Figure 1).

Figure 1

Respondents' age (*n* = 208) (2008)



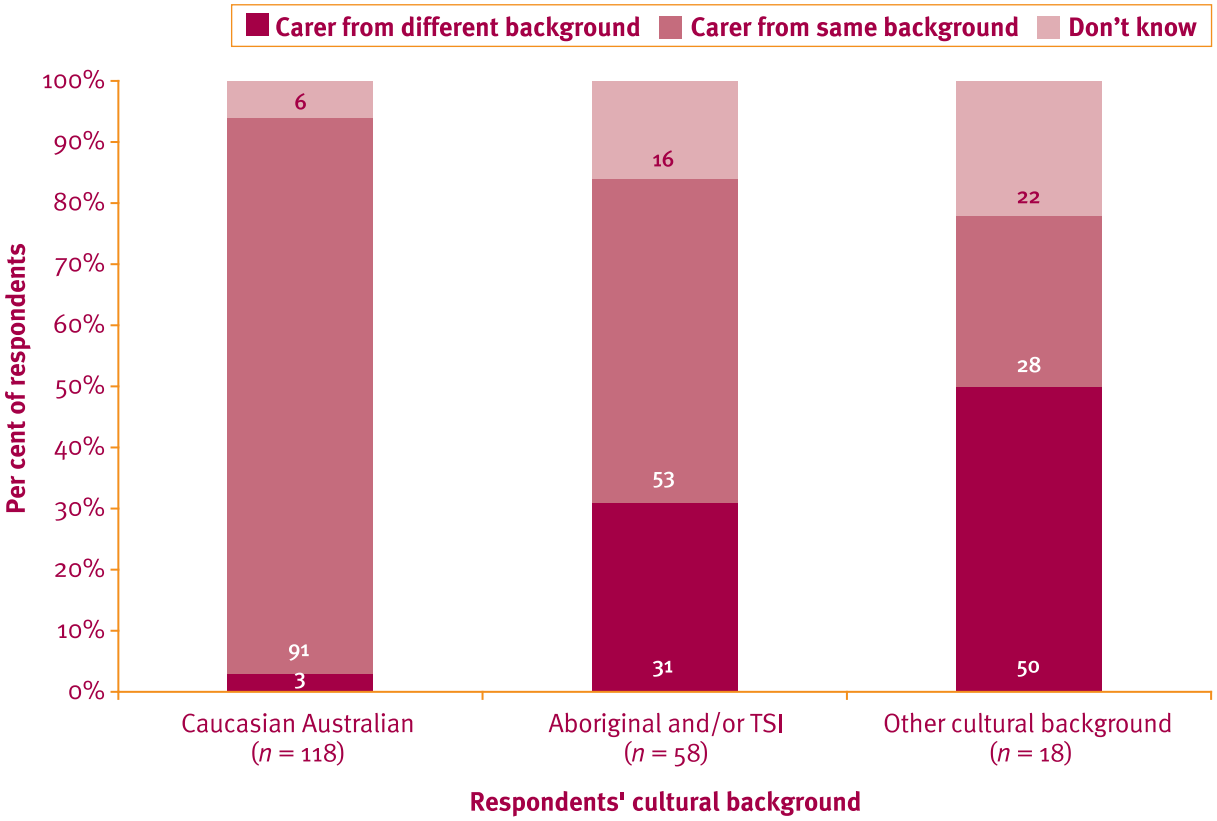
Cultural and linguistic background

Sixty per cent of respondents identify as Caucasian Australian. Twenty-seven per cent identify as Aboriginal, 1% as Torres Strait Islander and 3% as both Aboriginal and Torres Strait Islander. The remaining 10% of respondents, who reported having "other" cultural backgrounds, come predominantly from Europe or the Pacific region, mainly New Zealand.

Ninety-four per cent of respondents reported being born in Australia and 96% said that English is the main language spoken by their birth parents. Fifteen per cent of respondents reported that they do not have a carer from the same cultural background as themselves, and a further 12% do not know if their carer has the same cultural background as themselves. Responses varied by cultural background; Aboriginal and/or Torres Strait Islander respondents and those from "other" cultural backgrounds stated more commonly than Caucasian Australian respondents that they are not cared for by someone of the same cultural background (31% and 50%, compared with 3% – see Figure 2).

Figure 2

Carer from same cultural background by respondents' cultural background (2008)

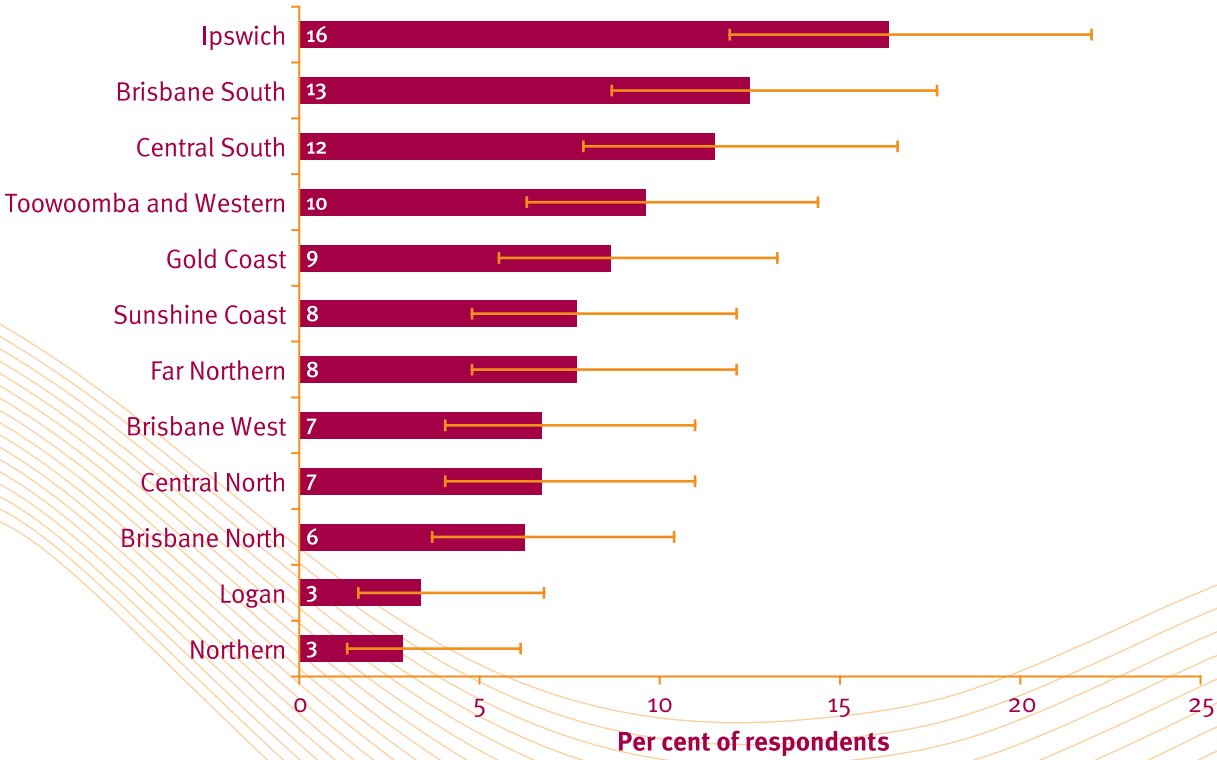


Geographical location

All 12 geographical regions (Community Visitor Zones) are represented in the sample. The largest representation is from the Ipswich Zone (16%), followed by Brisbane South (13), Central South (12%) and Toowoomba and Western (10%) – see Figure 3.

Figure 3

Respondents' geographical location (Community Visitor Zone) (*n* = 208) (2008)



Sample and population comparison

Reliable population data are only available for the cohort of the residential care population that is in the care of DChS, so it is not possible to determine absolutely how representative the sample obtained is. However, when the demographic characteristics of respondents in the care of the department are compared with population data for those in DChS care visited by the CV Program, the sample obtained in relation to this considerable component of the residential care population very closely reflects population parameters for age, sex, cultural background and geographical location (see Table 1). This suggests that the sample obtained is broadly representative of the residential care population.

Table 1

Demographic characteristics of young people in residential care: sample and population (2008)

Characteristic	Total sample	Young people in DChS care	
		Sample	Population
Total number	221	169	503
Age (mean)	15 y, 0 m	14 y, 8 m	14 y, 6 m
Sex			
Male	62% (128/207)	66% (107/161)	66% (332/503)
Female	38% (79/207)	34% (54/161)	34% (171/503)
Born outside Australia	6% (13/210)	5% (9/164)	Not available
Parents' main language not English	4% (9/206)	4% (7/160)	Not available
Cultural background			
Caucasian Australian	61% (118/195)	59% (89/151)	Not available
Aboriginal	27% (50/195)	27% (40/151)	24% (115/489)
Torres Strait Islander	1% (2/195)	1% (2/151)	2% (9/489)
Aboriginal & Torres Strait Islander	3% (6/195)	3% (5/151)	1% (6/489)
Other cultural background	10% (19/195)	10% (15/151)	Not available
Geographical location (Community Visitor Zone)			
Brisbane North	6% (13/208)	7% (11/162)	7% (34/503)
Brisbane South	13% (26/208)	6% (10/162)	10% (53/503)
Brisbane West	7% (14/208)	9% (14/162)	8% (38/503)
Central North	7% (16/208)	5% (8/162)	7% (34/503)
Central South	12% (24/208)	11% (18/162)	6% (28/503)
Far Northern	8% (16/208)	10% (16/162)	12% (61/503)
Gold Coast	9% (18/208)	6% (10/162)	11% (57/503)
Ipswich	16% (34/208)	20% (33/162)	13% (64/503)
Logan	3% (7/208)	4% (7/162)	6% (32/503)
Northern	3% (6/208)	2% (3/162)	7% (37/503)
Sunshine Coast	8% (16/208)	7% (12/162)	7% (37/503)
Toowoomba and Western	10% (20/208)	12% (20/162)	6% (28/503)

History in residential care

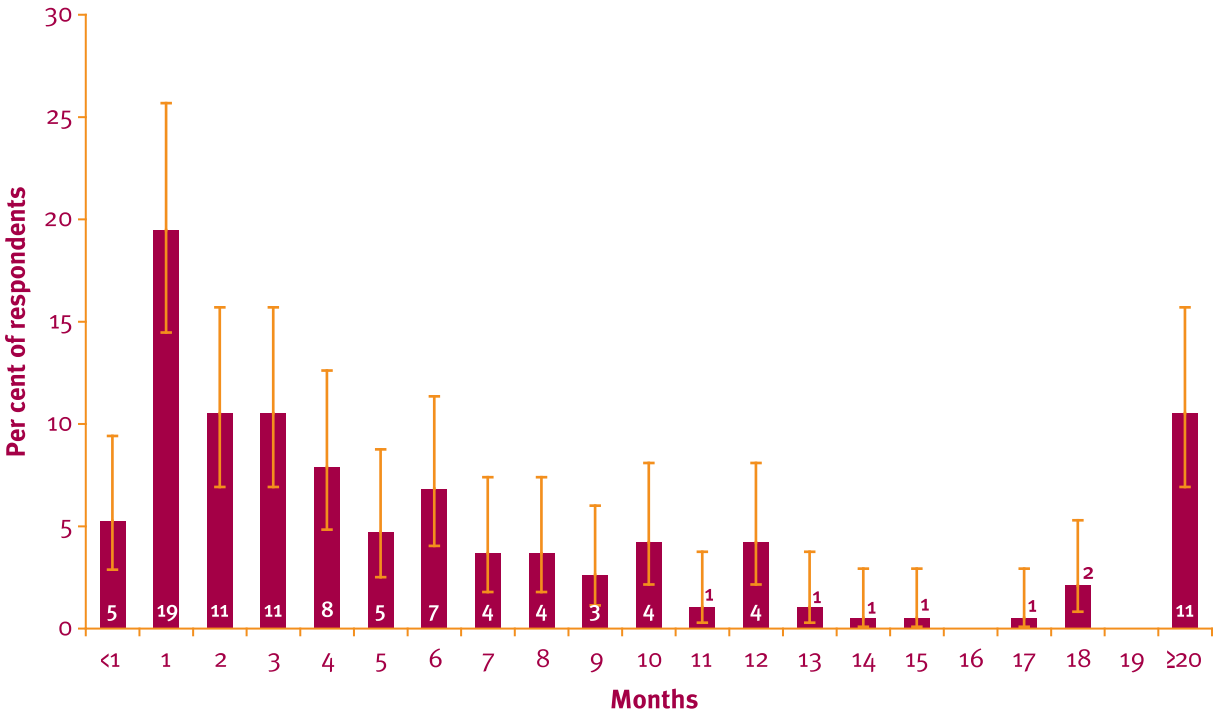
Respondents were asked various questions about their history in residential care. Those in the care of the department were then asked further questions about their history in the child protection system. These two sets of respondents' characteristics are described here and in the following subsection. Summary descriptive statistics for respondents' alternative care history are presented in Table 3, at the end of that subsection.

How long have you been living here?

The most common length of time respondents reported living in their current accommodation is 1 month. Half of the sample reported living in their current accommodation for 4 months or less and 85% have lived there for 12 months or less. The distribution of time in current accommodation is positively skewed (see Figure 4), with the maximum length of time a respondent reported living in their current accommodation being 8 years.

Figure 4

Length of stay in current living situation (*n* = 190) (2008)

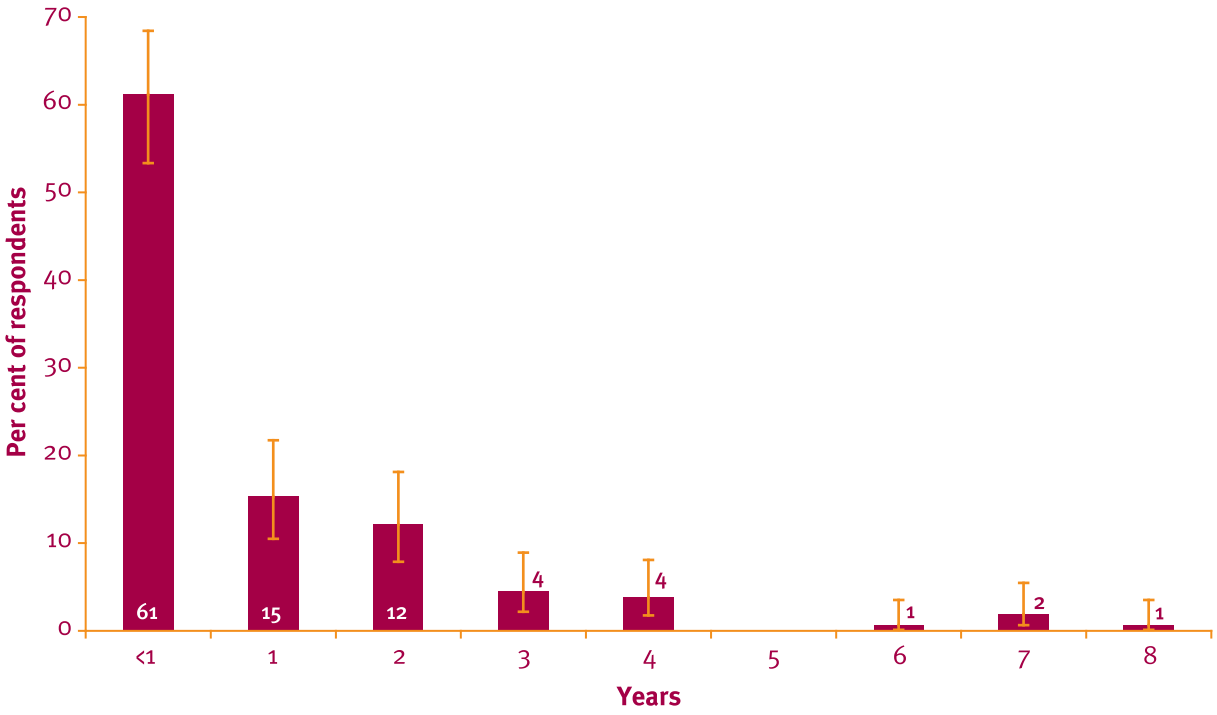


How long have you been living in residential facilities altogether?

The median length of time respondents reported living in residential facilities is 8 months. The distribution of time spent in residential facilities is positively skewed (see Figure 5), with the maximum length of time a respondent reported living in residential care being 8 years, 6 months. Twenty per cent of respondents do not know how long they have been living in residential facilities.

Figure 5

Total time lived in residential facilities (*n* = 157) (2008)

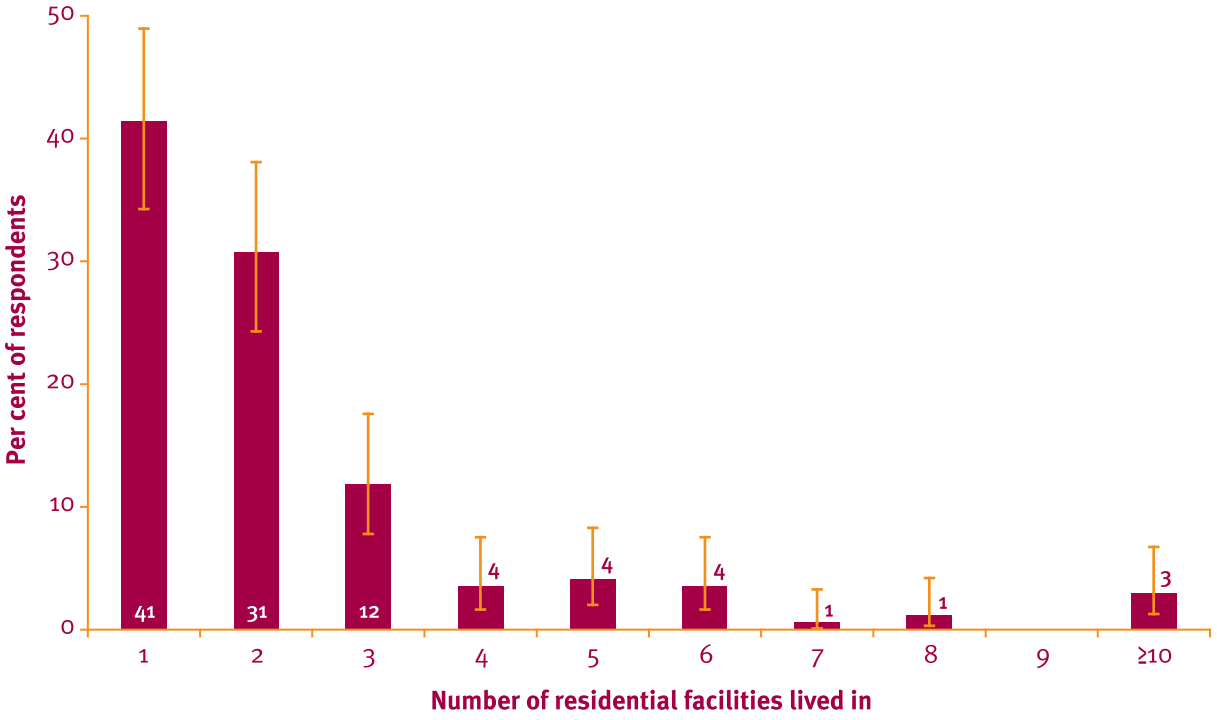


How many different residential facilities have you lived in altogether (not counting respite or foster care)?

The median number of residential facilities respondents reported living in is 2. Twenty-eight per cent of respondents indicated having lived in 3 or more different facilities. The distribution of number of facilities lived in is positively skewed (see Figure 6), with the maximum reported number of facilities being 40. Sixteen per cent of respondents do not know how many different facilities they have lived in, with several writing comments such as "too many to count" and "heaps" beside their answer. This suggests that the sample statistics presented here may be an under-representation of the instability respondents have experienced.

Figure 6

Number of different residential facilities lived in (*n* = 169) (2008)

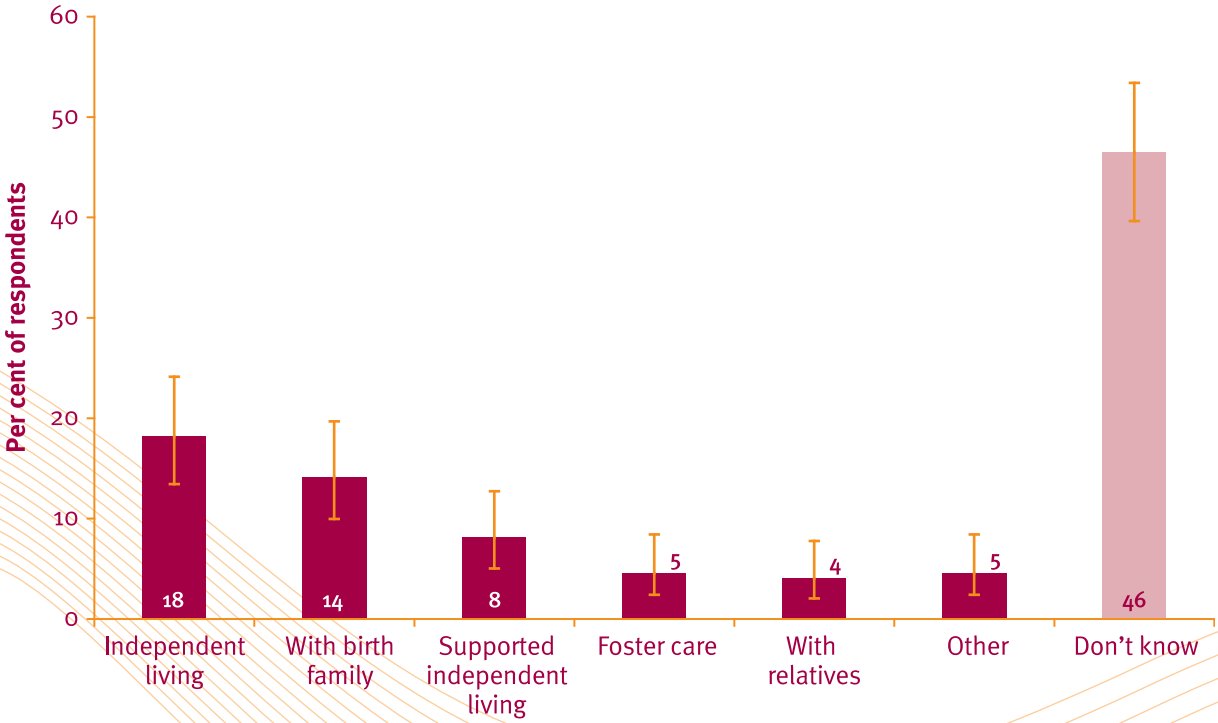


Where will you be going after your time here?

Forty-six per cent of respondents do not know where they will be going in the future, 26% believe they will be exiting to independent or supported independent accommodation, 14% think they will be returning to their birth family, and 9% per cent anticipate they will be going into foster or kinship care (see Figure 7).

Figure 7

Where respondents anticipate living next (*n* = 198) (2008)



History in DChS care

Current DChS care status

Seventy-eight per cent of respondents reported that they are currently in the care of DChS. A further 3% indicated that they have previously been in the department's care. Respondents in the department's care are younger on average and more likely to be male (see Table 2).

Table 2

Characteristics of respondents by DChS care status (2008)

Characteristic	All respondents	In DChS care	Not in DChS care
Mean age	15 y, 0 m	14 y, 8 m	16 y, 5 m*
Age group			
12 years or younger	14% (30/208)	16% (26/162)	9% (4/46)*
13 to 15 years	45% (93/208)	56% (90/162)	6% (3/46)
16 to 18 years	41% (85/208)	28% (46/162)	85% (39/46)
Sex			
Male	62% (128/207)	66% (107/161)	46% (21/46)*
Female	38% (79/207)	34% (54/161)	54% (25/46)

* Represents a statistically significant difference between respondents in DChS care and those not in care.

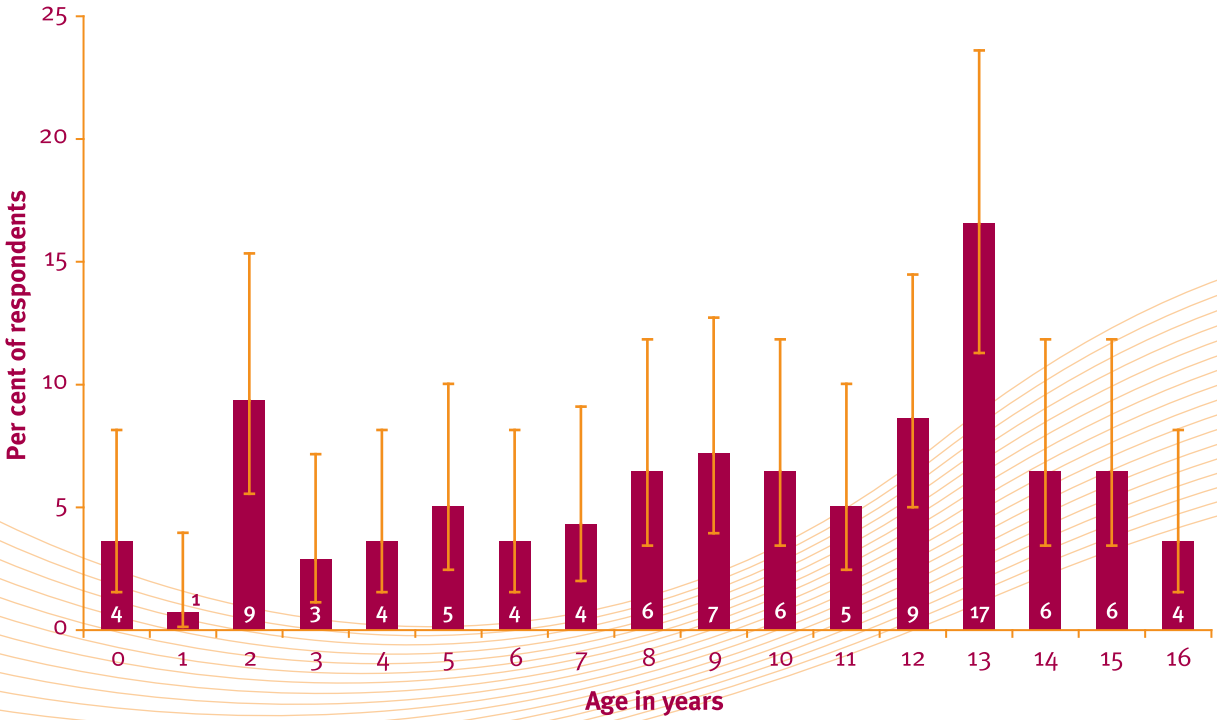
All respondents with a history of DChS care were asked the following questions:

How old were you when you first came into the department's care?

The median age at which respondents reported entering the department's care is 10 years, 0 months. Figure 8 shows the distribution of respondents' ages at commencement of DChS care. An evident peak in the distribution is 13 years of age. Fifteen per cent of respondents with a history of being in the department's care do not know how old they were when they first came into care.

Figure 8

Age at commencement of DChS care (*n* = 139) (2008)

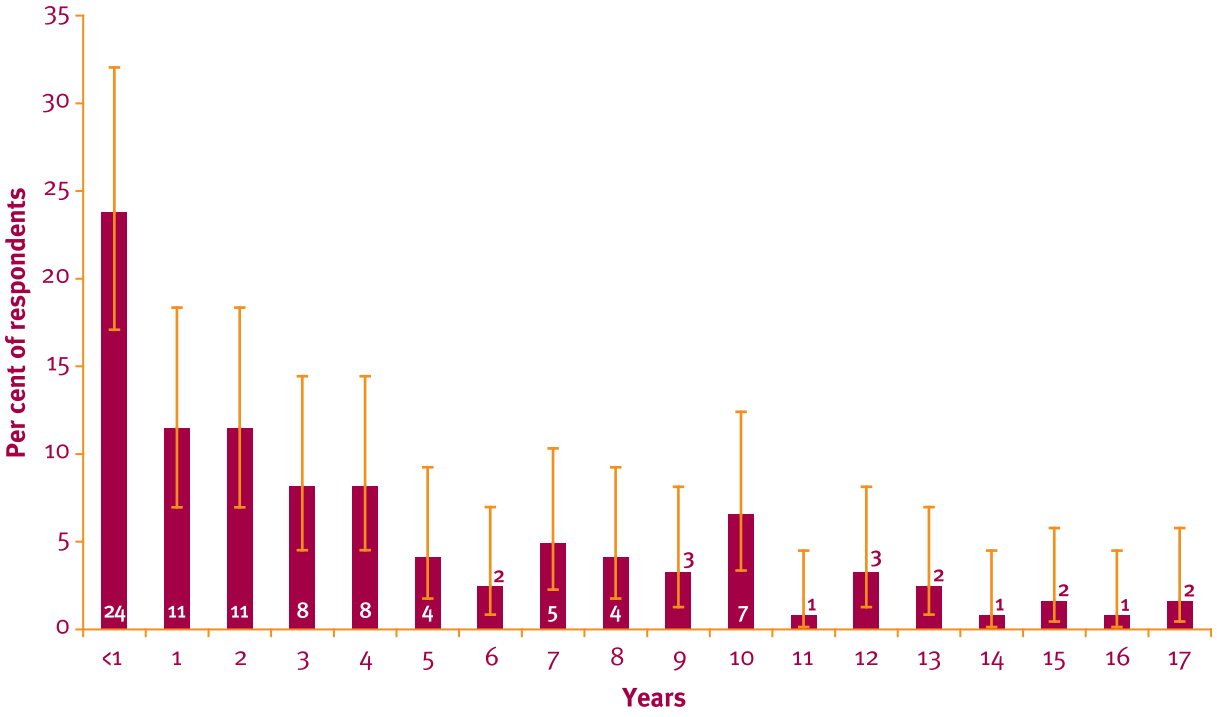


How long have you been in the department's care altogether?

The median length of time respondents reported being in the department's care is 3 years, 0 months, but 24% of respondents have been in DChS care for less than 1 year. The distribution of time spent in DChS care is positively skewed (see Figure 9), with the maximum length of time a respondent reported being in DChS care being 17 years, 3 months. Twenty four per cent of respondents with a history of being in the department's care do not know how long they have been in the department's care altogether. Some wrote comments about being very young at the time of entering care, but are unable to state how old they were at this time.

Figure 9

Total time in DChS care (*n* = 122) (2008)



Have you ever been in foster care?

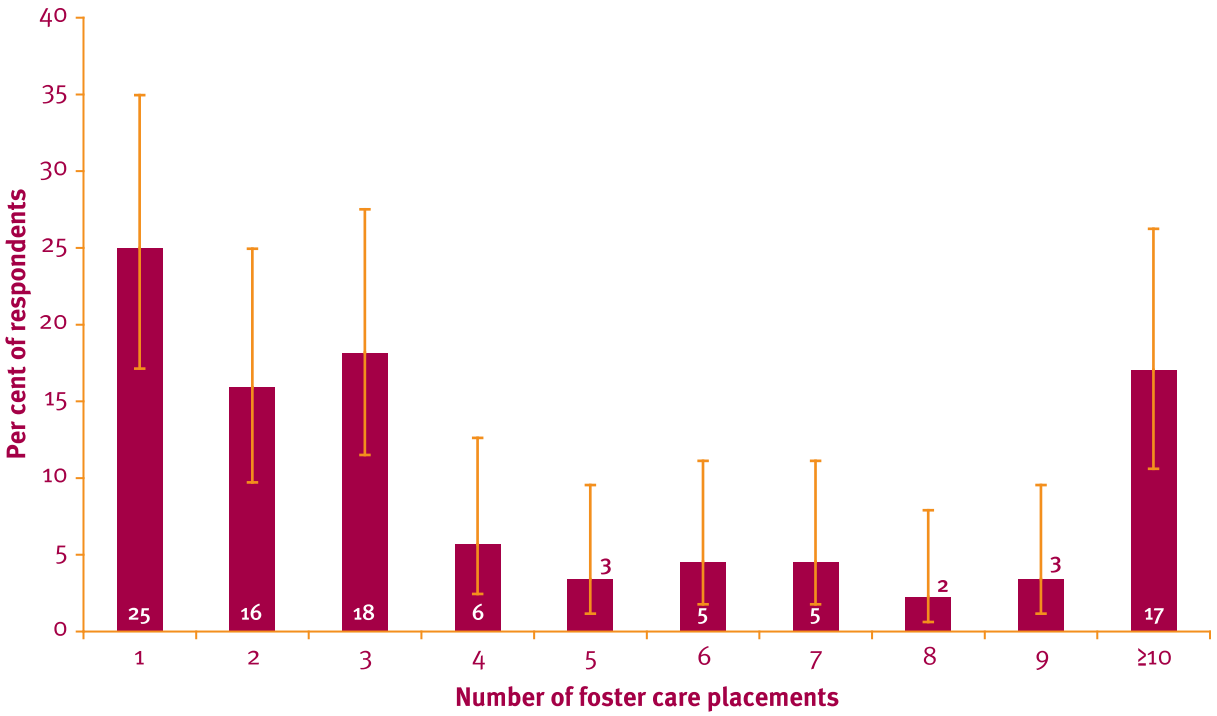
Seventy-seven per cent of respondents in DChS care reported being in foster care in the past. Females were more likely to report a history of foster care than males (86% compared with 71%).

How many foster care placements have you had (not counting respite care)?

The median number of foster care placements respondents reported having is 3, but one-third of respondents (32%) reported having 6 or more placements. Figure 10 shows that the distribution is positively skewed. The maximum number of reported placements is 40. Twenty-five per cent of respondents who have been in foster care do not know how many foster placements they have had, with a number writing comments such as "too many to count" and "heaps" beside their answer; this suggests that the sample statistics presented here may be an under-representation of the instability experienced by respondents in foster care.

Figure 10

Number of foster care placements (*n* = 88) (2008)



How many times have you gone back to live with your own family (reunified) since you first came into care (not counting visits or holidays)?

Fifty-seven per cent of respondents have not been reunified with their families since coming into DChS care. Thirty-four per cent reported having 1 or 2 reunifications. The maximum number is 8 (see Figure 11). Eighteen per cent of respondents with a history of being in the department's care do not know how many times they have been reunified with their family.

Figure 11

Times reunified with family since commencement of DChS care (*n* = 126) (2008)

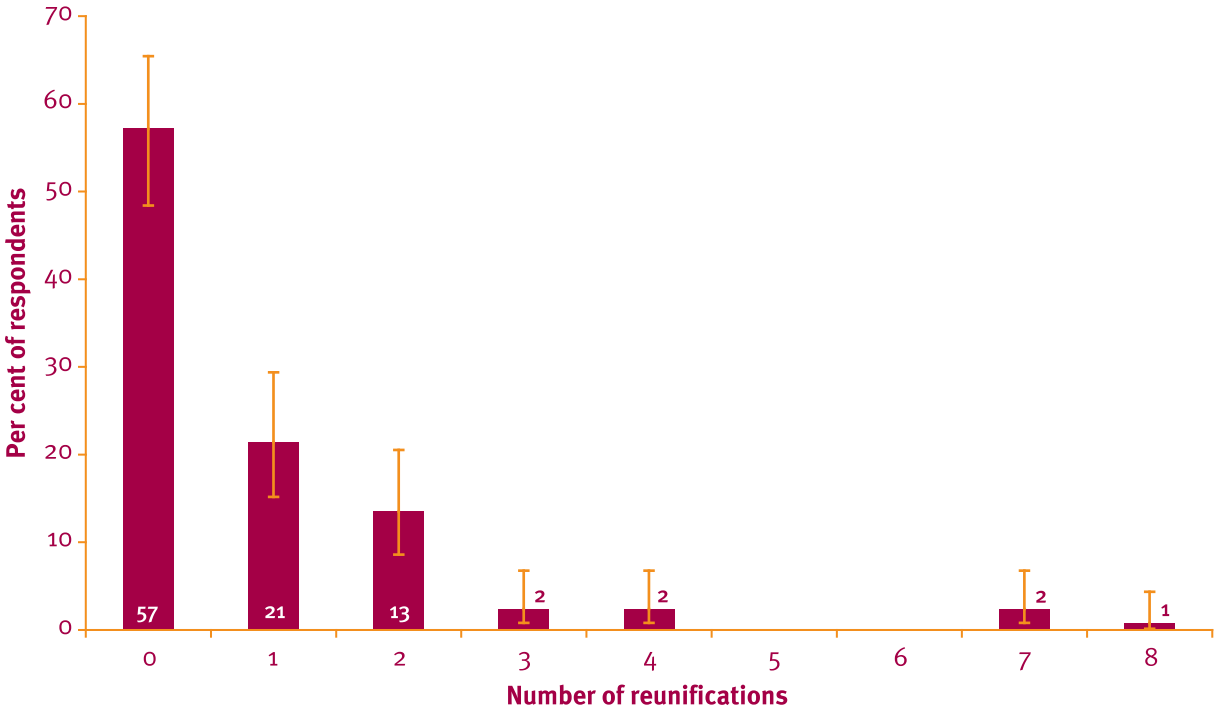


Table 3

Respondents alternative care history: summary statistics (2008)

Characteristic	Statistics	
Residential care history (all respondents)		
Length of time living in current residential facility (*n* = 190)	Mean (SD): Median: Min/Max:	8 m (13 m) 4 m 0 m/8 y, 6 m
Length of time living in residential facilities altogether (*n* = 157)	Mean (SD) Median: Min/Max:	1 y, 3 m (1 y, 6 m) 8 m 0 m/8 y, 0 m
Number of different residential facilities lived in altogether (*n* = 169)	Mean (SD) Median: Min/Max:	3 (4) 2 1/40
Proportion currently in DChS care	79% (169/215)	
Proportion previously in DChS care	3% (6/215)	
Respondents with history in DChS care		
Age at commencement of DChS care (*n* = 139)	Mean (SD): Median: Min/Max:	9 y, 4 m (4 y, 7 m) 10 y, 0 m 0 m/16 y, 10 m
Total time in all forms of DChS care (*n* = 122)	Mean (SD): Median: Min/Max:	4 y, 8 m (4 y, 6 m) 3 y, 0 m 1 m/17 y, 3 m
Proportion previously placed in foster care	77% (126/164)	
Number of foster care placements (*n* = 88)	Mean (SD) Median: Min/Max:	6 (7) 3 1/40
Number of times reunified with birth family since commencement of DChS care (*n* = 126)	Mean (SD) Median: Min/Max:	1 (1) 0 0/8

Current living situation

Residential facility type

Respondents were given a list of residential facility types and asked to identify the category that best describes where they are currently living. Figure 12 shows the distribution of responses across facility types. Half (51%) of respondents identified themselves as living in group residentials, just under one-fifth (18%) said they are living in individual residentials, and a similar proportion (17%) are living in youth shelters. Accommodation in other facility types is less common. Of the 3% indicating "other" facility types, all described themselves as living in a disability respite centre.[11]

Figure 12

Residential facility type (*n* = 208) (2008)

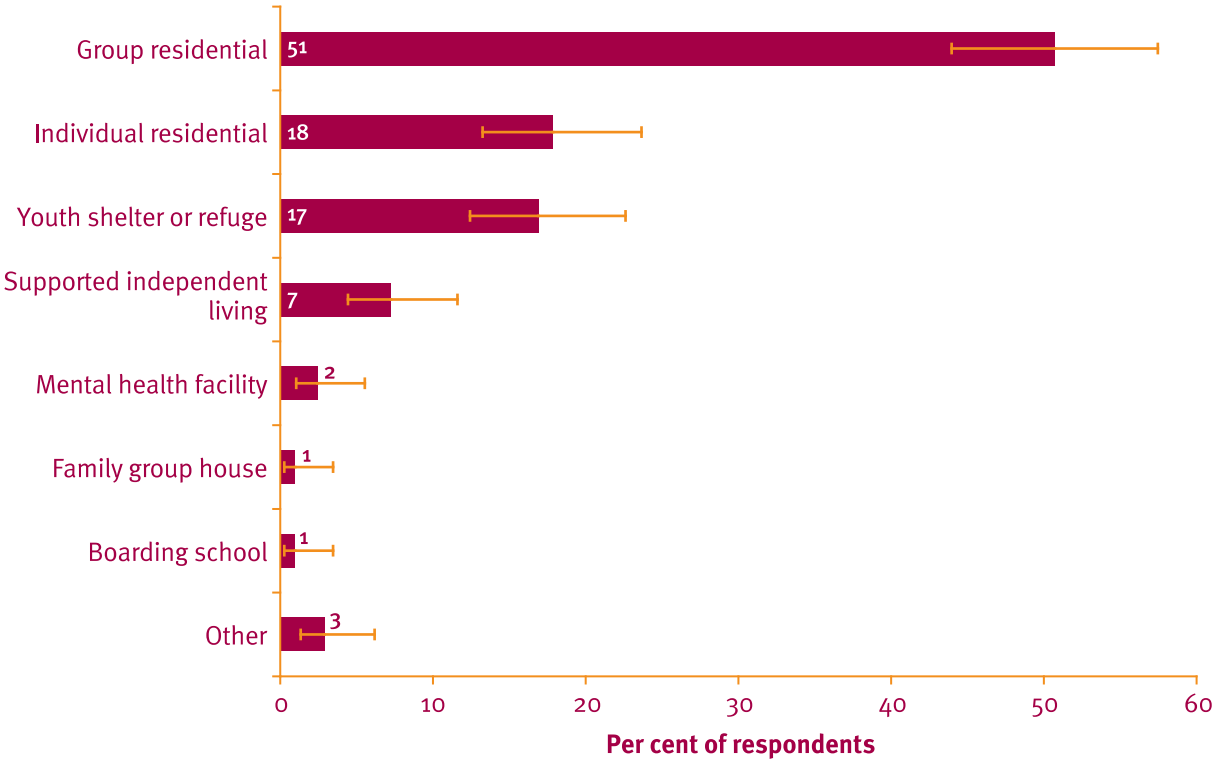
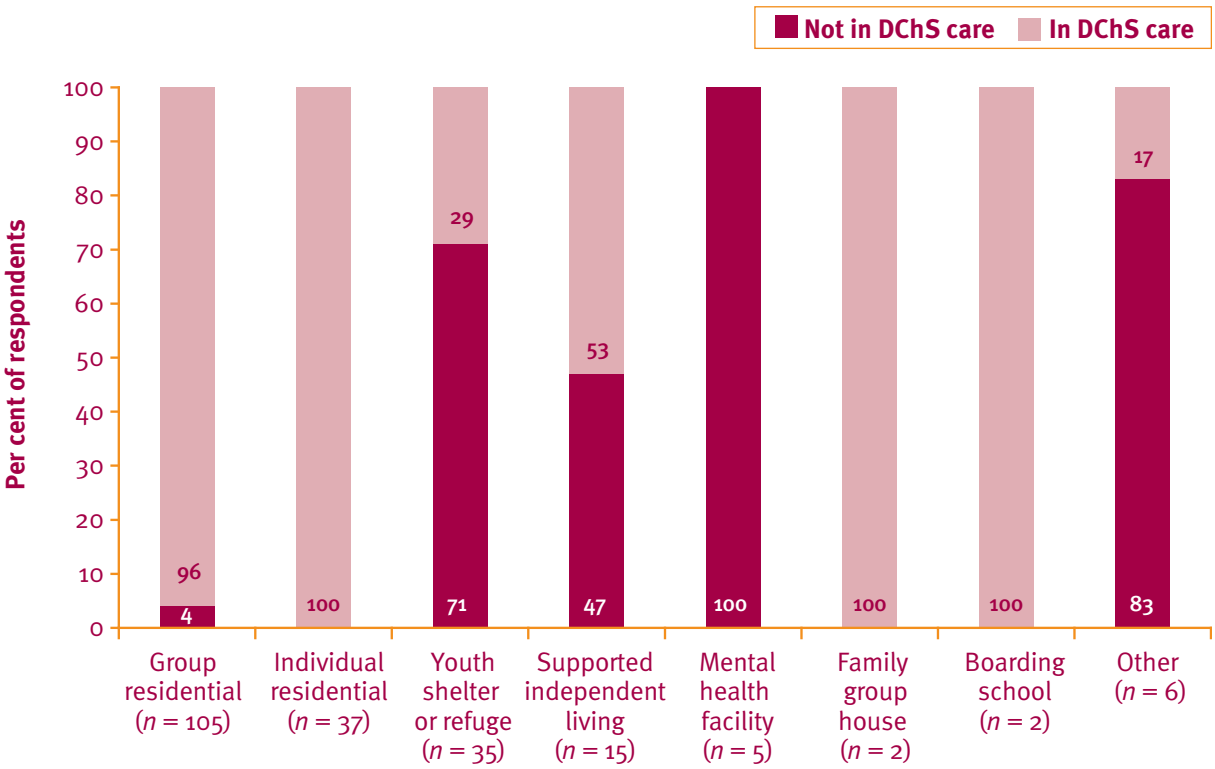


Figure 13 shows the type of residential accommodation respondents reported living in by their DChS care status. Respondents in the care of the department mainly reported living in group and individual residentials. Compared with those not in care, they were less likely to report living in youth shelters and in mental health and "other" facilities.[12]

11 Note: (1). Respondents were not given the option of "disability respite", so those living in this form of residential care may have selected "group residential" alternatively. (2). "Group residential" was the first response option listed on the questionnaire, and as this might legitimately describe a range of group accommodation options, such as youth refuges or family group homes, respondents living in these other forms of residential care may have selected this option before realising that a more specific facility type was available for them to select.

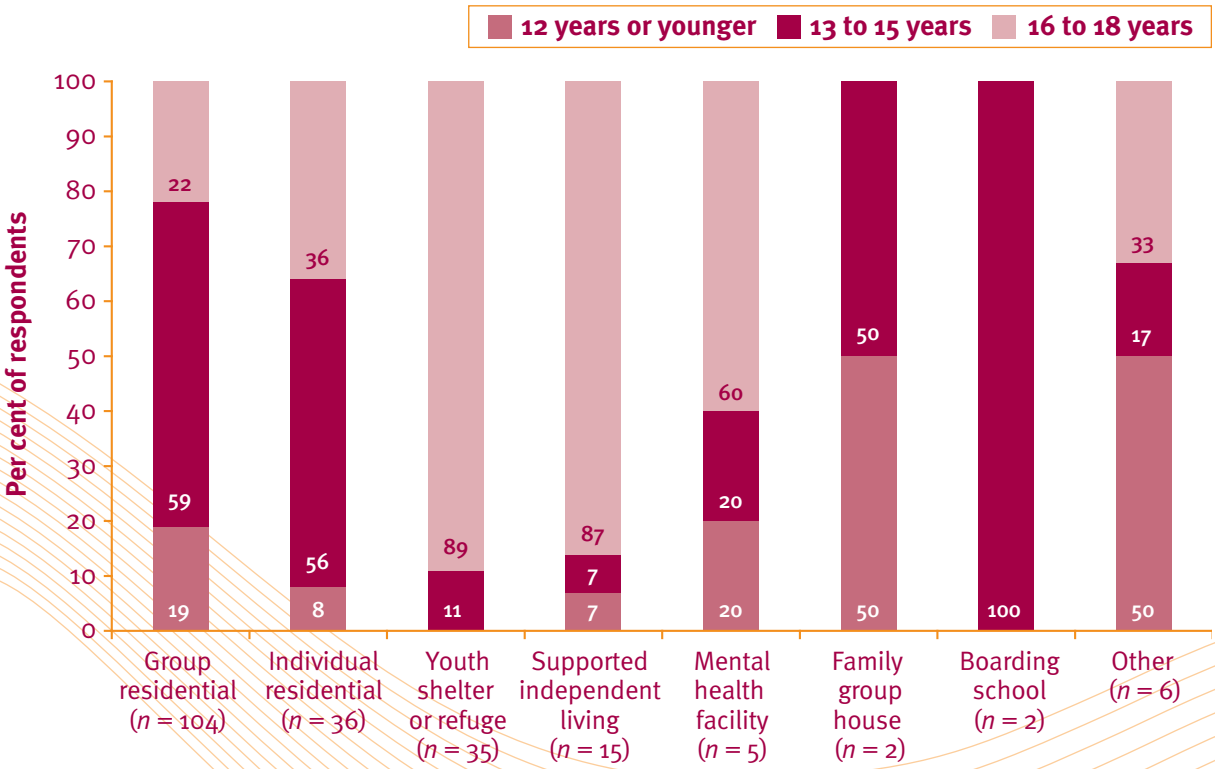
12 Although these differences are statistically significant, they are unreliable because of small cell sizes in cross-tabulations arising from the large number of accommodation types for the sample size.

Figure 13
Facility type by DChS care status (2008)



The type of residential accommodation reported by young people also reflects their age. As would be expected, respondents living in youth shelters and supported independent accommodation tend to be older (see Figure 14).

Figure 14
Facility type by age group (2008)

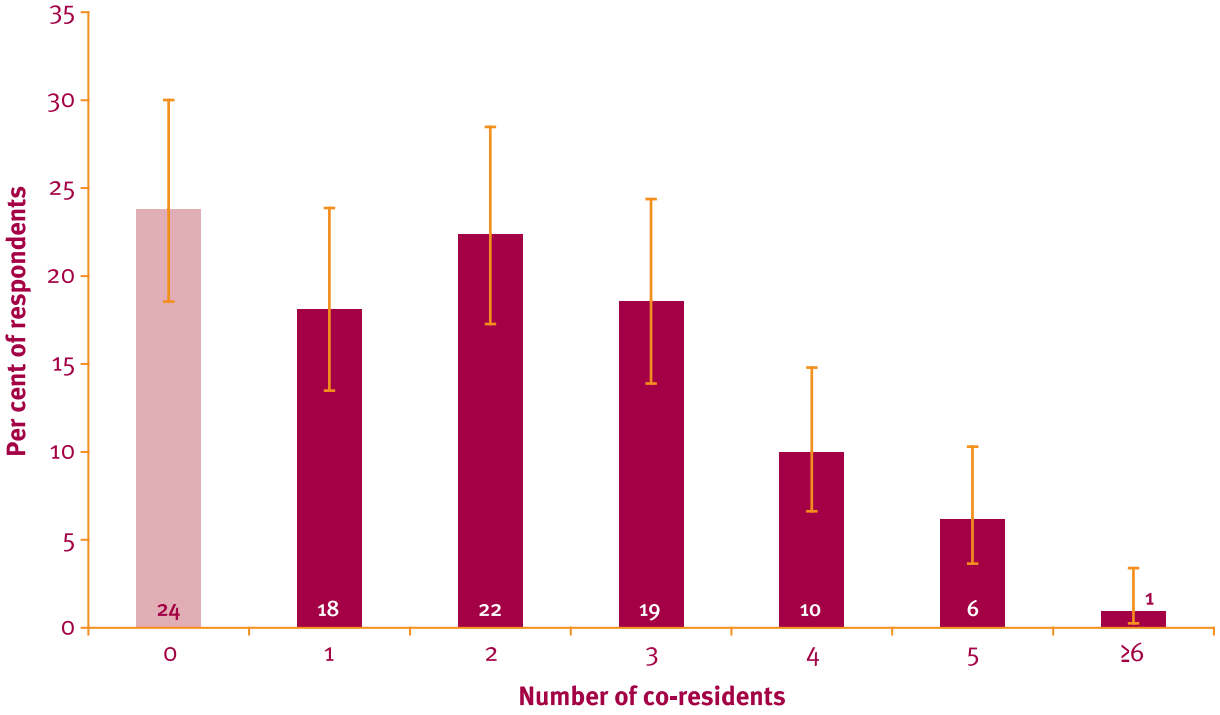


Number of co-residents

Seventy-seven per cent of respondents indicated living with other young people. Those in the care of the department were less likely than those not in DChS care to report living with other young people (71% compared with 96%). Of those living with other young people, the median number of other young people they reported living with is 2. All but 2 respondents living with other young people reported living with 5 or fewer others (see Figure 15).

Figure 15

Number of co-residents (*n* = 210) (2008)



Number of workers

All but 1 young person reported having workers either living with them or supporting them on an outreach basis. The median number of residential care and/or outreach support workers that respondents reported seeing on a weekly basis is 5. The maximum number of workers a young person reported seeing each week is 42. However, 95% of respondents reported seeing 14 or fewer workers each week (see Figure 16).

Figure 16

Number of workers/carers respondents see each week (*n* = 193) (2008)

Siblings in residential care

Seventeen per cent of respondents indicated that they have siblings in residential care but living apart from them, 8% reported that they currently live with their siblings, and 2% said that they had some siblings living with them and some siblings living elsewhere.

Comparing 2007 and 2008 samples

Comparison between the 2007 and 2008 samples reveals significant differences with regard to sex and residential facilities type (see Table 4). Compared with 2007, the 2008 sample has a larger proportion of male respondents, a greater proportion of respondents living in both group residentials and youth shelters, and a smaller proportion living in both supported independent accommodation and boarding schools.[13] The smaller proportion of respondents in the department's care in the 2008 sample is also approaching statistical significance.[14]

No significant differences were found between the groups according to alternative care history, age and cultural background.

Table 4

Respondent characteristics by survey year (2007, 2008)

Characteristic	2007	2008
Sample size	94	221
In care of DChS	87% (79/91)	79% (169/215)
Age (mean)	14 y, 4 m	15 y, 0 m
Sex		
Male	44% (41/93)	62% (128/207)
Female	56% (52/93)	38% (79/207)
Type of residential facility		
Group residential	40% (34/85)	51% (105/207)
Individual residential	17% (14/85)	18% (37/207)
Youth shelter or refuge	11% (9/85)	17% (35/207)
Supported independent living	11% (9/85)	7% (15/207)
Boarding school	13% (11/85)	1% (2/207)
Family group house	2% (2/85)	1% (2/207)
Mental health facility	2% (2/85)	2% (5/207)
Other	5% (4/85)	3% (6/207)

13 Although differences in accommodation type from 2007 to 2008 are statistically significant, they are unreliable on account of small cell sizes in cross-tabulations because of the large number of accommodation types for the sample sizes.

14 $p = 0.094$.

Health, disability and education

Children and young people in alternative care have poorer health and educational outcomes than the population as a whole and are also more likely to have certain disabilities (see *Background*). Respondents to the survey were asked various questions to explore their health, education and disability support needs and the extent to which they feel these needs are being met. Those in the care of DChS were asked further questions about their engagement in two initiatives that have been designed to address disadvantage in these areas – the Education Support Plan and the Child Health Passport.

Key messages

- Consistent with the 2007 survey findings, one in five respondents reported having a health problem of concern to them, and one in four of these has not been able to see someone about their problem. In addition, one in three respondents reported having a health problem – other than attention-deficit hyperactivity disorder (ADHD) – for which they currently take medication. The most common reasons given for taking medication are anxiety/depression and asthma.
- One in five young people (21%) reported taking medication for ADHD, a proportion identical to that observed in 2007. This implies a rate of medical diagnosis of ADHD in the residential care population at least two times that of ADHD prevalence in the Australian childhood population, underscoring the mental health and educational challenges faced by this cohort.
- As was the case in 2007, one in four respondents (26%) reported having a disability, and 9% of these indicated that they have unmet support needs in relation to their disability. The most commonly reported disabilities are intellectual or learning disabilities, ASD and ADHD.
- The survey reflects findings in Australian and international research concerning the early disengagement of young people in care from formal education. Almost half (44%) of respondents aged 16 years and over do not attend school, and of these, two-thirds are not involved in any other training or education. However, for the sample as a whole, those in the care of DChS who are not attending school are more likely to be engaged in other forms of training or education.
- The survey reveals instability in schooling for many respondents, with just under a third reporting 5 or more primary schools and a fifth reporting 4 or more secondary schools. This instability should be viewed in the context of other instabilities in these young people's lives, as suggested by the high number of residential and foster care placements they report on average.

- The survey reinforces the observation made elsewhere that young people in alternative care commonly experience problems at school. One in three reported repeating at least one year of school and over half the sample (57%) reported being excluded from school at least once. Three in ten indicated that they currently have a problem at school that they have not been able to get help with. The most common problems cited are not being understood or listened to by teachers, needing help to keep up with school work, and being bullied by other young people.
- Respondents who have a problem at school that they have not been able to get help with are significantly more likely to report that they have a health problem of concern to them. This relationship may reflect the impact that mental health problems can have on young people's ability to function well at school, or the impact that stresses at school can have on physical and mental health. It suggests the importance of a holistic response to the educational problems of young people in care.
- Just under half (45%) of those in DChS care who attend school reported having an Education Support Plan (ESP). This is only half the proportion of children and young people in DChS care who have ESPs or have these in development (90%) (DChS, 2009). One in two of those with an ESP regards it as helpful, suggesting that this initiative is going some way towards meeting the needs of this group.

Summary quantitative data for survey items relating to respondents' health, disability and education are presented at the end of this chapter, in Table 5. This table also identifies significant differences between characteristics of respondents in DChS care and the characteristics of those not in the department's care.

Health

Current health problems for which medication is taken

Thirty-four per cent of respondents indicated taking medication for some purpose other than ADHD. Fifty-seven of these 60 respondents (95%) specified either the medication(s) they are taking or the reason(s) they are taking medication. The most common purposes indicated for taking medication are depression/anxiety (21%) and asthma (21%). ASD was specified by 6 young people (11%), and sleeping disorders by 5 (9%). Less commonly reported reasons for taking medication include contraception, pain control, skin problems, and neurological or behavioural disorders.

The proportion of respondents who reported taking medication for conditions other than ADHD is significantly higher among those in the care of DChS compared with those not in the department's care (38% compared with 21%).

Current health problems concerning young people

Nineteen per cent of respondents indicated having one or more health problems that concern them. Thirty-four of these 39 respondents (87%) specified the nature of these problems: 7 (21%) indicated having asthma or another respiratory problem; 5 (15%) indicated musculoskeletal problems; 4 (12%) mental health problems (self-harming, eating disorders, anxiety and depression); 3 (9%) dental problems; and 3 (9%) problems with excessive weight or poor fitness.

Help with current health problems

As was the case in 2007, approximately three-quarters (73%) of those reporting health problems of concern to them said they have been able to see someone about these.

Attention-deficit hyperactivity disorder

The Royal Australasian College of Physicians (RACP) defines ADHD as "a persistent pattern of inattention and/or hyperactive and impulsive behaviour that is more frequent and severe than is typically seen at a given stage of development" (RACP, 2008: 7). It is associated with problems in educational, social and emotional functioning:

> Many individuals with ADHD ... have ... problems in areas including language, learning, mood, emotional regulation, and motor control. Academic and social struggles can lead children with ADHD to feel demoralised and depressed, or angry and oppositional. They are at increased risk of a range of adverse outcomes including academic underachievement, difficulties with interpersonal relationships and low-self-esteem, with potentially serious consequences for the individual and society. (RACP, 2008: 7)

The survey asked respondents if they take medication for ADHD to gauge approximate rates of ADHD diagnosis in this population, particularly given the implications that ADHD can have for further social and educational disadvantage, and given the greater likelihood of this cohort's exposure to known risk factors, such as adverse early childhood experiences. Twenty-one per cent of respondents indicated that they take medication for ADHD, a proportion identical to that observed in 2007. With a 95% confidence interval of 16% to 27%, this proportion implies medical diagnosis of ADHD in the residential care population at a rate at least twice that of ADHD prevalence in the Australian childhood population.[15] This is a conservative estimate, however, given that not all individuals diagnosed with ADHD are prescribed medication.

The proportion of respondents reporting medication for ADHD is significantly higher among those in the care of DChS than those not in the department's care (25% compared with 2%). Males are also more likely than females to report taking medication for ADHD (26% compared with 9%), an observation that mirrors a consistent finding in ADHD prevalence studies, where male to female prevalence ratios are found to range from 2 : 1 to 9 : 1 (RACP, 2008).

In Australia, the medications that are licensed for use in individuals over 6 years of age with ADHD are methylphenidate, dexamphetamine sulphate and atomoxetine (Strattera). Other medications that have been used or studied in the treatment of ADHD, but are not currently licensed for the treatment of ADHD, include clonidine, bupropion, selegiline, modafinil, imipramine, risperidone and nicotine patches (RACP, 2008).

Two-thirds of respondents who reported taking ADHD medication specified the type(s) of medication they are taking. Less than half (39%) reported taking medications currently licensed for the treatment of ADHD: 21% indicated taking methylphenidate (for example, Ritalin) and 18% dextroamphetamine (for example, Dexedrine). Fifty-four per cent indicated taking antipsychotic preparations (such as Risperidone) for ADHD, 25% said they are taking antidepressants and 11% said they are taking clonidine (Catapres).

Possible explanations for the high rate of reported use of non-ADHD medications include:

- young people believing that they are being treated for ADHD when they are actually being treated for other mental health or behavioural conditions
- confusion on the part of respondents about what medication they take specifically for ADHD, particularly if they are taking medication for co-morbid mental health or behavioural conditions, and
- doctors prescribing non-licensed medications for the treatment of ADHD.

15 Graetz et al. (2001) (cited in RACP, 2008: 6) found the prevalence of ADHD in the Australian childhood population to be 6.8%.

Child Health Passport

The Child Health Passport is an initiative of DChS developed in collaboration with Queensland Health to ensure that the health needs of children and young people in care are identified and met (see *Background* on the health vulnerabilities and needs of children and young people in care). Under the initiative, health practitioners throughout Queensland undertake age-related baseline health assessments of children entering care and develop health plans for each child or young person. The health plan, together with all other health information needed for effective day-to-day care of the child or young person, is recorded in their health passport and incorporated in case planning. The long-term aim is for all children and young people in the department's care to have a Child Health Passport by 2010 (DChS, 2009).

To gauge the participation of young people in residential care in the initiative, respondents in DChS care were asked whether they have a Child Health Passport. Nine per cent reported that they have one, 31% said they do not have one, and 60% said they do not know if they have one. These proportions are not significantly different from those in 2007.[16]

Disability

Prevalence and type

Twenty-six per cent of respondents identified themselves as having a disability. Females were significantly less likely to report having a disability than males (13% compared with 35%). Similarly, respondents from Aboriginal and/or Torres Strait Islander backgrounds were significantly less likely to describe themselves as having a disability than other respondents (16% compared with 30%).

Respondents were asked to describe their disability in an extended response field. Forty-eight of these 52 young people (92%) described their disabilities. Seventeen (35%) identified themselves as having an intellectual or learning disability, 15 (31%) said they have ASD, 12 (25%) described their disability as ADHD or attention-deficit disorder (ADD), 8 (17%) reported physical disabilities, 5 (10%) described neurological disabilities and 3 (6%) reported psychiatric disabilities.

Support with disability

Two-thirds (66%) of respondents who reported having a disability said that they receive special help because of their disability. Twenty-six per cent indicated that they do not receive special help but do not require it. Nine per cent reported that they do not receive special assistance but feel that they need such help.[17]

16 Care needs to be taken in interpreting these data as there is no formal requirement on the part of child protection officers or residential care staff to inform the child or young person about their Health Passport.

17 Individual percentages sum to more than 100% because of rounding.

Education

Participation in school and other training/education

Seventy-two per cent of respondents reported attending school. Of those not attending school (n = 53), 47% reported participating in other training or education. Respondents in the care of the department who are not attending school more commonly reported being engaged in other forms of training or education (58% compared with 15%).[18]

Among respondents aged 16 years (n = 40), participation in school is significantly lower than for the Queensland population (60% compared with 80%) (Australian Bureau of Statistics, 2007).[19] In addition, 71% of respondents in this age group who said that they are not attending school reported that they are not involved in any other training or education.

Among respondents aged 17 years (n = 43), participation in school is not significantly different from the Queensland population (56% compared with 48%)[20] (Australian Bureau of Statistics, 2007). However, similarly to the 16-year-olds, two-thirds (65%) of those not attending school in this age group are not involved in any other training or education.

Types of other training or education

Those not attending school but involved in other training or education were asked to describe this. Twenty-four of these 25 young people (96%) provided a description: 9 (38%) said they are enrolled in a TAFE course, 6 (25%) are participating in an alternative schooling or distance education program, 3 (12%) are involved in a work-readiness program and 2 (8%) are engaged in apprenticeships.

Alternative activities to involvement in education

Those not attending school and not involved in other education or training were asked what they do with their time instead. Twenty-six of these 28 young people (93%) described what they do: 8 (31%) indicated that they are looking for work or taking steps to prepare for work, 7 (27%) said they are not doing anything and 6 (23%) described social or recreational activities. Other activities less commonly reported include working, preparing to return to school, looking for accommodation and attending a youth justice program.

18 The proportion of respondents in 2008 who reported attending school appears lower than in 2007 (72% compared with 82%). However, the proportion of those not at school but involved in alternative education or training is significantly higher in 2008 (47% in 2008, compared with 26% in 2007). The observed difference may reflect the slightly older mean age of the 2008 sample (15 years compared with 14 years, 4 months), suggesting that a great proportion of the sample have moved into post-secondary education.

19 NB: The 95% confidence interval for the sample proportion is 45–74%.

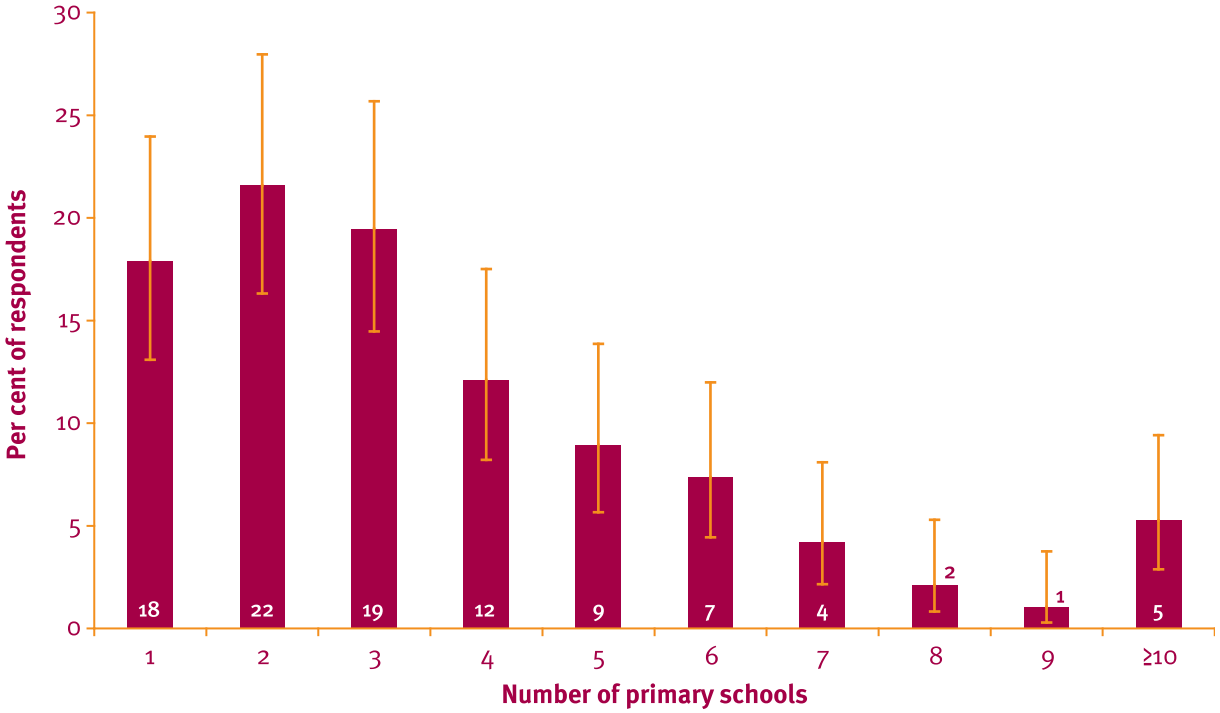
20 NB: Queenslanders leave school at 17; hence the low school participation rate for 17-year-olds in the population. The mean age of students undertaking Year 12 in Queensland is 16.7 years (Australian Bureau of Statistics, 2007).

Stability in schooling

The median number of primary schools respondents reported attending is 3. Just under a third (29%), however, reported attending 5 or more primary schools (see Figure 17). The maximum number of primary schools respondents reported attending is 25.

Figure 17

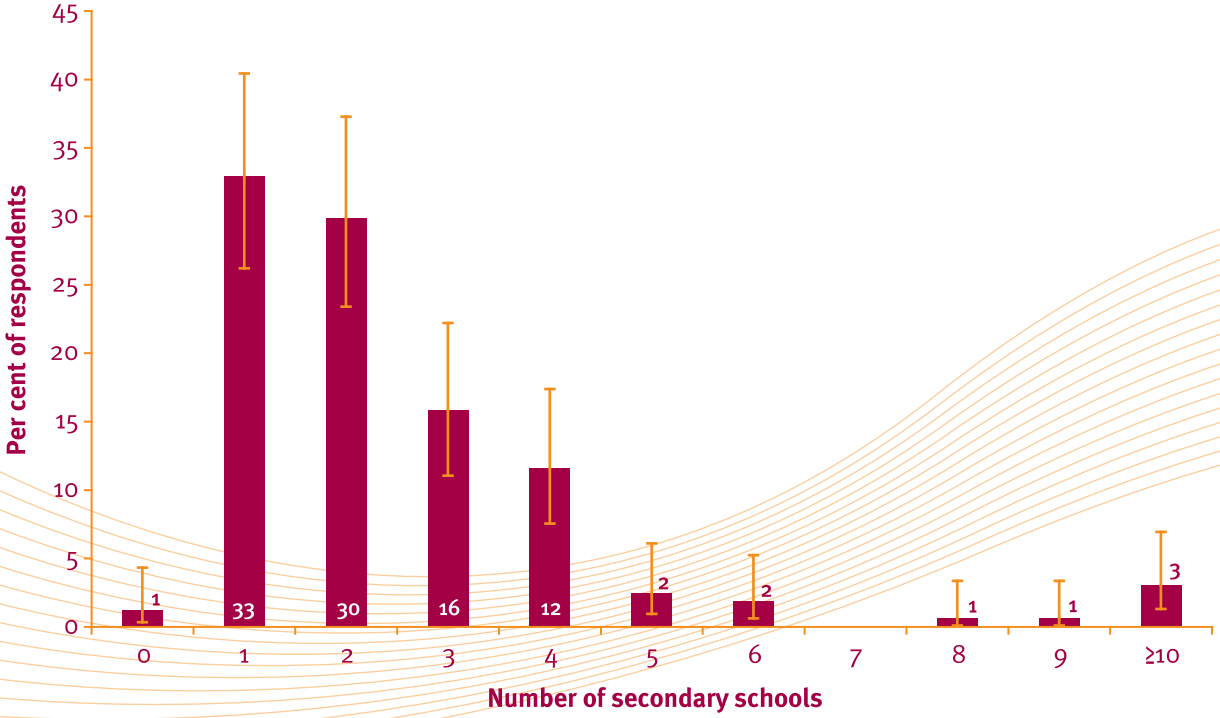
Number of primary schools attended (*n* = 190) (2008)



Of those respondents who have commenced secondary school, the median number of secondary schools they reported attending is 2. However, 20% reported attending 4 or more secondary schools (see Figure 18). The maximum number of secondary schools respondents reported attending is 11.

Figure 18

Number of secondary schools attended (*n* = 164) (2008)



Repeating school

Thirty-two per cent of respondents reported that they have repeated school at least once. This proportion is considerably higher than the 5% estimated for the population of Australian school children.[21] Among those who reported repeating a year at school, only 1 young person reported repeating on more than one occasion (twice).

Exclusion from school

The *Education (General Provisions) Act 2006* defines "exclusion" as the prohibition or cancellation of a student's enrolment in a state school or state schools, either for a period of up to a year or on a permanent basis. A student can be excluded either by a school principal's supervisor for disciplinary reasons (ss. 289–296) or by the chief executive of DChS where the student is deemed to pose an unacceptable risk to the safety or wellbeing of other students or staff (s. 298). Students may be prohibited from attending school without cancellation of enrolment for disciplinary reasons for shorter periods (up to 20 days, depending on the seriousness of the behaviour). This is referred to in the Act as "suspension".

Respondents were asked if they had ever been excluded from school. Fifty-seven per cent of respondents reported that they have been excluded in the past (50%) or are currently excluded from school (7%). This represents a significant increase from the 2007 survey, in which only 8% of respondents reported having been excluded from school, either at the time of the survey (3%) or at some point in the past (5%).[22, 23]

Although the proportion of respondents in DChS care who reported experiencing school exclusion now or in the past is considerably higher than for those not in DChS care (61% compared with 46%), the difference falls short of statistical significance.[24]

Current unresolved problems at school

Of those currently attending school, 30% indicated that they are having problems at school that they have not so far been able to get help with.

Respondents experiencing problems were asked to nominate from a list of possible problems those that apply to them.[25] The list included the option of "other", and respondents could specify the nature of this problem if they desired. On average, respondents reported two problems each. The most common problem is feeling that teachers do not listen to or understand them (45% of those with school problems). Needing more help to keep up with school work is the next most commonly reported problem (43%), followed by problems with being bullied (38%), and problems with their own behaviour (36%). A third of these young people also reported not having the equipment and resources they need for school, such as uniforms, books, computers or money for excursions. A moderate and statistically significant correlation is apparent between respondents

21 Data from the Australian LifeCourse Study reported in Stone (1997).

22 One possible explanation for this increase is rewording of the question from "Are you currently excluded from school?" (Yes/No/No, but I have been excluded before) in 2007 to "Have you ever been excluded from school?" (Yes, currently/Yes, in the past/No, never) in 2008. Although the two questions gather identical information, the broader framing of the question in 2008 may have resulted in more accurate capture of those previously excluded, who could easily have responded "No" to the 2007 question without ever reviewing the third response option, "No, but I have been excluded before".

23 Care should be taken in interpreting these responses. Respondents were not provided with a definition of exclusion, and neither were CVs administering the survey. Although the *Education (General Provisions) Act 2006* defines exclusion and suspension as distinct forms of disciplinary action, the Department of Education, Training and the Arts (DETA) has reported to the Commission that students sometimes refer to suspensions as exclusions. Definitions of exclusion and suspension will be provided to respondents in future surveys to improve the reliability of data collected.

24 $p = 0.063$.

25 The list of school problems provided in the 2008 survey was based on thematic analysis of young people's responses to an open-ended field included in the 2007 residential and foster care surveys.

identifying themselves as having behavioural problems at school and reporting problems with teachers not listening to or understanding them ($r = 0.42$).[26]

Co-occurrence of education and health problems

Respondents reporting that they have an unresolved problem at school are significantly more likely to indicate that they currently have a health problem of concern to them than are those without problems at school (38% compared with 13%). One of the factors identified as playing a part in the poorer educational outcomes of children and young people in care is traumatic experiences before coming into care, which can result in a range of emotional, behavioural and physical health problems that affect performance at school (Veltman & Browne, 2001). The observed relationship between education and health problems in the present study may reflect this reality. Alternatively, it may suggest that stresses at school are affecting young people's physical and mental health. Either way, the observation lends weight to the suggestion made elsewhere – for example, by Cashmore et al., (2008) – that multi-agency and interdisciplinary cooperation are necessary to respond holistically to the educational needs of young people in alternative care.

Education Support Plans

Education Support Plans are a joint initiative of DChS and the DETA. The aim of the initiative is to help children and young people in state care to access effective cross-agency support to improve their educational outcomes. An ESP is a formal written document that identifies the educational goals of the child or young person in care. It includes the strategies needed to achieve these goals, the required and available resources, the individuals who are responsible for implementing the strategies, and the processes that will be used for monitoring and reviewing the plan.

At the time of survey, 90% of children and young people in DChS care enrolled in Queensland schools were reported by DETA to have an Education Support Plan either finalised (76%) or under development (14%) (DChS, 2009).

Respondents in DChS care were asked about ESPs to assess the extent to which young people in residential care are aware of this initiative, engaged in it and finding it of value to them. Of those respondents in care currently attending school ($n = 126$), 45% reported having an ESP, 10% said they do not have one, and 45% said that they do not know if they have one. Fifty-one per cent of those reporting having an ESP said it has been helpful to them.[27]

26 r = Spearman's rank correlation. Value is between 0 and 1, with higher values indicating stronger relationships.

27 The proportion of respondents describing their ESP as helpful appears to have decreased significantly since 2007 (from 75% to 51%). This difference may be attributable to a minor change to the survey instrument in 2008. Two previously consecutive questions ("Has an educational plan been developed for you because you are in care?" [yes/no/don't know] and "If yes, have you found it helpful?" [yes/no]) were combined in a single question ("Has an educational plan been developed for you because you are in care?" [yes, and I have found it helpful/yes, but I have not found it helpful/no/don't know]). The intention of this change was to address invalid responses resulting from participants completing the second question when it was not necessary to do so (i.e. when they did not have an ESP).

Table 5

Respondents' health, disability and education by DChS care status (2008)

Characteristic	All respondents	In DChS care	Not in DChS care
Health			
Current health problems			
*Take medication for a health problem^*	34% (60/178)	38% (50/133)	21% (9/44)*
Concerned about a health issue	19% (39/206)	17% (27/160)	24% (11/45)
Able to see someone about health issue	73% (27/37)	77% (20/26)	60% (6/10)
Child Health Passport			
Have passport	n/a	9%	n/a
Don't have passport	n/a	31%	n/a
Don't know	n/a	60%	n/a
Disability			
Have disability	26% (52/198)	29% (45/154)	16% (7/44)
Receive help for disability	66% (31/47)	67% (28/42)	60% (3/5)
Don't receive help and need it	9% (4/47)	10%(4/42)	40% (2/5)
Take medication for ADHD	21% (43/208)	25% (41/161)	2% (1/46)*
Education			
School participation			
All age groups	72% (155/215)	73% (123/168)	67% (31/46)
16 years and older	56% (48/85)	64% (25/39)	50% (23/46)
Participation in other training/education if not at school			
All age groups	47% (25/53)	58% (23/40)	15% (2/13)*
16 years and older	34% (11/32)	45% (9/20)	17% (2/12)
Stability in schooling			
Primary schools attended (median)	3	3	3
Secondary schools attended (median)	2	2	2
Problems at school			
Repeated school	32% (66/207)	34% (54/160)	24% (11/46)
Been excluded from school	57% (121/211)	61% (100/164)	46% (21/46)
Current unresolved problem at school	30% (43/145)	30% (34/115)	28% (8/29)
Education Support Plan			
Have ESP	n/a	45% (57/126)	n/a
Find ESP helpful	n/a	51% (29/57)	n/a

* Represents a statistically significant difference between respondents in DChS care and those not in care.
^ Excluding ADHD.

Satisfaction with current living situation

The survey investigated young people's experiences and views of their current living situation to gauge their overall satisfaction with this situation and to gain an understanding of the aspects of residential care that young people are most and least satisfied with. Responses to these items are presented in this chapter. The relationship between respondents' satisfaction with their current living situation and their age, sex, cultural background and DChS care status was investigated. Where measures have been replicated across the two years of the survey, changes over time in young people's views and experiences have also been examined.

Key messages

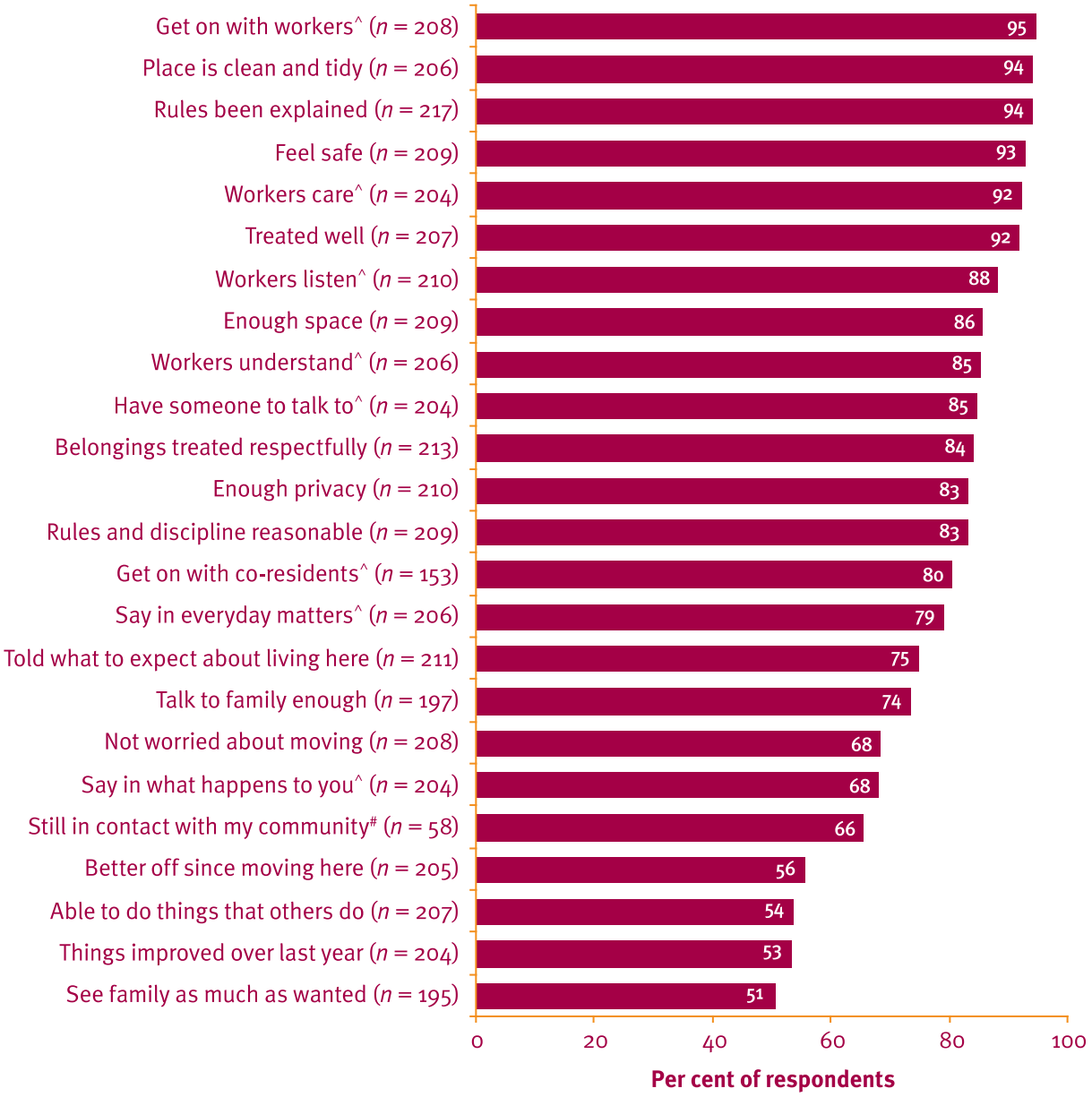
- Consistent with observations reported in 2007, the survey found that a majority of respondents are reasonably happy with most aspects of their care and accommodation in residential facilities:
  - at least nine out of ten said that they feel safe and well-treated, have workers who care about what is best for them all or most of the time, and get along with their workers all or most of the time, and
  - at least four out of five said they feel that their workers listen to or understand them all or most of the time, they have someone to talk to if they are worried about something, the premises are sufficiently clean, they have enough personal space and privacy, their belongings are treated with respect, and the rules and discipline in the facility are reasonable enough.
- Despite the generally positive view most respondents have of many aspects of their care, the survey reveals that almost half (44%) do not feel that they are better off since coming into their current living situation and almost half (47%) do not believe that things have improved for them in the last 12 months.
- As in 2007, the three areas that respondents least commonly expressed satisfaction with are:
  - having sufficient contact with their family
  - having a say in what happens to them, and
  - being able to do the same sorts of things that their peers outside the residential care system can do.
- The last item above is reflected in young people's views about what they would most like to see improved about their current living situation. The most commonly desired improvement, expressed by at least one in four young people, is to have more flexible rules governing their behaviour and activities, enabling them greater independence and the option of doing what "normal" young people can do. This is often expressed in relation to participation in social activities such as going out with friends or having "sleepovers".

- Multiple regression analysis of quantitative data confirms the importance of this issue to young people's sense of happiness in residential care. Being able to do what other young people can do is found to be a significant predictor of young people's happiness with their current living situation. Other significant predictors are having sufficient privacy and believing that things have improved for them in the preceding 12 months. As might be expected from young people's views about necessary improvements, perceiving the rules and discipline of the facility to be reasonable very closely approached significance as a predictor of happiness in their current living situation.
- The survey also reveals that young people's satisfaction with their current living situation varies significantly according to their age group and DChS care status:
  - Younger respondents tend to be less satisfied than older respondents: they are less likely to report feeling safe, getting along with their co-residents, being told what to expect about living in the residential, being able to do the same things as their friends not in residential care, having sufficient phone and email contact with their families, and having a say in everyday issues and in what happens to them more generally. On the other hand, they are more likely to report having an issue that no one is listening to them about.
  - Respondents in the care of DChS tend to be less satisfied than those not in the department's care: they are less likely to report feeling treated well in their accommodation, being told what to expect about living in the residential, having sufficient space and privacy, feeling their possessions are treated respectfully, getting along with other young people they live with, feeling they have a say in what happens to them, and feeling they are better off since coming into their current living situation. In addition, young people in care are more likely to report having an issue that no one is listening to them about.
- Overall, a strong consistency is apparent between the two years of the survey in responses to items about respondents' satisfaction with their current living situation. Only two moderate and statistically significant differences were observed, both of which are positive: an increase in 2008 in the proportion of respondents who report
  - getting along with their workers/carers all or most of the time, and
  - having a say about what happens to them all or most of the time.

Figure 19 summarises and ranks responses to measures of respondents' satisfaction with their current living situation. These measures are described in more detail in this chapter.

Figure 19

Measures of satisfaction with current living situation (2008)



^ Data pertain to respondents who answered "all/most of the time".
# Question only asked of ATSI respondents.

Sense of safety and stability

Do you feel safe here?

Ninety-three per cent of respondents said that they feel safe where they are currently living, a similar proportion to that in 2007.[28]

Forty comments were recorded for this question. Twenty respondents (50%) wrote comments qualifying an affirmative response in some way, for example: "most of the time", "sometimes", "yes and no", "it depends on everything". Some of these qualifications referred to the specific circumstances that undermine their sense of safety, such as the presence of a particular person or living in premises are insecure or unsafe:

> "Most of the time, except worried about the house falling down." [Male, 15, individual residential]

> "Would feel safer if certain people were not here." [Female, 16, youth shelter]

> "Except the screen door that's not hard to break down." [Male, 17, youth shelter]

> "But I feel bad when [female name] goes mental." [Female, 15, group residential]

Eleven respondents (28%) wrote comments elaborating on why they feel safe where they are living. A feeling of protection, comfort or care generated by the service and/or the staff is a recurring theme in these responses:

> "I do feel safe here at [service/location name]." [Female, 10, group residential]

> "Good workers." [Male, 14, group residential]

> "I like the lifestyle. [Service name] – it's my home." [Sex/age not stated, individual residential]

> "Because I don't like families. I feel comfortable with youth workers." [Female, 15, individual residential]

> "Always, they try to help us and make us feel loved." [Female, 16, group residential]

> "Very protected." [Female, 17, group residential]

Eight of the 15 respondents who reported that they do not feel safe where they are living elaborated on this in the comments field. The most common source of feeling unsafe described by respondents is the presence or actions of co-residents, for example:

> "The other girls here make my life hell." [Female, 16, group residential]

> "Because other resident threatens my animals and me." [Sex not stated, 14, group residential]

This is followed by concerns about carers/workers or having these concerns disregarded by others:

> "They follow me around everywhere." [Male, 14, individual residential]

> "When I report stuff about workers, no one listens." [Male, 13, individual residential]

Insecure premises (absence of security screens) was indicated by one young person as the basis of their feeling of unsafety.

28 Where respondents indicated that they did not feel safe or that they were being harmed or were at risk of harm, information about the young person was used to try to identify them for purposes of providing follow-up or, in serious cases, for notifying DChS (as the Commission is required to do under s. 20 of the *Commission for Children and Young People and Child Guardian Act 2000)*.

Are you worried that you will have to move to another place in the next few months?

Sixty-eight per cent of respondents said they were not worried about moving in the next few months. Twenty-three of these 142 respondents (16%) made further comments. The most common theme in these responses (14 occurrences, or 61%) was a strong desire by respondents to move from where they are currently living (for example, "[Moving] would be great", "I would love to move very, very much"). Other respondents explained that they are not concerned about this likelihood because they are "used to moving".

Thirty-two per cent of respondents, however, said that they are worried about the possibility of moving soon. Twenty-three of these 66 respondents (35%) wrote comments elaborating on their anxiety or qualifying it in some way (for example, "a little bit", "normal worry – doesn't keep me awake at night"). Not wanting to leave where they are living, or not knowing where they will be moving to, are recurrent themes:

> "I don't want to leave." [Sex/age not stated, individual residential]
>
> "Don't want to move again." [Male, 14, group residential]
>
> "I really want to stay here until I leave care." [Female, 15, individual residential]
>
> "Because in the house that I'm living in now, it is really cosy and homey." [Female, 12, group residential]
>
> "Dunno where I'm going." [Female, 14, group residential]
>
> "Am a bit worried – I have no idea where I'm going to go next." [Male, 18, individual residential, scheduled to leave care indefinitely in 3 months time]
>
> "I know I'm going to be moved soon. Wouldn't have a clue where." [Male, 16, individual residential]

General treatment and living conditions

On the whole, young people regard their treatment and living conditions in residential facilities positively:

- 94% regard the facility/household as clean and tidy.
- 94% said that the rules of the facility/household were explained to them.
- 92% feel that they are treated well.
- 86% feel they have enough space for themselves.
- 84% feel that their possessions are treated with respect.
- 83% feel that the rules and discipline are reasonable.
- 83% feel they have enough privacy.
- 75% said that they were told what to expect about living in the facility/household.

There are no significant differences according to sex or cultural background for any of these measures, nor is there a significant change in the proportion of respondents holding these views between 2007 and 2008.

Relationships with residential care workers

Does it cause problems for you having many different workers?

As reported previously, the median number of residential care and/or outreach support workers that respondents indicated seeing on a weekly basis is 5. Ninety-five per cent of respondents reported seeing 14 or fewer workers each week (see Figure 16).

Eighty-seven per cent of respondents regard themselves as having "many different workers". Of these respondents, 79% do not consider this to be a problem. A few commented that they actually like the variety (for example, "One to do fishing, another one to go bowling. It's good to have different people").

The remaining 21%, who said that having many different workers does cause problems for them, were asked to describe these problems in an open-response field. Thirty-two of these 37 young people (86%) responded. Problems indicated by respondents can be grouped into four themes, which are summarised in Table 6.

Table 6

Problems experienced as a result of having many different workers (2008) (*n* = 32)

Theme	%^#	Sample responses
Inconsistency of discipline/ styles of working, leading to lack of clarity about expectations	25% (8/32)	"Different workers do different things." "I don't like all of them and they have different rules all the time." "Inconsistent styles." "If one worker puts you on a breach or something to do, the other workers don't know."
Difficult to form stable/ satisfying relationships	25% (8/32)	"It's harder having so many workers. They keep changing over." "I hate it. It doesn't feel like a family because there's so many people looking after you. They say they'd rather be with their own kids." "Sometimes people I don't know." "Can't form a relationship."
Confusion about worker timetables and roles	16% (5/32)	"Uncertain of who's on from shift to shift." "These problems are that I get confused with who is on my team." "Sometimes I feel confused about having three youth workers because they come in on all sort of days."
Behavioural problems within household	9% (3/32)	"They play favourites." "My brothers and me get agitated when so many workers are on because it causes fights." "Behavioural difficulties with other residents."

^ Sum of percentages is less than 100% as not all responses were coded to these themes.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Respondents indicated that having many different workers results in a lack of clarity about discipline and other expectations; it creates difficulties for them in forming stable and satisfying relationships with their carers; it generates confusion for them about worker roles and timetables; and it can cause conflict and other behavioural problems among the residents in the household.

Do your workers understand you?

Eighty-five per cent of respondents feel that their workers understand them all the time (29%) or most of the time (57%).[29] The remaining 15% feel that their workers understand them not very often (10%) or never (5%). Young people from Aboriginal and/or Torres Strait Islander backgrounds were less likely to feel that their workers understand them all or most of the time than other respondents (77% compared with 89%).

Twenty-three comments were recorded for this question. Fourteen comments (61%) either constitute qualifying statements (such as "Some do, some don't", "One worker only") or indicate not knowing if workers understand them. Seven comments (30%) elaborate on a positive response to the question. For example:

> "They listen when I have a problem." [Sex/age not stated, individual residential]
>
> "When I need help and when I am really sick." [Female, 18, youth shelter]
>
> "Sometimes they don't understand what I'm trying to say." [Male, 12, disability respite]
>
> "Yes, but sometimes I'm not that understandable." [Male, 17, group residential]
>
> "Not sure if I understand myself yet." [Female, 13, individual residential]

Only two respondents (9%) made explicitly negative comments about their workers ("They don't listen", "They are a***holes").

Do your workers listen to you?

Eighty-eight per cent of respondents said they believe their workers listen to them all the time (40%) or most of the time (48%). Eleven per cent feel their workers listen to them not very often, and only 1% feel their workers never listen to them.

Just under half of the 21 comments made by respondents in relation to this question are qualifications (such as "Some do, some don't"). Of the remaining comments, some elaborate on the listening qualities of workers (for example, "When I tell them there is something wrong, they try and do something about it"). Others highlight that listening doesn't equate to workers understanding them, believing them or taking action in relation to what they have said to the worker:

> "They don't understand what we are going through." [Female, 17, mental health facility]
>
> "Sometimes they don't believe what you say." [Male, 13, group residential]
>
> "It's whether they do things." [Female, 17, supported independent living]

Other comments acknowledge that listening can be a complex and reciprocal process:

> "They can't quite understand. Then when I explain more, they say 'oh yeah, I get it'." [Male, 13, individual residential]
>
> "[They] only don't listen when I'm talking rubbish – which is most of the time." [Male, 16, individual residential]
>
> "It is me that does not listen." [Male, 17, individual residential]

29 Individual percentages for "most of the time" and "all the time" sum to more than the combined percentage quoted because of rounding.

Do your workers care about what's best for you?

Ninety-two per cent of respondents said they believe their workers care about what is best for them all the time (56%) or most of the time (36%). Eight per cent feel their workers care about them not very often (3%) or never (4%).[30]

Twenty-five respondents made comments in relation to this question. Of these, 8 (32%) commented that they do not know whether their workers care about what is best for them and 7 (28%) made comments of a qualifying nature (for example, "Some do, some don't", "One worker only"). A handful of those who responded positively to the question elaborated on their response. For example:

> "Definitely." [Sex/age not stated, individual residential]
>
> "They are kind and don't yell." [Male, 12, group residential]
>
> "They encourage me to do things I like." [Male, 14, group residential]
>
> "Our health and whatever we take." [Female, 18, youth shelter]

A few of those who responded negatively to the question also commented:

> "They don't care about me." [Female, 14, boarding school]
>
> "I think they just see it as their job." [Female, 17, group residential]
>
> "They think they do – but what the f**k would they know!" [Female, 14, group residential]

Do you get on with your workers?

Ninety-five per cent of respondents reported that they get along with their workers all the time (41%) or most of the time (54%), a statistically significant increase from 2007, when only 86% of respondents reported this.[31] Four per cent of respondents said they get along with their workers not very often, and 1% said they never get along with their workers. As might be expected, moderately strong and statistically significant correlations exist between respondents reporting that they get along with their workers all or most of the time and reporting that workers all or most of the time listen to them ($r = 0.59$), understand them ($r = 0.52$), or care about what is best for them ($r = 0.42$).

Thirty-four respondents made further comments. Twenty-two of these (65%) qualified their response in some way, most commonly indicating that there are some workers whom they get along with better than others. For example:

> "'Never' for [particular worker], 'all the time' for the rest." [Male, 17, group residential]
>
> "Only with [two workers] and the case manager, but not with [another worker]." [Female, 13, group residential]
>
> "I get on well with the girls more than the boys, though." [Male, 14, group residential]
>
> "Except I don't like one of them. He's creepy and I stay away from him." [Female, 15, group residential]

Would it help to keep in contact with the workers after you leave here?

Of those young people who reported having workers living with them ($n = 191$), almost three-quarters (73%) feel it would help to maintain contact with workers after leaving the facility.

30 Individual percentages for "not very often" and "never" sum to less than the total percentage quoted because of rounding.

31 As the 2007 and 2008 survey samples are quite differently composed, the subset of the sample in DChS care was compared across the two years of the survey to provide a more reliable comparison. The observed difference is still statistically significant.

Sixty respondents made further comments. Thirty-five of these (58%) come from young people who responded positively to the question, usually qualifying their response in some way (for example, "Only one or two", "Only a little", "But I never want to see [particular worker] again") or elaborating on the reasons for wanting to maintain contact. Some clearly regard workers as friends or pseudo family members and anticipate maintaining contact for personal and social support:

> "As a support group I'll stay in contact with them." [Male, 17, group residential]
>
> "When I am stuck." [Female, 18, youth shelter]
>
> "They are very kind and I'd love to keep in touch." [Female, 14, individual residential]
>
> "They feel like family." [Female, 17, individual residential]
>
> "Yes, a couple for footy." [Male, 14, group residential]
>
> "It would be great to catch up with my mates after I've gone home." [Female, 13, individual residential]

A few also commented that maintaining contact with staff after leaving the residential is not permitted:

> "Have been told not allowed to." [Female, 15, group residential]
>
> "I have asked some workers and I already do. But it is not allowed by the service." [Male, 13, individual residential]

Eight comments (13%) come from those who indicated that they do not want to maintain contact with staff after leaving the residential, elaborating on this point. For example:

> "No – not really." [Sex/age not stated, group residential]
>
> "Only unless I had to talk to them." [Male, 17, youth shelter]
>
> "But I'll occasionally come in and say 'hi'." [Female, 17, youth shelter]
>
> "But I would with the workers at [name of other service]." [Female, 10, group residential]

The remaining 17 comments (28%) come from respondents who did not respond to the question. These comments all indicate indecision (for example, "Unsure", "Undecided", "Possible") or a conditional response ("Depends on who it is", "Maybe. Some yes, some no").

Relationships with other residents

Of those living with other young people (n = 153), 80% said they get along with their co-residents all the time (27%) or most of the time (53%). Twelve per cent said they get on with other residents not very often, and 8% never get on with other residents.

As was the case when describing their relationships with workers, young people reported getting on better with some of their co-residents than with others. Twenty-three of the 37 comments (62%) recorded for this question are statements to this effect. For example:

> "It all depends on who it is." [Male, 16, youth shelter]
>
> "Two I don't and the other two sometimes. My sister all the time." [Female, 15, group residential]
>
> "Only one person I get along with well." [Female, 14, group residential]
>
> "The boys can be very annoying." [Female, 15, group residential]

The remaining comments elaborate equally on respondents' positive or negative relationships with their co-residents. For example, positive comments are:

"[I get on with them] always and every day." [Female, 18, youth shelter]

"We're really good friends." [Male, 12, group residential]

"We have little fights, but that's normal." [Female, 15, group residential]

Negative comments are:

"He steals my stuff, he comes into my room." [Male, 13, group residential]

"Different interests. Fishing, fishing conversation, fishing. :-(." [Male, 16, group residential]

"Bullied by one other resident." [Female, 14, group residential]

Having the same opportunities as peers

Young people were asked if they feel able to do the same sorts of things that their friends not in residential care are able to do. Just over half (54%) said they are able to do the same sorts of things as other young people all the time (23%) or most of the time (30%), while 29% said they are not very often able to do the same sorts of things and 17% said they can never do what other young people can.[32] This finding is consistent with the 2007 survey.

The perceived source of restriction is not always clear from young people's comments, but would appear to be a combination of household/facility rules and those attributed to DChS where the respondent is in the department's care.

The most common set of limitations, referred to by 12 of the 48 respondents (25%) who commented on this issue, pertains to contact with friends: limitations on having friends, going out with them, visiting them at their homes or having them visit the residential. Being unable to stay over at friends' houses was mentioned by half of these respondents.

"Lots of things that are unable to do – play with friends." [Male, 15, individual residential]

"Not allowed to have a girlfriend." [Male, 14, individual residential]

"I cannot have friends over as they do not have approval from Child Safety." [Male, 13, individual residential]

"I reckon someone should explain to me why my friends can't come and sleep over here, because that makes me feel different." [Sex not stated, 14, group residential]

Nine respondents (19%) identified other restrictions on them that they perceive are not present for their peers outside residential care; in particular, they list their inability to leave the premises without carers, to stay up late or come home late, and to spend time in the house without supervision. These comments tend to be made by older respondents:

"Not allowed to leave the house without the carers and can't stay up late." [Female, 15, group residential]

"Need free-time." [that is, time without carers – male, 16, individual residential]

"I can't come and go as I please, can't just go anywhere without a carer." [Female, 13, individual residential]

32 Individual percentages for "all the time" and "most of the time" sum to less than the total percentage quoted because of rounding.

"Curfew of 9:30pm is limiting." [Male, 16, youth shelter]

Several respondents (4%) identify financial factors limiting their ability to do what their friends can do. For example:

"No pocket money. Not able to work." [Male, 17, group residential]

"... I don't have enough money when I go out." [Male, 12, individual residential]

However, a handful of respondents (8%), including two young people living in individual residential facilities in the care of the department, stated their belief that they have more freedom and opportunities than their friends not in residential care.

A complete list of comments recorded for this question is provided in the appendix at the end of this report.

Contact with family and community

Are you able to see your family as much as you would like?

Fifty-one per cent of respondents feel they are able to see their family as much as they would like, 44% said they do not get to see them enough, and 5% see them more than they want to. No significant differences are apparent according to sex, cultural background, age group or DChS care status.

Fifty-eight young people wrote comments about seeing their family. A summary of themes evident in these comments is provided in Table 7 with sample responses. Although only 5% of respondents indicated seeing their family more than they wanted to and almost half said they would like to see them more often, the most common theme observed in the comments is not wanting to see family or not caring whether or not they see them. A less common theme in the comments is a desire for more contact or reunification with siblings and/or parents. Being unable to see family because of geographical distance is another recurring comment. A complete list of comments is provided in the appendix.

Table 7

Seeing family: themes in open-ended responses (2008) (*n* = 58)

Theme	%^#	Sample responses
Don't want to see family or don't care whether see them	21% (12/58)	"I see them just enough – NEVER." "I don't want to see them." "To be honest, I don't see my family much, but it doesn't worry me."
Description of frequency of contact with family	17% (10/58)	"Three nights per week and Friday to Sunday." "See them every Saturday." "Only had one family visit in two months."
Would like more contact or to be reunified with siblings	12% (7/58)	"Would like to spend more time with my sister." "Would like more contact with brothers."
Family members are too far away for regular contact or don't know where they are	12% (7/58)	"They live 300km away." "No family in this area." "Don't see them at all. Their whereabouts are currently unknown."
Would like more contact or to be reunified with birth parents	10% (6/58)	"I want to live with my dad but I can't..." "I want sleepover."

^ Sum of percentages is less than 100% as not all responses were coded to these themes.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Are you able to phone or email your family as much as you would like?

Seventy-four per cent of respondents can phone or email their family as much as they like, 22% do not get to phone or email them enough, and 5% have to phone or email their family more than they want to.

Four of the 20 respondents who commented on this issue indicated that they do not have a computer or access to the internet. Other restrictions young people identify in their comments include limited time to talk or email, having their communication with their family supervised by staff, not having the credit to make phone calls, being disallowed by the service from using the phone, and having their mobile phone confiscated.

If you are Aboriginal and/or Torres Strait Islander, do you feel that you are still in touch with your community?

Among Aboriginal and/or Torres Strait Islander respondents ($n = 58$), 66% feel that they are still in touch with their community. No differences are evident according to age group, sex or DChS care status; neither has this proportion changed significantly from 2007.[33]

Having a say and being listened to

Input into household decision-making

Young people were asked if they have a say in everyday household matters such as the purchase of groceries, choice of television programs, chores and internet access. Seventy-nine per cent of respondents feel they have a say about such matters all the time (38%) or most of the time (41%), while 15% feel that it is not very often that they have a say and 6% feel they never have a say.

Fifty comments were recorded for this question. Over half of these comments qualify respondents' answer to the question in some way, usually indicating the spheres of decision-making they do or do not have a say in: 17 comments (34%) indicate that respondents do not have internet connection or do not have a say in relation to use of the internet; 5 comments (10%) indicate that respondents do not have a say in relation to food or grocery shopping; and 4 (8%) indicate they do not have a say in television programs. Respondents' comments also highlight differences across residential facility types, with those in more institutional settings (boarding schools and mental health facilities) commenting that they have negligible say in such things, and those in independent living settings indicating that they have complete control over such decisions.

The following are examples of comments from young people about having a say in everyday matters:

> "They take my choices, like lunch, like tuna in spring water." [Female, 15, group residential]
>
> "Some do, some don't. We get told what to do." [Female, 15, group residential]
>
> "Pick lollies." [Male, 8 years, group residential]
>
> "No access to kitchen. TV and internet are a pay/get basis." [Female, 17, mental health facility]
>
> "All the time. Live on my own." [Female, 17, supported independent living]
>
> "It depends on who is working and if other people want something different." [Male, 16, youth shelter]
>
> "I would like more of a choice." [Male, 12, individual residential]
>
> "I don't have internet access but I would like to so I could send emails or do school work." [Female, 13, group residential]
>
> "I do whatever I want." [Male, 16, individual residential]

33 Although this appears to be an increase from the proportion reported in 2007 (56%), the difference does not reach statistical significance because of the small number of respondents involved in the analysis.

Having a say in what happens to you

Sixty-eight per cent of respondents feel they have a say about what happens to them all the time (24%) or most of the time (44%). Twenty per cent feel they have a say in what happens to them not very often and 12% said never.

There is a statistically significant increase since 2007 in the proportion of those who feel they have a say in what happens to them all or most of the time (from 55% in 2007 to 68% in 2008). When the sub-sample of those in DChS care is compared across the two years, the increase in the proportion of those who feel they have a say about what happens to them all or most of the time (from 56% in 2007 to 63% in 2008) is not statistically significant.

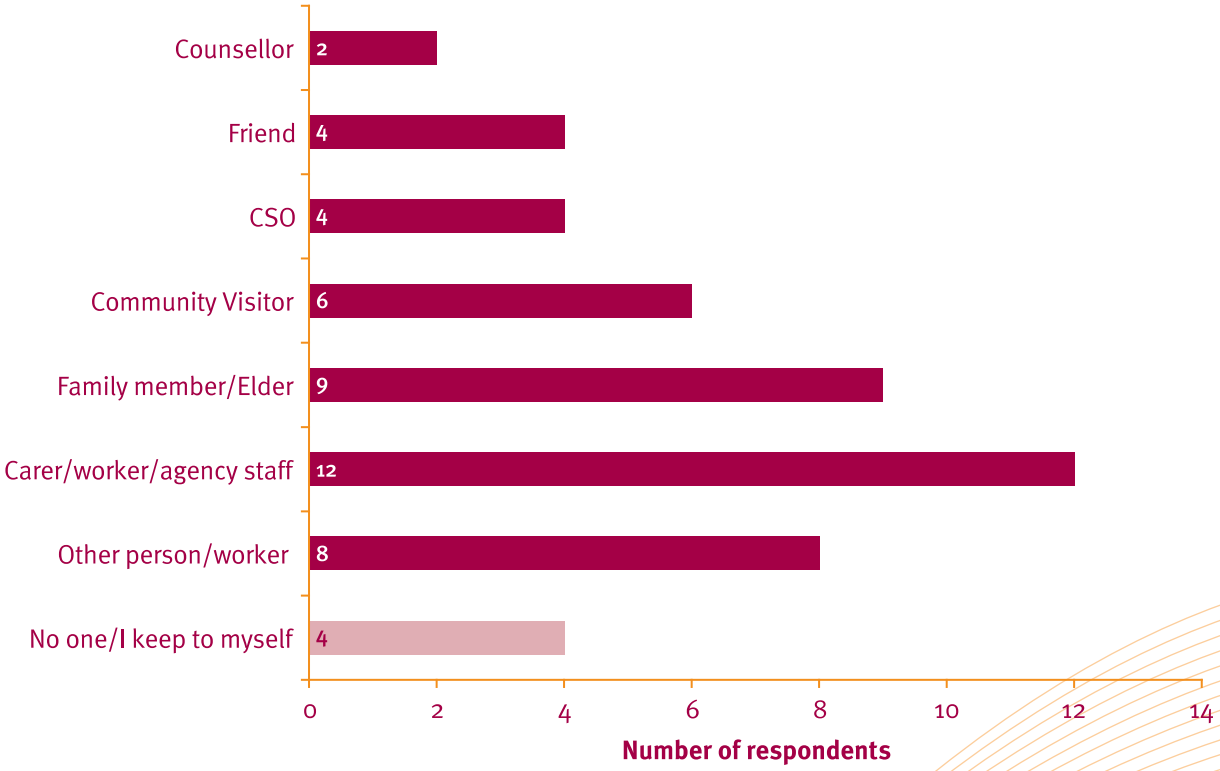
Having someone to talk to

Young people were asked how commonly they have someone to talk to if something is worrying them. Eighty-five per cent of respondents reported having a person, or people, in their life that they can talk to about such things all the time (46%) or most of the time (39%). Nine per cent indicated that they have such a person available to them not very often, and 6% said they never do.

Forty-two respondents commented in relation to this question. Thirty-five of the comments (83%) specify the individual or individuals in the young person's life to whom they talk about such things. The frequency with which particular groups of individuals are named is shown in Figure 20. The group of individuals that young people most commonly say they talk to is their carers/youth workers, followed by family members or Elders.

Figure 20

People respondents talk to when worried (*n* = 42)^ (2008)



^Caution should be exercised in interpreting frequency data as they are generated through coding qualitative data from a non-directed comments field responded to by less than one–fifth of the total sample. Respondents were not specifically asked whom they talk to, neither were they provided with response options.

Talking to the Children's Commission

Young people were asked if they had ever contacted the Commission about a complaint or concern. Twelve per cent reported that they have previously contacted the Commission.

Is there anything you would like to have happen that no one is listening to you about?

A quarter of respondents (25%) indicated that they have such a problem. All except one of these young people (n = 50) provided some detail about their concerns. Table 8 summarises responses into various themes or categories and provides sample responses for each. Where responses are applicable to multiple themes, they have been coded multiple times to give a rough proportion of responses that pertain to each theme. A complete list of responses to this question is provided in the appendix.

The most common set of concerns, raised by just under two-fifths of these respondents, relates to care or family contact arrangements. Matters relating to the management of the facility, including problems with staff, co-residents, house rules and the state of premises, were raised by about a quarter of these respondents. A similar proportion raised problems with the provision of material goods and resources. A smaller proportion reported problems with school or difficulties accessing extracurricular educational opportunities.

Table 8

Issues that no one is listening to respondents about (n = 49) (2008)

Theme	%^#	Sample responses
Issues with care or contact arrangements	39% (19/49)	"I want to move out of the motel and into a proper home. The department says there are no carers for me." "I would like to live with my older sister but no one is doing anything about it." "Go home and have a normal life like everyone else." "Like to go into SILL (independent living)."
Issues with facility management (including issues with staff, co-residents, house rules and the state of premises)	24% (12/49)	"Management doesn't listen to me at all." "Lawn mowing – if don't do it, I lose marks. Lawn is very big – rural area." "I want to be able to see my friends more." "[Worker name] to be gone [along] with [co-resident name]."
Issues with provision of material goods and resources	22% (11/49)	"Yes, I would like a road bike." "Get curtains, washing machine, fire extinguisher, vacuum." "Getting internet."
Issues with school or access to extracurricular educational opportunities	12% (6/49)	"Kids stop teasing and bullying me at school." "I WANT TO MOVE SCHOOLS!!" "Country music and rap and hip hop dance lessons."
Other	6% (3/49)	"I want a new family."

^ Sum of percentages is greater than 100% due to multiple coding.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Sense of improved wellbeing

Are you better or worse off since moving here?

Fifty-six per cent of respondents regard themselves as better off since moving into their current living situation, 14% consider themselves worse off, and 31% think they are about the same.[34, 35] Respondents' view of themselves as better or worse off does not appear to be influenced by their gender or cultural background.

Nineteen of the 42 comments (45%) for this question come from those who feel they are better off since moving into their current living situation. Their comments include:

"I have changed a lot." [Female, 15, group residential]

"I was picked up, off the street, so 'better' is the inevitable answer." [Male, 17, youth shelter]

"I like it because just to get away from my mum for a while so I won't listen to her talking to herself again." [Male, 18, individual residential]

"I've been under the department my whole life. I've been everywhere. This set-up is better than foster care." [Male, 16, individual residential]

"I've started school with the support of my carers." [Sex/age not stated, individual residential]

"Get pocket money." [Sex/age not stated, group residential]

Eleven of the comments recorded (26%) come from those who feel they are worse off since moving into their current living situation. Their comments include:

"Since moving here I have gained weight." [Male, 15, individual residential]

"But I was in a good placement." [Male, 13, group residential]

"Not living with Mum. A s**t-hole box in the middle of nowhere." [Male, 11, group residential]

"No freedom – can't be by myself." [Male, 15, individual residential]

"I don't like this house or the other girls." [Female, 16, group residential]

"Never had a police record until moving here." [Male, 15, group residential]

Comments recorded for this question are presented in full in the appendix.

Have things got better for you over the last 12 months?

Fifty-three per cent of respondents regard things as having improved for them over the previous 12 months, 21% disagree and 26% are not sure.[36] Responses to this question do not appear to be affected by respondents' gender, cultural background or age. As half of all respondents have been

34 Sum of the individual percentages is greater than 100% because of rounding.

35 The proportion of respondents who regard themselves as better off (56%) appears to be much lower than in 2007 (79%). However, responses to this question cannot be directly compared with 2007 data as the survey instrument was altered in 2008 to include a neutral response option ("about the same"). This option was introduced to reduce a high non-response to the 2007 item and thereby increase the reliability of findings. The response rate to the 2008 question is now comparable to the rates for other survey items and the figures presented here are arguably a more accurate representation of respondents' views. Also note that, while the proportion of respondents who regard themselves as better off has apparently decreased, so has the proportion who regard themselves as worse off, if to a lesser degree (21% in 2007, 14% in 2008).

36 The proportion of respondents who regard things as having improved (53%) appears to be lower than in 2007 (64%). However, responses to this question cannot be directly compared with 2007 data as the survey instrument was altered in 2008 to include a neutral response option ("not sure"). This option was introduced to reduce a high non-response to the 2007 item and thereby increase the reliability of findings. The response rate to the 2008 question is now comparable to the rates for other survey items and the figures presented here are arguably a more accurate representation of respondents' views. Also note that, while the proportion of respondents who regard things as having improved has decreased, so has the proportion who regard things as not having improved (36% in 2007, 21% in 2008).

in their current accommodation for 4 months or less, responses to this question are not necessarily indicative of young people's satisfaction with their current living situation.

Eighteen of the 47 comments recorded for this question (38%) come from those who disagree that things have improved for them in the last year. Some of their comments include:

"I stop hitting myself, at least, but I hate it here." [Female, 14, boarding school]

"Too many things happen in a short amount of time." [Male, 13, group residential]

"They've gotten worse. Different people showed up in my life." [Male, 11, group residential]

"Not really – got into more trouble." [Male, 13, individual residential]

"My life has gone downhill." [Female, 17, mental health facility]

"It's been hard." [Male, 12, group residential]

"I wouldn't be here if things weren't bad." [Male, 16, youth shelter]

Sixteen of the comments recorded for this question (34%) are from respondents who agree that things have improved over the previous year. Their comments include:

"Learnt new things, gained access and awareness of resources around me." [Male, 17, youth shelter]

"I got a job." [Male, 17, supported independent living]

"A little." [Female, 13, individual residential]

"Treated like a grown up." [Female, 17, individual residential]

"More time with Mum." [Male, 14, group residential]

"[Service name] have helped me and supported me a lot." [Male, 14, group residential]

Satisfaction with living situation by age group and DChS care status

Responses to certain measures of satisfaction in residential care vary significantly according to respondents' age group, with younger respondents tending to be less satisfied than older respondents (see Table 9). Younger respondents are less likely to report:

- feeling safe
- getting along with their co-residents
- being told what to expect about living in the facility
- being satisfied with the amount of phone or email contact they have with their families
- having a say in everyday matters and in what happens to them more generally, and
- being able to do the same things as their friends not in residential care.

On the other hand, they are more likely to report having a problem that no one is listening to them about.

Respondents in the middle age group (13 to 15 years), however, are significantly more likely than both older and younger respondents to:

- regard the rules of the residential as unreasonable
- feel they have insufficient space for themselves, and
- regard themselves as worse off since coming into their current living situation.

Table 9

Satisfaction with current living situation by age group (2008)

Measure of satisfaction	All respondents	Age group		
		≤ 12 years	13–15 years	16–18 years
Satisfaction increases with age				
Feel safe	93% (194/209)	82% (23/28)	94% (82/87)	96% (80/83)*
Get on with other young people in household^	80% (123/153)	67% (14/21)	75% (48/64)	92% (54/59)*
Get on with workers^	95% (197/208)	86% (25/29)	93% (81/87)	99% (82/83)*
Say in everyday household matters^	79% (163/206)	68% (19/28)	76% (67/88)	88% (70/80)*
Able to do things friends not in residential care can^	54% (111/207)	42% (11/26)	48% (44/91)	65% (52/80)*
Say in what happens to you^	68% (139/204)	56% (14/25)	57% (51/90)	87% (71/82)*
Have someone to talk to^	85% (173/204)	73% (19/26)	79% (69/87)	95% (80/84)*
Would like something to happen that no one is listening to them about	25% (50/198)	40% (10/25)	29% (26/89)	17% (13/79)*
Family contact – phone/email				
As much contact as wanted	74% (145/197)	57% (16/28)	70% (59/84)	85% (66/78)*
Want more contact	22% (43/197)	39% (11/28)	23% (19/84)	14% (11/78)
Want less contact	5% (9/197)	4% (1/28)	7% (6/84)	1% (1/78)
Belongings treated with respect	84% (179/213)	72% (21/29)	83% (74/89)	91% (76/84)
Middle age group least satisfied				
Rules/discipline reasonable	83% (174/209)	90% (26/29)	74% (66/89)	89% (71/80)*
Enough space	86% (179/209)	86% (24/28)	78% (70/90)	95% (77/81)*
Better/worse off since coming here				
Better	56% (114/205)	62% (16/26)	47% (41/87)	64% (53/83)*
Worse	14% (28/205)	12% (3/26)	22% (19/87)	6% (5/83)
About the same	31% (63/205)	27% (7/26)	31% (27/87)	30% (25/83)

* Represents a statistically significant difference between respondents of different age groups.
^ Data pertain to respondents who answered "all/most of the time".

Similarly, on a number of measures of satisfaction with current living situation, respondents in the care of the department appear to be less satisfied than those not in DChS care (see Table 10).

Table 10

Satisfaction with current living situation by DChS care status (2008)

Measure of satisfaction	All respondents	In DChS care	Not in DChS care
Treated well here	92% (190/207)	90% (141/156)	100% (46/46)*
Told what to expect about living here	75% (158/211)	71% (114/161)	87% (39/45)*
Enough space	86% (179/209)	82% (129/158)	100% (46/46)*
Enough privacy	83% (175/210)	80% (127/159)	98% (45/46)*
Belongings treated with respect	84% (179/213)	82% (133/162)	96% (44/46)*
Get on with other young people in household^	80% (123/153)	75% (82/109)	98% (39/40)*
Say in what happens to you^	68% (139/204)	63% (101/161)	88% (38/43)*
Would like something to happen that no one is listening to them about	25% (50/198)	29% (46/157)	10% (4/41)*
Better/worse off since coming here			
Better	55% (114/205)	51% (81/160)	76% (32/42)*
Worse	14% (28/205)	15% (25/160)	5% (2/42)
About the same	31% (63/205)	34% (54/160)	19% (8/42)
Able to do things friends not in residential care can do^	54% (111/207)	51% (81/159)	64% (28/44)
Have someone to talk to^	85% (173/204)	82% (130/158)	94% (43/46)
Rules and discipline reasonable	83% (174/209)	81% (129/160)	93% (43/46)
Say in everyday household matters^	79% (163/206)	77% (122/159)	88% (38/43)
Workers listen all/most of time	88% (185/210)	86% (138/161)	96% (44/46)

* Represents a statistically significant difference between respondents in DChS care and those not in care.
^ Data pertain to respondents who answered "all/most of the time".

A majority of these differences are statistically significant. Respondents in DChS care are less likely to report:

- being treated well in their accommodation
- being told what to expect about living in the residential
- having sufficient space and privacy
- feeling their possessions are treated respectfully
- getting along with other young people they live with
- feeling they have a say in what happens to them, and
- feeling that they are better off since coming into their current living situation.

In addition, young people in DChS care are significantly more likely than those not in DChS care to report having a problem that no one is listening to them about.

Best aspects of current living situation

Respondents were asked to specify the "best thing" about their current living situation. Ninety per cent of respondents answered this open-ended question. Table 11 summarises responses into various themes or categories and provides sample responses for each. A complete list of responses to this question is provided in the appendix.

Table 11

Best thing about living here (*n* = 199) (2008)

Theme	%^#	Sample responses
People in the household (workers and co-residents)	31% (62/199)	"Workers who help you with stuff that not everyone can help you with and, most of all, driving you around. LOL." "I feel that I am cared for and am understood." "Two other young people in the unit." "Having people in my age group."
Resources provided (activities, food, facilities, equipment, premises, pocket money, etc.)	25% (50/199)	"Food, social activities, nice people, PlayStation." "Pocket money, Foxtel, generally pretty good." "I like doing the same thing. Drawing, playing games, going out somewhere. My mother didn't really take me to cinema – thinks there are bad people there. I've just gone out [to] do some shopping."
Personal space, privacy or autonomy	20% (39/199)	"Independence. More time for yourself. Here you can wake up at any time." "Control of my life. Independent living with some youth worker support." "Fun people, nice, clean, and I get privacy." "I get my own room."
Nothing	11% (22/199)	"Nothing much". "Nothing. I hate it."
Atmosphere in household (comfortable, fun, safe, peaceful, happy, stable, respectful)	11% (21/199)	"I don't get yelled at and they treat me the same as everyone else." "I know this is where I am staying." "That it is cosy and safe...."
Basic needs met	6% (11/199)	"Knowing that you have a bed every night of the week and food on the table." "A place to stay instead of the streets."
Location	4% (7/199)	"Close to the city and close to transport..." "Being in the country."
Maintaining contact with family	3% (5/199)	"I am not separated from my brothers." "Seeing my mummy."
Other	5% (9/199)	"Birthday, Xmas, Easter." "Doing the gardening and going to school."
Don't know	7% (13/199)	"Don't really know – everything." "I don't really know!!" [respondent in placement for few days only]

^ Sum of percentages is greater than 100% due to multiple coding.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Almost a third of respondents identified people in the household or facility, usually their workers and/or co-residents, as the best thing about their current living situation. A quarter identified the resources provided to them as the best thing. These resources include the facilities, equipment, pocket money, food and activities provided by the service. One-fifth indicated that what they enjoy most is having more personal space, privacy or autonomy than previously. Minor themes include appreciating the comfortable atmosphere of their household or facility, having basic needs for food and shelter met, being in a good location, and being able to maintain contact with siblings or birth parents. About one in ten respondents indicated that "nothing" is good about where they are living.

Most desired improvements and changes

Respondents were asked two questions about improvements and changes they would like. The first question concerns improvements and changes to their current living situation. The second question asks them to consider improvements and changes to the provision of residential care more generally.

What would you most like to see improved or changed to make living here better?

Eighty-eight per cent of respondents to the survey provided answers to this open-ended question. Table 12 summarises responses into various themes or categories and provides sample responses for each. A complete list of responses to this question is provided in the appendix.

Just over a quarter of respondents identified changes they would like to see to facility rules and management. Respondents reported that there are too many rules or that the rules are too strict or inflexible and undermine a sense of their personal freedom or independence, particularly in relation to social interaction with other young people. Rules about bedtimes, curfews and "sleepovers" are commonly cited in this category.

Just under a quarter of respondents identified improvements in the provision of material goods and resources as what they would most like. These include obtaining or upgrading facilities such as the internet and pay-television, household appliances, recreational and other equipment, furniture and/or pocket money. Having more activities and outings organised by the service, and improvements to the condition or size of premises, bedrooms or grounds, are also included in this category.

A minor theme identified is the desire for change in the people in the household – typically, modifications to the membership of the household or changes to the behaviour or attitudes of particular workers or co-residents. A desire for more personal space and/or privacy is another minor theme.

Just over one-fifth of respondents stated that there is nothing that requires change or improvement.

Table 12

Most desired improvements or changes to current living situation (*n* = 194) (2008)

Theme	%^#	Sample responses
Changes to facility rules and management (more flexible rules, greater independence, etc)	26% (51/194)	"Curfew changes. Everyone treated equally, even upstairs." "Consequences for the other girls for being a bully." "Being allowed to have animals." "Bed times changed to 9pm or 9:30pm and rules not so strict." "Go see friends and be able to go somewhere by myself."
Improvements to resources provided (activities, food, facilities, equipment, premises, pocket money, etc)	23% (44/194)	"More recreational activities – gym, boxing bag, push bikes." "More kitchen appliances. Getting a vacuum." "More pocket money." "Maybe have internet access for assignments."
Nothing	22% (42/194)	"Nothing. It's good how it is now." "Nothing. Everything is alright."
Changes to people in household (presence/behaviour/ attitudes of workers or co-residents)	14% (27/194)	"The respect between people." "The arguments and bitchiness with the other girls." "That girl to stop hitting me." "For people who work here to get your permission before barging down the hallway and telling what to do."
More personal space or privacy	4% (7/194)	"Locks on bedroom doors." "I'd like to move into a flat." "A better accommodation so I have more privacy."
Other	11% (22/194)	"Move me to Popy." "I get angry because I am sick of living here."
Don't know	8% (16/194)	"No idea." "I'm not sure."

^ Sum of percentages is greater than 100% due to multiple coding.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

What would you most like to see improved or changed to make residential living better for young people?

Seventy-one per cent of respondents to the survey provided an answer to this open-ended question. Table 13 summarises responses into various themes or categories and provides sample responses for each. A complete list of responses to this question is provided in the appendix.

Although this question aimed to elicit from respondents their views about the residential care system more generally and how it could be improved, responses closely mirrored those given to the previous question concerning improvements or changes to respondents' immediate living situation (for example, "A bigger TV and more games to play"); however, a number framed these issues more generally (for example, "Activities to take your mind off your own situation").

Improvements to resources provided to young people in residential care, and changes to the rules, discipline or management of facilities, are again the most commonly occurring themes. In addition, just under a tenth of respondents identified issues relating to the staffing of facilities. These respondents indicated a desire to have more staff rostered in their facility, staff with better or more appropriate skill-sets for working with the client group, and/or staff who are more understanding,

supportive or respectful. Just under a tenth also indicated that they want greater personal space, privacy, freedom and/or the opportunity to have a say or be heard in matters affecting them. A handful said they think an expansion is needed in accommodation options for young people unable to live at home. As with the previous question, one-fifth of respondents stated that nothing requires change or improvement to make residential living better for young people.

Table 13

Most desired improvements or changes to the residential care system (*n* = 157) (2008)

Theme	%^#	Sample responses
Nothing	20% (32/157)	"Nothing, happy as it is." "Nothing needs to be changed."
Changes to rules, discipline or facility management (i.e. to allow greater personal freedom, social opportunities, safety/wellbeing)	18% (29/157)	"Rules to be less harsh." "That you're allowed to do stuff that your friends can do." "Less restriction on sports and activities – they're worried we'll get hurt." "Seeing people, like going to [name]'s place and having friend's sleep over." "That we could wake up at 8:30am instead of 7:00am." "Stop bullying."
Improvements to resources provided (activities, food, facilities, equipment, premises, pocket money, etc)	17% (27/157)	"Internet and television. More space for belongings." "More different foods, like Aussie instead of Asian." "Activities to take your mind off your own situation." "Better house. Better appliances." "... more pocket money."
Changes to staffing (more staff, better skills, more support, understanding, respect, consistency)	9% (14/157)	"Better carers in all the houses. Some carers shouldn't work with teenagers 'cause they make the problems we have worse." "More females working in the residentials." "Need more disability workers for the young people with disabilities."
More personal space, privacy, freedom or opportunity to have a say/ be listened to	9% (14/157)	"Space to oneself." "Would like to ring my mum and dad and see them without anyone else there." "More freedom. Can't leave the site without workers." "DChS taking more care with what kids say."
More accommodation options for young people/ better publicity about options	4% (6/157)	"More places like this one [youth shelter]." "More places that house 14 to 18 year olds." "Wouldn't have known about it [youth shelter] if my friend hadn't told me. Put up signs at the train stations."
Don't know	14% (22/157)	"Ummmm, I don't know." "Unsure."
Other	15% (24/157)	"Get a better approval process. Allow the Coordinator to sign stuff rather than your CSO. It's really annoying." "Stay in one place for a while."

^ Sum of percentages is greater than 100% due to multiple coding.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Overall happiness in current living situation

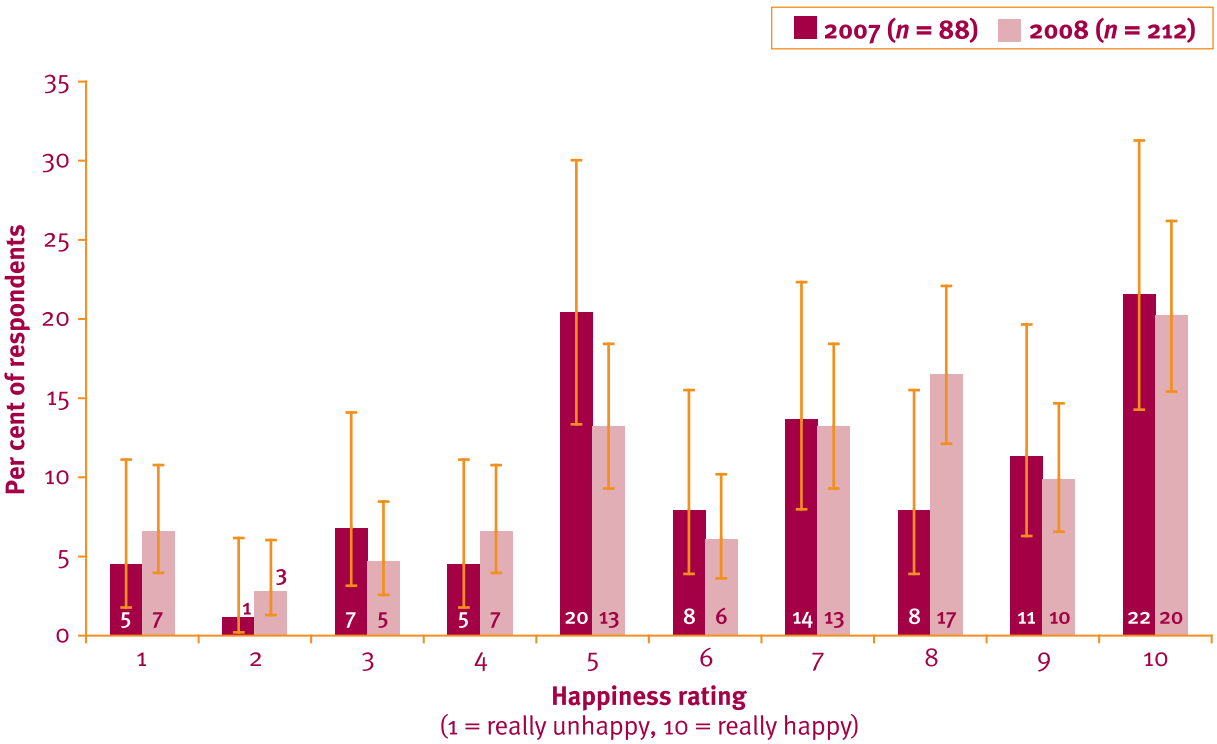
Out of 10, how would you rate your happiness with where you are living now? (where 1 = really unhappy and 10 = really happy?)

The mean happiness rating for the total sample is 6.7 (SD = 2.7). There are no significant differences in the mean happiness rating according to age group, sex, cultural background or DChS care status. However, among those respondents in DChS care, females report a lower mean happiness score than males (5.9 compared with 6.9).

There is no change in the mean satisfaction rating given by respondents between 2007 and 2008. Figure 21 shows the distribution of happiness scores by survey year.

Figure 21

Happiness with current living situation by survey year (2007, 2008)



Predictors of happiness in current living situation

The relationship between respondents' happiness in their current living situation and various potential predictors was examined using multiple regression analysis. A wide range of variables considered to be relevant in determining happiness were included in the multiple regression analysis. These variables (or "predictors") are all moderately correlated with happiness, with the exception of demographic variables, "worried about moving soon" and "length of time in this residential facility" (see Table 14). These variables were retained, however, for their potential interaction with other predictors.

Because of likely variation in the views and experiences of young people of different ages, cultural backgrounds and sex, these variables were controlled for by being entered in the first step of the regression analysis. The initial regression model, containing only these control variables, predicted just 1% of the variance in happiness.[37] The remaining 18 predictors were entered simultaneously in the second block of the analysis. The overall variance explained by all 21 predictors is 63%.[38]

37 $R^2 = 0.012$; $F(3,125) = 0.493$, $p = 0.688$, n.s.

38 $F(21,107) = 8.676$, $p < 0.001$.

Only three of the predictors contribute significantly to the multiple regression model. Each of these predictors is positively related to happiness – having enough privacy, being able to do things other young people can do, and believing that things have improved over the last 12 months. Perceiving rules and discipline to be reasonable approached significance in the final regression model.[39]

Table 14

Predictors included in multiple regression analysis and the correlation with happiness in current living situation

Variable	Correlation with happiness	Beta#	Significance (*p*-value)
Age (≤ 14 years compared with > 14 years)	−0.039	−0.023	0.727
Sex	−0.089	−0.042	0.518
Indigeneity (ATSI compared with non-ATSI)	0.056	−0.014	0.831
Feel safe	0.316	0.014	0.844
Treated well	0.468	0.061	0.541
Told about what to expect living there	0.312	0.087	0.208
Rules and discipline reasonable	0.483	0.144	0.055
Have enough privacy	0.483	0.161	0.033*
Possessions treated with respect	0.424	0.054	0.510
Worried about moving soon	0.057	0.072	0.259
Get on with others in the facility^	0.417	0.064	0.454
Get on with workers^	0.310	– 0.037	0.694
Workers listen to you^	0.332	0.073	0.354
Have a say in everyday household matters^	0.338	0.048	0.510
Able to do things others can do^	0.454	0.143	0.041*
Better off since moving here	0.469	0.051	0.518
Worse off since moving here	−0.537	−0.127	0.131
Things have got better in the last 12 months	0.514	0.215	0.010*
Things have not got better in the last 12 months	−0.512	−0.141	0.082
Length of time in this residential facility	−0.023	0.090	0.174
In DChS care	−0.100	0.170	0.801

* Indicates statistically significant predictor of happiness in current living situation.
^ Variable based on "all/most of the time" responses.
# Coefficient of the explanatory variable. Sign of coefficient indicates direction of influence (negative or positive), magnitude indicates extent of predictive influence – larger values indicate greater influence.

39 $\beta = 0.144$, $p = 0.055$.

The child protection system

The survey asked young people in DChS care additional questions to gauge their satisfaction with the department and their CSO; their engagement in child protection decision-making, such as the development of case plans and transition from care plans; and their awareness of advocacy services designed to promote their rights and best interests. Respondents' answers to these questions are presented in this chapter. The impact of age, sex and cultural background on young people's views and experiences of the child protection system was investigated and, where measures have been duplicated across the two years of the survey, changes over time in young people's views and experiences were also examined.[40]

Key messages

- Overall the survey found strong consistency in young people's views and experiences of the child protection system between the two years of the survey. As observed in 2007, young people in residential care have mixed feelings and experiences of the child protection system.
- The survey highlights that the experience of being in DChS care is often associated with frustrations for young people:
  - more than one in four feel they have to do things that they don't want to do, such as see people and attend meetings, all or most of the time
  - two out of five say that, all or most of the time, they are made to feel different because they are in care, and
  - three out of five say they are not confident that, when the department says they can do something or have something, this will eventuate.
- The survey found that young people in DChS care have varying experiences of being involved in or informed about decisions related to their care. Just under half (44%) do not feel that decisions about them are explained to them all or most of the time and roughly a third (35%) reported that the reason they came into care has not been explained to them. A majority are aware of having a case plan (60%), but less than a third (28%) know what is in their case plan, suggesting a lack of engagement by the majority of young people in this important sphere of decision-making about their care.

40 Young people's engagement in DChS initiatives designed to improve their health and educational outcomes, such the Education Support Plan and the Child Health Passport, was also investigated and findings are presented separately in the chapter on health, disability and education.

- The survey's findings on transition-from-care planning reinforce this impression. Although the department's policy stipulates that transition planning must start before a young person's fifteenth birthday, and that the young person must be centrally involved in this planning process, fewer than three in four young people aged 16 years or older reported that they have been spoken to about what will happen to their care situation when they turn 18. Less than half are aware of having a leaving care plan, and only one in three can report being involved in the development of that plan. The survey does reveal, however, a statistically significant increase from 2007 in the proportion of young people reporting that they have been spoken to about what will happen to their care situation when they turn 18.
- Young people's responses to questions about their CSO suggest that a majority have a relatively positive relationship with their CSO. At least two out of three know the name of their CSO, feel they can contact them all or most of the time if they need to, and feel that their CSO listens to them and cares about what is best for them all or most of the time. However, almost half (44%) would like to see their CSO more often.
- The survey found a level of instability in young people's relationships with their CSO, with one in four (28%) reporting 4 or more different CSOs in the last year. Young people's rating of their CSO's helpfulness is found to decrease with the number of different CSOs they have had in the last year.
- Although continuity in young people's relationship with their CSO may be ideal, multiple regression analysis reveals that other factors are more important in predicting young people's perception of their CSO as helpful. Having a CSO who is contactable all or most of the time when needed, feeling confident in the department to follow through on promises, and feeling that a CSO cares about one's best interests all or most of the time were found to be significant positive predictors of perceived helpfulness. On the other hand, dissatisfaction with the amount of contact young people have with their CSO undermines their sense of the CSO's helpfulness.
- The survey found considerable consistency in views and experiences of the child protection system across age groups, sex and cultural background. Against three measures, however, female respondents show a lower level of satisfaction with their experiences. Compared with males, females are:
  - less likely to report confidence in the department to follow through on promises to them
  - more likely to report being made to feel different all or most of the time because they are in care, and
  - less likely to report that people in the child protection system explain decisions about them all or most of the time.

  Female respondents in the care of the department also recorded a lower mean happiness rating with regard to their current living situation than males in DChS care (see the previous chapter).

Impacts of being in the department's care

Do you have to do things, such as see people or go to meetings, or other things, you don't want to do?

Twenty-eight per cent of respondents said they have to do things they don't want to do all the time (8%) or most of the time (20%). Thirty-nine per cent said it is not very often that they have to do such things and 33% said they never have to do such things. There are no reportable differences according to age, sex or cultural background, nor is there a significant change in these proportions from 2007.

Are you made to feel different because you are in care?

Thirty-nine per cent say they are made to feel different all the time (17%) or most of the time (22%). Thirty-four per cent say it is not very often they are made to feel different and 27% say they are never made to feel different. No significant change is evident in this measure from 2007. Females are more likely to report being made to feel different all or most of the time than males (50% compared with 32%).

Of the 19 comments recorded for this question, 11 (58%) come from those who said they are made to feel different all or most of the time, and a majority of these respondents identified as Aboriginal. Examples of these comments include:

"Because I am not living with a mum or dad." [Male, 15, Aboriginal, individual residential]

"Because of lads at school." [Male, 11, Aboriginal, group residential]

"Because people tease me because I'm in care." [Male, 14, group residential]

"People think we're rich and little princesses and that we're spoiled." [Female, 17, Aboriginal, group residential]

"Makes me feel my family is poor." [Male, 15, Aboriginal, individual residential]

"When I was in primary school." [Male, 16, Aboriginal, individual residential]

No comments were recorded from those who said they are never made to feel different and only 4 comments come from those who reported occasionally being made to feel different:

"It's better to be in care." [Male, 15, group residential]

"I'll bash them [if they make me feel different]. Care gives us a lot of anger." [Male, 14, group residential]

"From people from school." [Male, 17, group residential]

When the department says you can do something, or have something, do you feel sure that it will happen?

Sixty-one per cent of respondents in care responded negatively to this question, a similar proportion to that found in 2007. Females are more likely than males to lack confidence in the department following through on its promises to them (77% compared with 55%). Respondents who said they are not confident in the department following through on promises are more likely than other respondents to say that they are made to feel different all or most of the time because they are in care (47% compared with 29%).

Forty-three comments are recorded for this item. Twelve (28%) are qualifications to an affirmative response (for example, "Only sometimes", "But it is usually slow", "When they think about it") and 7 (16%) are indications of not knowing how to respond to the question. All except 3 of the remaining comments (that is, 49% of all the comments recorded) come from respondents who are not confident in the department to follow through on its promises to them. As a group, these comments stand out in the survey data with regard to the level of negativity they express.

Respondents' anger and frustration with the department in this area are reflected in the common use of expletives and derogatory terms that are only irregularly evident in responses to other survey items.

Common themes in young people's responses are feeling lied to, that promises made to them are commonly broken or do not result in any action being taken, and that obtaining permission for things is a frustratingly slow and arduous process. For example:

> "CSOs say they are going to do things all the time but mostly it never happens." [Female, 13, group residential]
>
> "Department never get back in time to give permission to camp." [Male, 16, group residential]
>
> "I have been trying to have sleepovers for three months." [Male, 13, group residential]
>
> "Lots of times it doesn't happen." [Male, 13, group residential]
>
> "It never does. They are lying scum." [Male, 14, group residential]
>
> "They are full of s**t. Said I would be in care six months and it's been much more." [Male 15, group residential]
>
> "They suck." [Male, 15, youth shelter]

A full list of comments is provided in the appendix.

Involvement in case planning and other decision-making

All respondents to the survey were asked questions about their involvement in decisions affecting their lives *(Do you have a say in everyday household matters? Do you have a say in what happens to you? Are there things that you would like to have happen that no one is listening to you about?)*. As reported in the previous chapter, young people in the care of the department are less likely than those in residential care who are not in DChS care to regard themselves as involved in such decision-making, and they are more likely to report having problems that they feel no one is listening to them about (see Table 10). The following questions were asked specifically of young people in DChS care in relation to participating in case planning and other decision-making that is more specifically related to being in the child protection system.

Did anyone explain to you why you came into care?

Sixty-five per cent of respondents reported having this explained to them. There are no reportable differences according to age, sex or cultural background, nor is there a significant change in this proportion from 2007.

Do you have a case plan? Do you know what is in your case plan?

Sixty per cent of respondents said they have a case plan, 34% do not know if they have one and 6% said they do not have one. Less than half of those who know they have a case plan (47%) know what is contained in it. Although this represents an increase from last year (34%), the difference does not reach statistical significance.

Do people explain the decisions made about you?

Fifty-six per cent of respondents feel that decisions about them are explained to them all the time (15%) or most of the time (40%).[41] Thirty-one per cent feel decisions are not very often explained to them, and 13% said they are never explained to them. Male respondents are significantly more likely to feel that decisions are explained to them all or most of the time than female respondents (65% compared with 40%). No significant change is evident in this measure from 2007.

41 Individual percentages sum to less than 56% because of rounding.

Transition from care planning

Australian and international research has highlighted that young people leaving state care face a range of challenges additional to those faced by other young people in their transition to independent adult life, and they commonly have poorer social and economic outcomes (see *Background*). This points to the need for careful planning for young people's eventual independence. Recognising this, DChS stipulates that transition from care planning is to commence in the month before a young person in care turns 15 years of age. CSOs are responsible for undertaking the planning process, in collaboration with the young person and relevant individuals and agencies in the young person's support network. The planning process is to involve a comprehensive assessment of the young person's strengths and needs, and the development of a leaving care case plan that identifies the young person's goals, along with the roles and responsibilities of the young person, their family, carers, friends and other support persons, in achieving these goals (DChS, 2008a: Ch. 7.20).

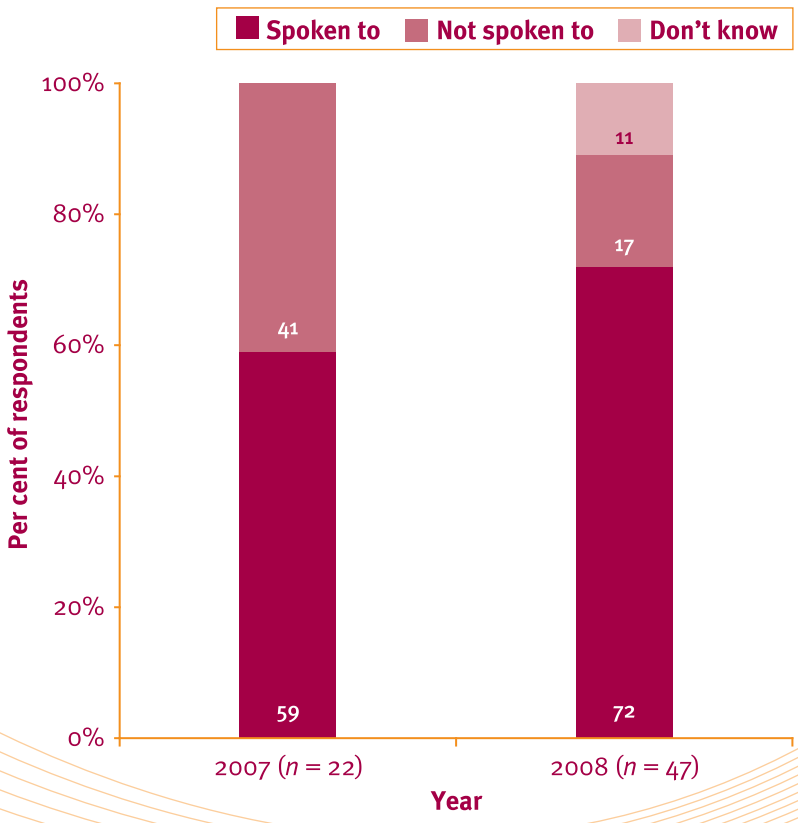
Young people aged 16 years and over in DChS care ($n = 56$) were asked about transition from care planning in order to gauge the extent to which such planning is being undertaken, how engaged young people feel in this process, and whether there have been improvements over time.

Has anyone spoken to you about what happens to your care situation once you turn 18?

Seventy-two per cent of those aged 16 years or older said that someone has spoken to them about leaving care, 17% reported that no one has spoken to them, and 11% said they do not know. The proportion of young people who said they have been spoken to about leaving care arrangements has increased significantly since 2007 (see Figure 22).

Figure 22

Spoken to about leaving care arrangements by survey year (respondents in DChS care ≥ 16 years) (2007, 2008)

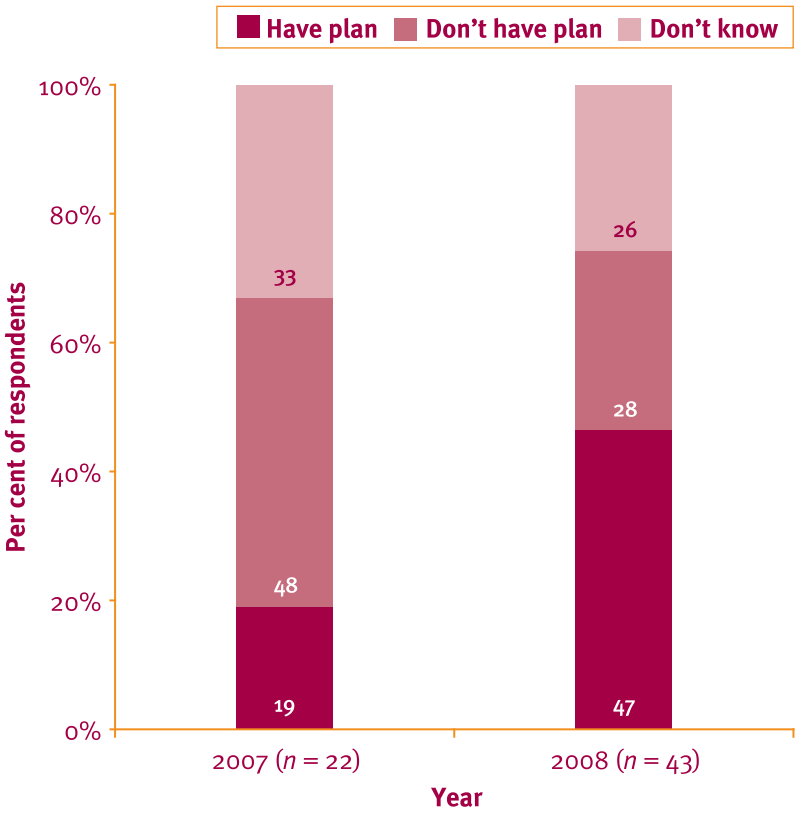


Has a leaving care plan been developed for you? If so, were you involved in its development?

Forty-seven per cent of those aged 16 years or older said that a leaving care plan has been developed for them, 28% said they have no plan and 26% said they do not know if they have a plan.[42] The proportion of respondents who report having a leaving care plan is considerably greater than the 2007 figure (19%), but because of the small sample sizes involved the difference does not reach statistical significance (see Figure 23).[43] Of the 20 young people who indicated having a leaving care plan, 14 (70%) stated they are, or have been, involved in its development.

Figure 23

Have leaving care plan by survey year (respondents in DChS care ≥ 16 years) (2007, 2008)



Awareness of advocacy services

Do you know you can contact the Children Services Tribunal if you have a problem with a decision made by the department?

The Children Services Tribunal has jurisdiction to conduct merit reviews of certain decisions made by DChS in relation to children and young people in state care. If a child or young person is unhappy about a decision made about them, they can apply to the tribunal to have the decision reviewed, provided it is the type of decision that the tribunal is permitted to review under the *Child Protection Act 1999* (Children Services Tribunal, 2008).

Forty-seven per cent of respondents said they know they can contact the Children Services Tribunal if they have a problem with a decision of the department. This proportion does not represent a significant increase on that reported in 2007.

42 Individual percentages sum to more than 100% because of rounding.

43 $p = 0.094$.

Did you have a Separate Representative (or lawyer acting in your best interest) when your case went to court?

A Separate Representative is a Legal Aid lawyer appointed by the Childrens Court to represent the interests of a child or young person before the court when the court is asked to decide whether a child protection order should be made. Separate Representatives are only appointed in cases where the court considers it particularly necessary to protect the best interests of the child or young person. The Separate Representative's role is to act in the child or young person's best interests and, as far as possible, to place their views and wishes before the court during the proceeding. The Separate Representative may gather information about the case from a range of sources, including the child or young person, but does not necessarily engage directly with the child or young person (Legal Aid Queensland, 2009).

This question was included at the request of the Department of Justice to assess young people's awareness of the appointment of a Separate Representative. Seventeen per cent of respondents in DChS care said they had a Separate Representative when their case went to court, 22% said they did not have a Separate Representative, and 61% do not know whether they did.[44] These proportions are unchanged from 2007.

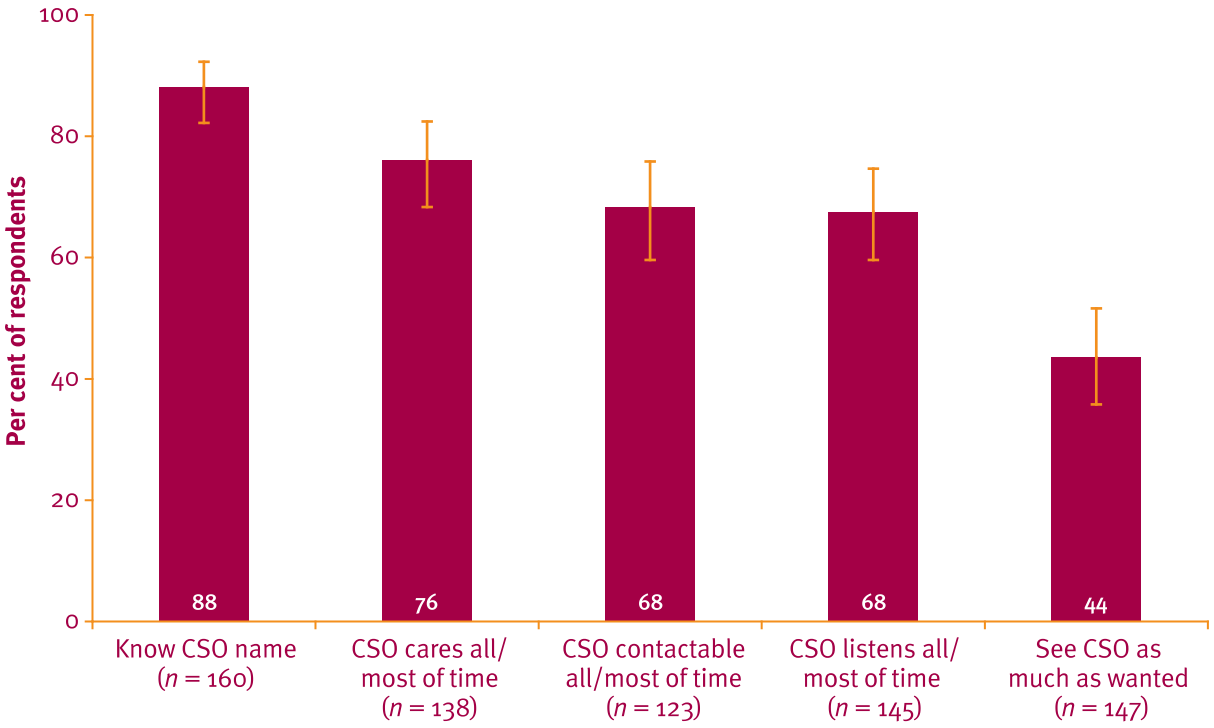
44 Care needs to be taken in interpreting these figures. CVs administering the survey observed that young people in both foster and residential care are often confused by this question. Some young people are in DChS care by parental agreement without their case ever going to court. Even when custody or guardianship is established through the courts, relatively few children and young people attend court and then many do not know if a Separate Representative was appointed for them or not. Most are not even familiar with the term "Separate Representative". The reference to "when your case went to court" is additionally confusing for young people who have current involvement with courts in relation to other situations in their life.

Relationship with Child Safety Officer

Responses to items about respondents' CSOs are not significantly different from those in 2007; with the exception of female respondents being more likely to know the name of their CSO, no significant differences are apparent according to age, sex or cultural background. Figure 24 summarises responses to key measures of satisfaction with CSOs that are reported in more detail in the following text.

Figure 24

Measures of satisfaction with Child Safety Officer (2008)



Do you know the name of your Child Safety Officer?

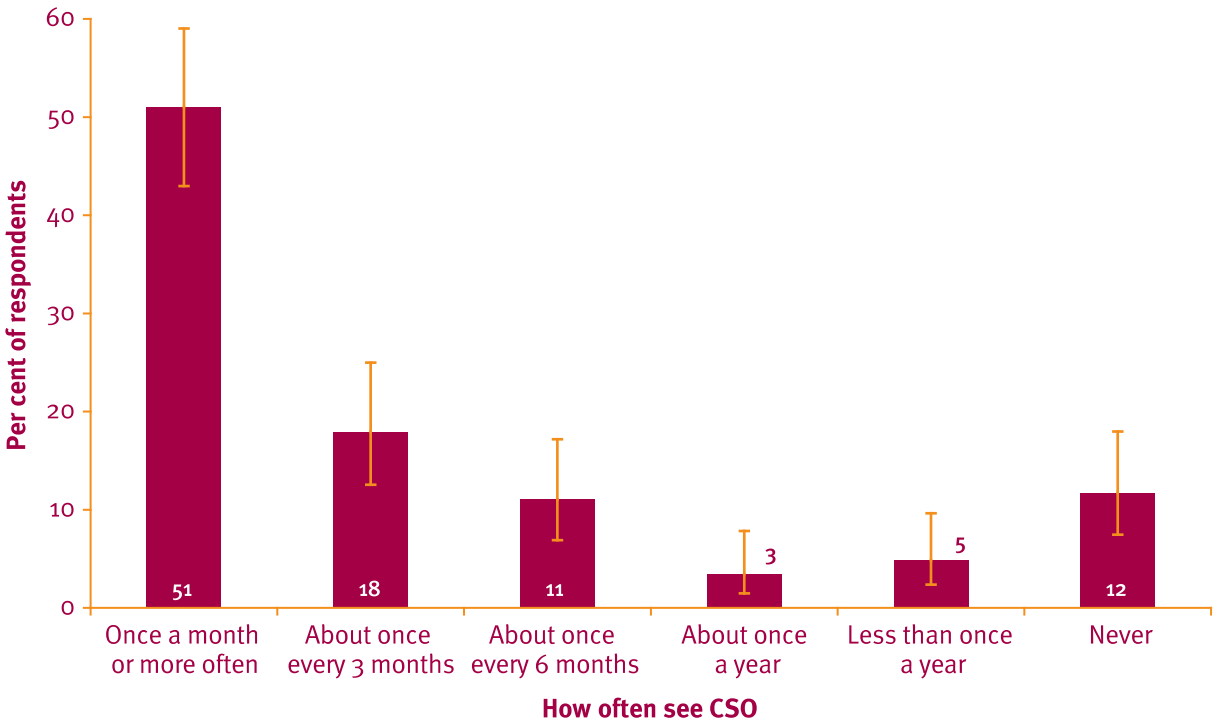
Eighty-eight per cent of respondents responded positively to this question. Female respondents are more likely to report knowing the name of their CSO than male respondents (94% compared with 87%).

How often do you see your Child Safety Officer?

Fifty-one per cent of respondents reported seeing their CSO at least once a month. Figure 25 shows the reported frequency with which young people see their CSO.

Figure 25

Frequency with which respondents see their Child Safety Officer (*n* = 145) (2008)



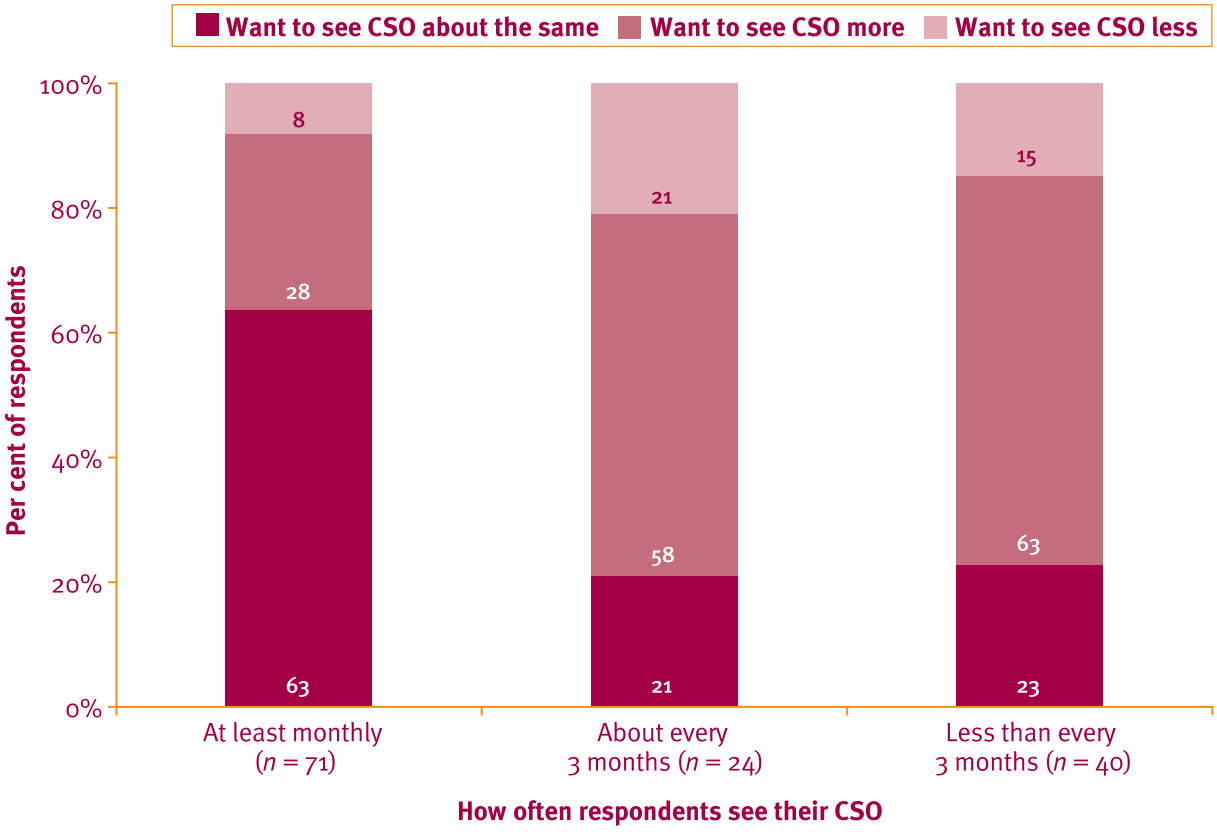
How often do you want to see your Child Safety Officer?

Forty-four per cent of respondents are happy with the frequency of contact with their CSO. The same proportion want to see their CSO more often, and 12% said they want to see their CSO less often.

Respondents' satisfaction with the current frequency with which they see their CSO is related to the frequency with which they report seeing their CSO. Those who report seeing their CSO at least monthly are significantly more likely to report satisfaction with the amount they currently see their CSO than are those who see their CSO less often – either once every 3 months, or less frequently than every 3 months (63% of those with monthly contact are satisfied, compared with 21% who see their CSO every 3 months and 23% who see their CSO less frequently than every 3 months – see Figure 26).

Figure 26

How often respondents see their Child Safety Officer by how often they want to see them (2008)



Does your Child Safety Officer listen to you?

Sixty-eight per cent of respondents feel their CSO listens to them all the time (26%) or most of the time (42%). Eighteen per cent said their CSO listens to them not very often and 14% said never.

Sixteen of the 26 comments recorded for this question (62%) are qualifications to a positive response (for example, "Only when she stops talking herself", "Some do, some don't", "When she comes") or an expression of "don't know". In other comments, respondents note that listening does not necessarily equate to CSOs understanding them or taking action on matters raised, and this disappoints them (for example, "But things don't always happen", "But [CSO] doesn't get what I want"). A few respondents appear unequivocally positive about their CSO, however:

> "CSO is really good and talks to me about stuff." [Male, 13, group residential]
>
> "She is the best CSO I have ever had." [Male, 14, group residential]
>
> "She is deadly and the best CSO." [Female, 17, group residential]

Does your Child Safety Officer care about what is best for you?

Seventy-six per cent of respondents feel their CSO cares about what is best for them all the time (31%) or most of the time (45%). Twelve per cent said their CSO cares about them not very often and 12% said never. A moderately strong and statistically significant correlation exists between respondents feeling that their CSO cares about what is best for them all or most of the time and feeling that their CSO listens to them all or most of the time ($r = 0.77$), suggesting that being listened to is important to young people's perception that their CSO cares about them.

Of the 28 comments recorded for this question, 18 (64%) indicate that the respondent is uncertain if their CSO cares about what is best for them (for example, "No idea", "Don't really know"). One non-respondent living in supported independent accommodation stated, "They don't know me and they are too busy to see me!", highlighting the importance, for this young person, of adequate time and contact with the CSO to the perception of being cared about.

Comments from those who feel their CSO cares about what is best for them all or most of the time include:

"She is helpful." [Male, 14, group residential]

"But not where family is concerned." [Male, 13, group residential]

"But she doesn't show it or do anything about it." [Female, 12, group residential]

Comments from those who feel their CSOs never or not very often cares about their best interests are:

"More worried about the rules." [Male, 16, individual residential]

"Only when it suits my probation officers." [Male, 17, youth shelter]

"If she cared, [she'd] give me back to Mum." [Male, 13, group residential]

Are you able to contact your Child Safety Officer when you need to?

Of those respondents who have needed to contact their CSO at some time (n = 123), 68% reported being able to contact them all the time (36%) or most of the time (32%). Twenty per cent reported that they can contact their CSO not very often and 11% said never.[45]

Only 14 comments were recorded for this question, 8 of which come from those who did not respond to the main question or those who have not needed to contact their CSO. All except 1 of the remaining comments are from those who reported never or not very often being able to contact their CSO. These comments describe obstructions to communication that these respondents experience:

"Never calls me back." [Male, 17, group residential]

"Most the time is on weekend." [Male, 13, group residential]

"It's hard lately to get to speak to her." [Female, 15, group residential]

"I ring but she does not ring back." [Male, 13, individual residential]

"Must go through … manager of [service provider] to contact CSO (CSO requested this)." [Male, 15, individual residential]

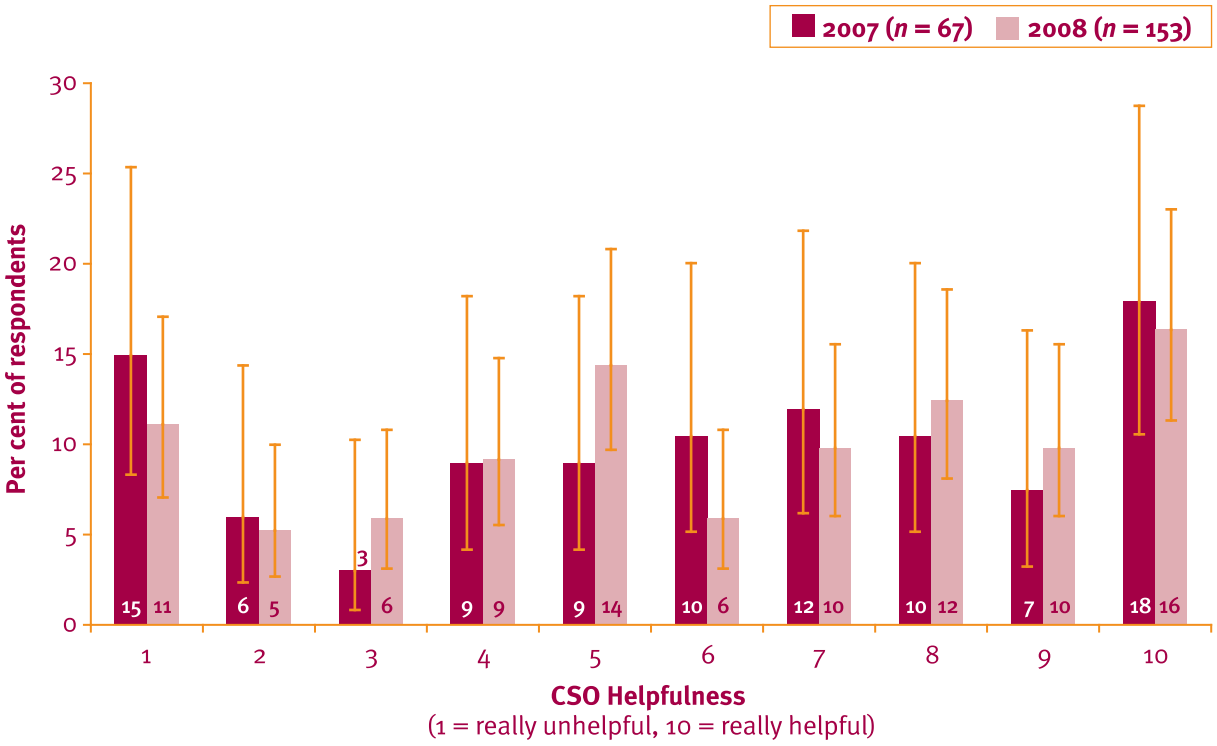
45 Individual percentages sum to less than 100% because of rounding.

Out of 10, how helpful has your Child Safety Officer been (where 1 = really unhelpful and 10 = really helpful)?

The mean helpfulness rating given by respondents is 6.0 (SD = 3.0). There are no significant differences in the mean helpfulness rating according to sex, cultural background or age group, nor is there a change in the mean helpfulness rating from 2007. Figure 27 shows the distribution of helpfulness scores by survey year.

Figure 27

Helpfulness of Child Safety Officer by survey year (2007, 2008)

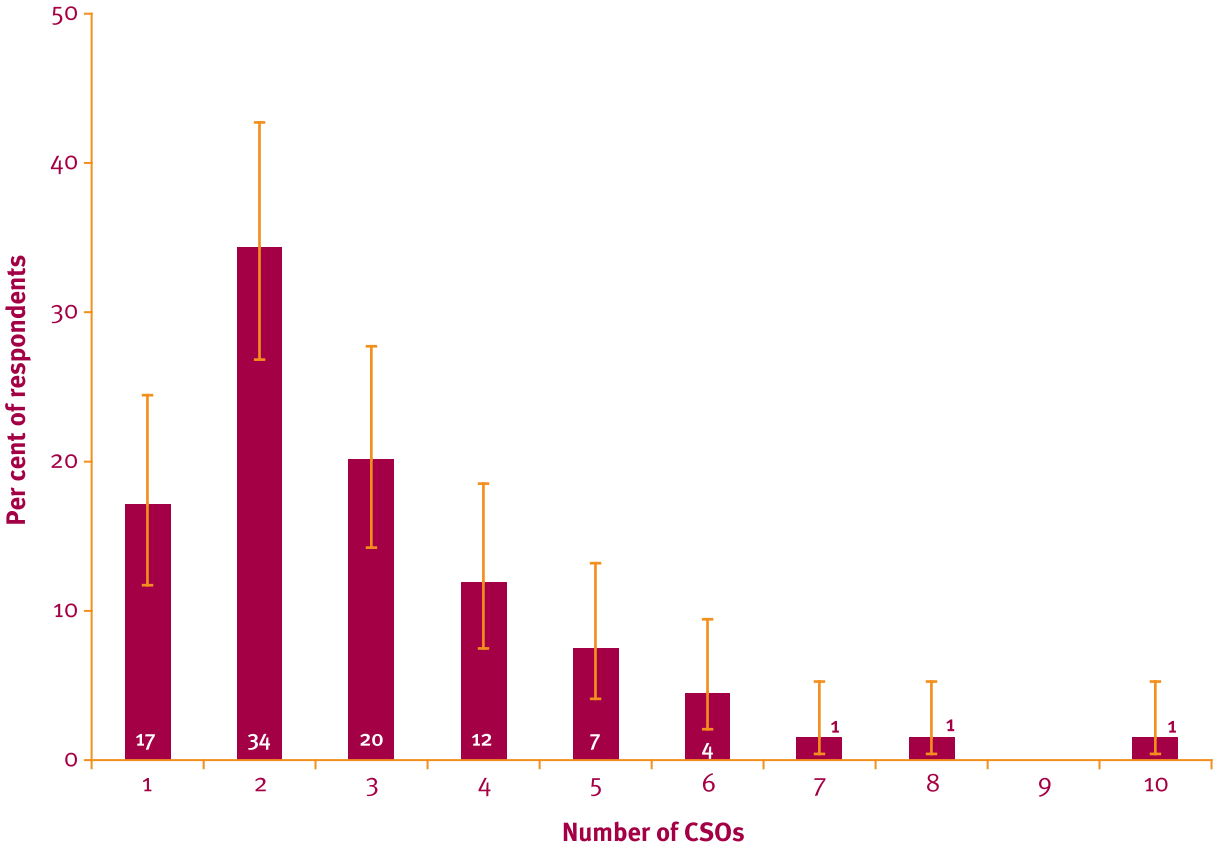


How many Child Safety Officers have you had in the last year?

The median number of CSOs that respondents reported having in the previous 12 months is 2. However, 28% reported having 4 or more CSOs in the last year. The maximum number of CSOs, reported by 2 respondents, is 10 (see Figure 28). Fourteen per cent of all respondents in DChS care indicated that they do not know how many different CSOs they have had in the last 12 months. A number of these young people wrote comments such as "heaps", "can't remember – too many" or "lost count" because of the high rate of CSO turnover. Accordingly the quantitative data presented here may be an underestimation of the instability in young people's relationships with their CSO.

Figure 28

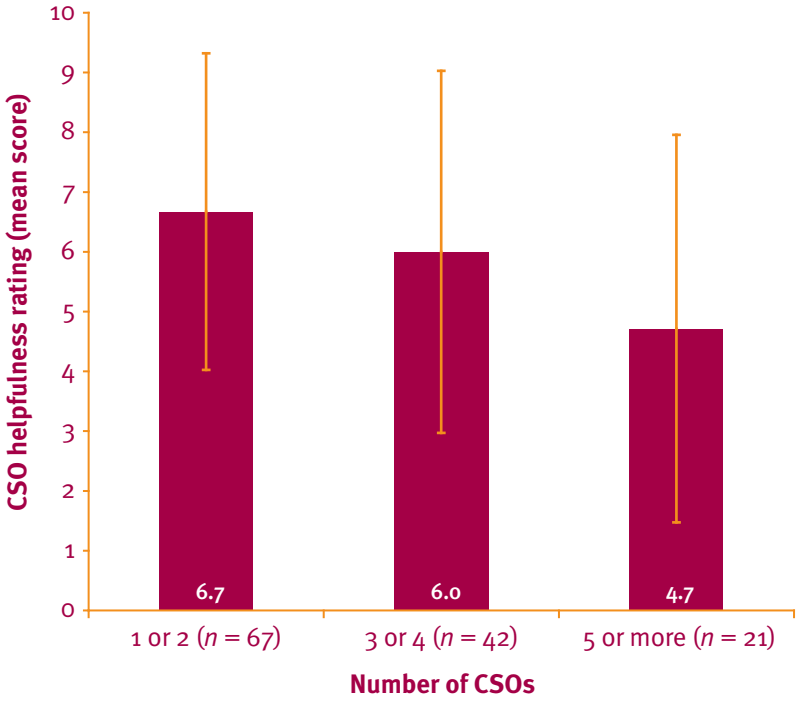
Number of different CSOs in last year (*n* = 134) (2008)



Respondents' rating of their CSO's helpfulness was found to decrease with the number of different CSOs they report having in the last year. The mean helpfulness score given by those reporting they have had either 1 or 2 CSOs or 3 or 4 CSOs in the preceding year is significantly higher than that given by those reporting 5 or more different CSOs (6.7 and 6.0, compared with 4.7 – see Figure 29).

Figure 29

Helpfulness of Child Safety Officer by number of different Child Safety Officers in last year (2008)



Predictors of perceived helpfulness of Child Safety Officer

Correlation and multiple regression analyses were used to examine the relationship between young people's perception of their CSO's helpfulness and various possible predictors. In the absence of theoretical foundations for hypothesising the factors that influence the perceived helpfulness of child protection caseworkers, a selection of predictors that, at face value, appear to be associated with CSO helpfulness were included in the multiple regression model. The predictors that were included are all moderately correlated with CSO helpfulness (see Table 15).

Because of likely variation in the views and experiences of young people of different ages, cultural backgrounds and sex, these variables were controlled for by being entered in the first step of the regression analysis. The regression model with these controls did not significantly predict any variance in CSO helpfulness.[46] The remaining 16 predictors were entered simultaneously in the second block of the analysis. The variance in CSO helpfulness explained by all 19 predictors is 65%.[47]

Five of the predictors contributed significantly to the multiple regression model. Having confidence in the department to follow through on promises, being able to contact the CSO when needed, and perceiving that the CSO cares about what is best for them are positively related to young people's perception of their CSO as helpful, while wanting to see their CSO more often and wanting to see their CSO less often were negatively associated with helpfulness.

46 $R^2 = 0.001$, $F(3,99) = 0.049$, $p = 0.985$, n.s.

47 $F(19,83) = 8.245$, $p < 0.001$.

Table 15

Predictors included in multiple regression analysis and the correlation with perceived helpfulness of Child Safety Officer (2008)

Variable	Correlation with CSO helpfulness	Beta#	Significance (*p*-value)
Age (≤ 14 years compared with > 14 years)	0.027	0.016	0.832
Sex	0.031	0.114	0.121
Indigeneity (ATSI compared with non-ATSI)	0.007	0.040	0.596
Feel safe	0.168	−0.113	0.150
Treated well	0.338	0.100	0.272
Better off since moving here	0.246	0.052	0.542
Worse off since moving here	−0.301	0.052	0.558
Things have got better in the last year	0.249	0.007	0.945
Things have not got better in the last year	−0.268	−0.108	0.239
Able to see family as much as wanted	0.075	0.042	0.570
People explain decisions^	0.314	0.014	0.863
Confident in department to following through on promises	0.501	0.306	< 0.001*
Have a say in what happens to you^	0.181	−0.059	0.440
CSO listens^	0.576	0.092	0.426
CSO cares^	0.632	0.293	0.020*
Able to contact CSO when needed^	0.446	0.185	0.018*
Number of different CSOs in the last year	−0.276	−0.041	0.612
Want to see CSO more	−0.252	−0.239	0.004*
Want to see CSO less	−0.292	−0.224	0.006*

* Indicates statistically significant predictor of perceived helpfulness of CSO.
^ Variable based on "all/most of the time" responses.
# Coefficient of the explanatory variable. Sign of coefficient indicates direction of influence (negative or positive), magnitude indicates extent of predictive influence – larger values indicate greater influence.

The Young People's Views of their Community Visitor Survey

Young people in residential care were given a second questionnaire to capture their views of their CV and gauge, from a service user's perspective, the success with which CVs are achieving their legislated functions (see *Background*). The questionnaire asked young people about the frequency of their contact with their CV and their perceptions and experiences of their CV's qualities, availability and helpfulness. A total of 146 young people in residential care responded to the questionnaire. Their responses are presented in this chapter.

Key messages

- As with the main residential care questionnaire, respondents came from all geographical regions of Queensland. Respondents have a mean age of 15 years and almost two-thirds are male. More than one in four identifies as Aboriginal and/or Torres Strait Islander. Comparison with available data on the residential care population suggests that the sample is broadly representative of this population.
- Respondents expressed a very high degree of satisfaction with their CV:
  - almost without exception, they said that their CV is nice, and listens to them and cares about what is best for them all or most of the time
  - more than nine out of ten see their CV monthly and three out of four are satisfied with this amount of contact, and
  - nine out of ten reported they are able to contact their CV all or most of the time when they need to.
- Young people rated the helpfulness of their CV very highly, with more than four in ten of those surveyed giving their CV a perfect score of 10 for helpfulness. One in two indicated that their CV has helped them with something in particular. The most common forms of assistance that young people identified their CV providing are:
  - help to obtain material goods and resources that they need, such as clothes
  - help to achieve better contact arrangements with their families
  - help to deal with problems that they have with their CSO or the department
  - emotional support
  - obtaining information, and
  - help to deal with problems that they have with the management of the residential facility.
- The survey findings suggest that, from a service user's perspective, CVs are effectively achieving their legislated functions with regard to the residential care system.

- None of the measures of satisfaction vary according to sex, cultural background or age group, nor are there any significant differences between the 2007 and 2008 surveys. This suggests that satisfaction with CVs is consistent across the population and stable over the two-year period that the survey has been conducted.

Respondent characteristics

Table 16 summarises the demographic characteristics of respondents to the CV questionnaire.

Sex and age

Sixty-three per cent of respondents are male and 37% are female. They range in age from 6 years, 9 months to 17 years, 11 months. The distribution of age is skewed towards the maximum, with the mean age being 15 years, 0 months (median = 15 years, 3 months).

Cultural and linguistic background

Fifty-six per cent of respondents identified as Caucasian Australian. Twenty-seven per cent identified as Aboriginal, 0% as Torres Strait Islander and 1% as both. The remaining 16% of respondents who reported having "other" cultural backgrounds come primarily from Europe or the Pacific region, mainly New Zealand.

Geographical location

All 12 geographical regions (CV Zones) are represented. Table 16 presents sample proportions for each region. The largest representations are from the Toowoomba and Western and Central South zones (15% each), followed by Ipswich (12%), Brisbane South (10%) and Central North (9%).

Sample and population comparison

Reliable population data are only available for the segment of the residential care population that is in the care of DChS. The survey did not collect information about respondents' DChS care status, so only a rough comparison between the sample and the population can be made. Table 16 compares demographic characteristics of all respondents with population data for young people in DChS care. The comparison shows that the sample obtained reflects parameters for age, sex, cultural background and geographical location in this significant subpopulation. The sample obtained is also very similar to that obtained for the main residential care survey (see the first chapter of Findings). The strength of these two comparisons suggests that the Community Visitor survey sample is representative of the residential care population.

Table 16

Demographic characteristics of respondents to Community Visitor satisfaction survey (2008)

Characteristic	Sample	Population^
Total number	146	503
Age (mean)	15 y, 0 m	14 y, 6 m
Sex		
Male	63% (89/141)	66% (332/503)
Female	37% (52/141)	34% (171/503)
Cultural background		
Caucasian Australian	56% (78/139)	Not available
Aboriginal	27% (37/139)	24% (115/489)
Torres Strait Islander	0% (0/139)	2% (9/489)
Aboriginal & Torres Strait Islander	1% (2/139)	1% (6/489)
Other cultural background	16% (22/139)	Not available
Geographical location (Community Visitor Zone)		
Brisbane North	8% (12/143)	7% (34/503)
Brisbane South	10% (14/143)	10% (53/503)
Brisbane West	6% (9/143)	8% (38/503)
Central North	9% (13/143)	7% (34/503)
Central South	15% (21/143)	6% (28/503)
Far Northern	6% (8/143)	12% (61/503)
Gold Coast	6% (8/143)	11% (57/503)
Ipswich	12% (17/143)	13% (64/503)
Logan	4% (6/143)	6% (32/503)
Northern	2% (3/143)	7% (37/503)
Sunshine Coast	8% (11/143)	7% (37/503)
Toowoomba and Western	15% (21/143)	6% (28/503)

^ Reliable population data not available. Population data presented here pertain to the subpopulation of children and young people in DChS care. The sample includes respondents not in DChS care. Caution should accordingly be exercised in interpretation of data.

Frequency of contact with Community Visitor

How often do you see your Community Visitor?

Ninety-seven per cent of respondents reported seeing their CV monthly, 1% said they see their CV once every 3 months, 1% indicated having 6-monthly visits, and 1% reported never seeing their CV.

How often do you want to see your Community Visitor?

Seventy-five per cent of respondents are happy with how often they see their CV, 20% want to see their CV more often, and 4% want to see their CV less often.[48]

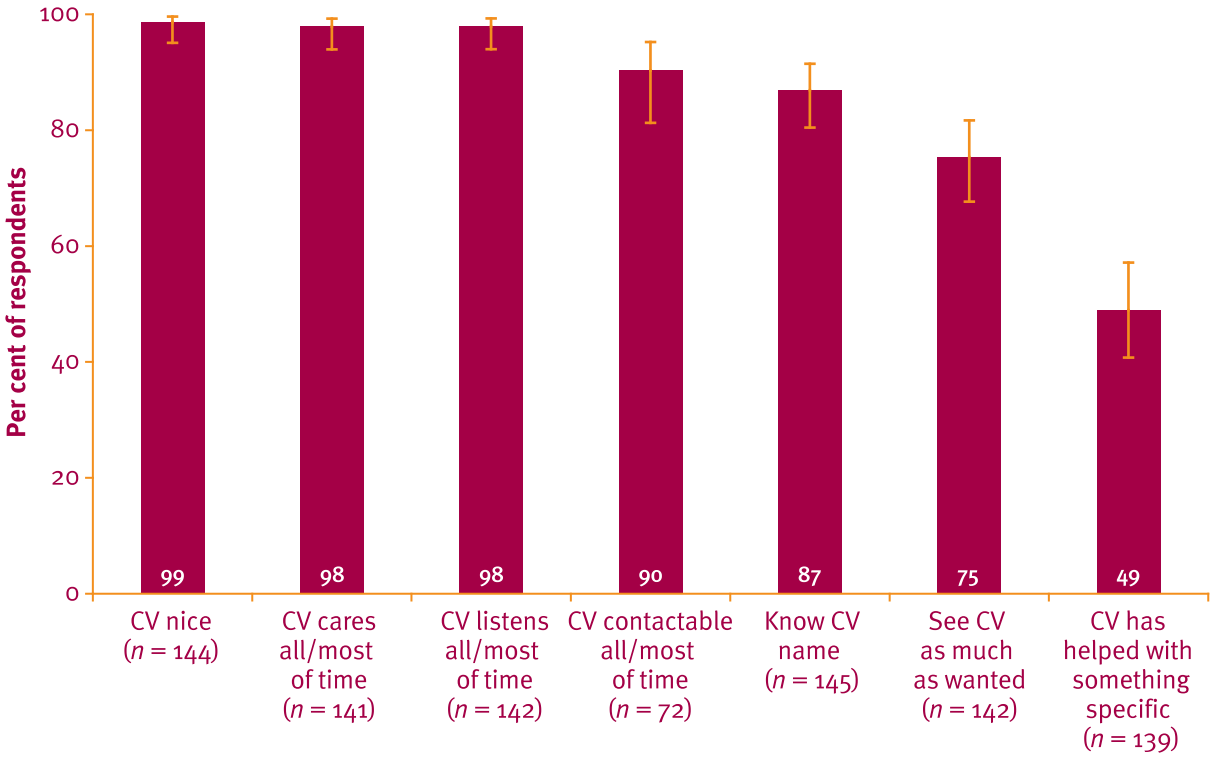
48 Individual percentages sum to less than 100% because of rounding.

Satisfaction with Community Visitor

Responses to items about respondents' satisfaction with their CV are not significantly different from those in 2007 and no significant differences are apparent according to age, sex or cultural background for these items. Figure 30 summarises responses to key measures of satisfaction with CVs that are reported in more detail in the following text.

Figure 30

Measures of satisfaction with Community Visitor (2008)



Do you know the name of your Community Visitor?

Eighty-seven per cent of respondents know the name of their CV.

Is your Community Visitor nice to you?

All except two respondents (99%) agree that their CV is nice to them. Twenty respondents who regard their CV as nice elaborated on this quality. For example:

"[CV] is very nice and someone I can talk to, finally." [Female, 14]

"He brings food." [Male, 13]

"He helps me out." [Male, 12]

"I feel very comfortable around him." [Female, 15]

"She is friendly and we have things in common." [Male, 14]

"She is the coolest youth worker. She cares about everyone. And once she attended my performance. That was cool." [Female, 16]

"She's awesome. Really good to get along with and helps you heaps." [Female, 17]

"Thoroughly explains everything, makes sure we understand and feel comfortable." [Female, 16]

"Very, very nice." [Male, 15]

"We cook together and enjoy talking." [Female, 16]

Does your Community Visitor listen to you?

Ninety-eight per cent of respondents feel that their CV listens to them all the time (82%) or most of the time (16%). One per cent said their CV listens to them not very often and 1% said never. A handful of respondents elaborated on the listening qualities of their CVs:

> "Yes, he was listening to me and I could see that he was." [Female, 16]
>
> "She concentrates on you and puts her time into you." [Female, 17]
>
> "She always listens and gives you feedback about what she thinks." [Female, 16]

Does your Community Visitor care about what is best for you?

Ninety-eight per cent of respondents feel their CV cares about what is best for them all the time (85%) or most of the time (13%). One per cent said their CV cares about what is best for them not very often and 1% said never. Just under half of the comments recorded for this question are statements of not knowing (such as "Can't tell", "Probably. I can't f**king read minds"). The remaining comments come from those who feel strongly that their CV cares about their best interests. For example:

> "Very much." [Female, 17]
>
> "She is a very caring person." [Male, 14]
>
> "She will write out a letter of notes for you to do and remember." [Female, 17]

Are you able to contact your Community Visitor when you need to?

Of those respondents who have needed to contact their CV at some point ($n = 72$), 90% reported being able to contact them all the time (75%) or most of the time (15%). Six per cent reported they can contact their CV not very often and 4% said never.

Is there anything in particular that your Community Visitor has helped you with? If yes, what is this?

Forty-nine per cent of respondents reported that their CV has helped them with something specific. Eighty-six per cent of these respondents completed the open-ended question asking them to elaborate on the nature of this assistance. Table 17 summarises responses into various categories of assistance and provides sample responses for each. A complete list of responses to this question is provided in the appendix.

The two most commonly reported forms of assistance specified by respondents are help with obtaining essential material goods and resources, such as clothes and furniture (22%), and improving contact with family and community (19%). Dealing with problems that respondents have with the DChS or their CSO (12%), and providing emotional support (12%), are other forms of assistance commonly reported. One in ten respondents stated that their CV helps them with "heaps of things" or "everything".

Table 17

Types of assistance provided by Community Visitors (*n* = 59) (2008)

Type of assistance	%^#	Sample responses
Obtaining material goods and resources	22% (13/59)	"Computer." "Driving lessons." "Getting a new bed." "Getting more clothes." "Got phone connected."
Improving family and community contact	19% (11/59)	"Community linking." "Contact with my family." "Information on locating my dad." "Sister contact."
Addressing issues with CSO/DChS	12% (7/59)	"...got CSO to come to court to support me." "Problems with department and CSO." "The Department of Child Safety and places to stay. She's been a big help."
Providing emotional support	12% (7/59)	"I like to talk to her when my anger builds up." "Just general self-esteem." "Listening to me."
Providing information	7% (4/59)	"Get me to understand some rights that I did not have ideas about." "Told me stuff."
Addressing issues with facility management/co-residents	7% (4/59)	"Listening to problems I have with [NGO service provider]." "Talking to staff about things that I want changed."
Helping with lots of things	10% (6/59)	"[She] has contributed to helping me gain many things." "Heaps of stuff." "Everything."
Other	22% (13/59)	"Getting employment." "Helped me work with my writing." "School and stuff."

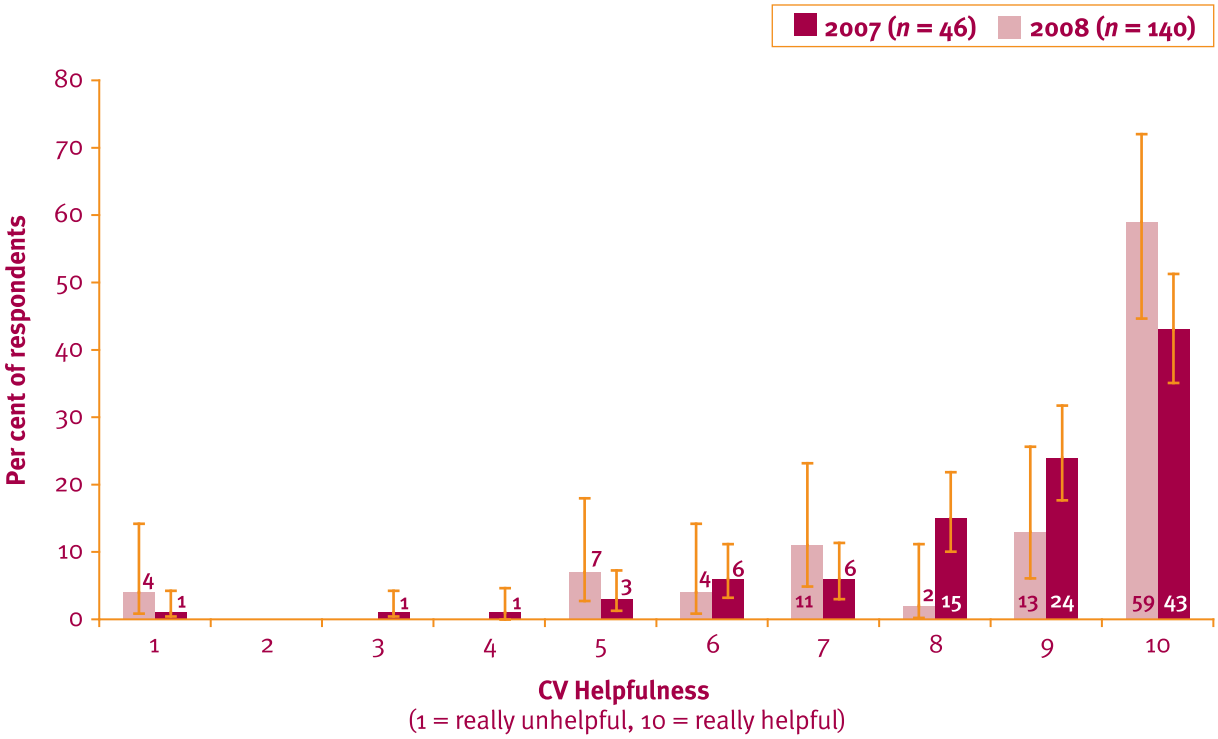
^ Sum of percentages is greater than 100% due to multiple coding.
# Percentages should be regarded only as a rough measure of response frequency. Coding qualitative data can be inexact and subjective.

Out of 10, how helpful has your Community Visitor been (where 1 = really unhelpful and 10 = really helpful)?

The mean helpfulness rating given by respondents is 8.7 (SD = 1.7). Forty-three per cent of respondents gave their CV the maximum helpfulness score of 10. There are no differences in the mean satisfaction rating according to sex, cultural background or age group, nor is there a difference in the mean helpfulness rating from 2007 to 2008. Figure 31 shows the distribution of helpfulness scores by survey year.

Figure 31

Helpfulness of Community Visitor by survey year (2007, 2008)



Conclusions and future directions

The survey findings presented in this report reveal some of the strengths of the residential care and child protection systems and the challenges they face. This concluding section highlights what the Commission views as the most significant of these strengths, while pointing to areas in need of reform or development. Most of these areas have been noted previously by others and their identification here reinforces their importance in policy development and performance monitoring. Some of these issues are complex to respond to. The Commission acknowledges the efforts made by a broad range of individuals and agencies to deal with them, and the evidence of incremental improvements. In the following text, strategies for responding to issues identified are suggested in italics for consideration in policy development processes.

Improving young people's safety and wellbeing

The survey suggests that a majority of young people in residential care are reasonably happy with most aspects of their care and accommodation. For example:

- at least nine out of ten said that they feel safe and well treated and have workers who care about what is best for them all or most of the time
- at least four out of five said they feel that their workers listen to or understand them all or most of the time, they have someone to talk to if they are worried about something, the premises are sufficiently clean, they have enough personal space and privacy, their belongings are treated with respect, and the rules and discipline in the facility are reasonable enough.

These are reassuring findings, suggesting that Queensland's residential care system is, on the whole, providing an environment that promotes young people's sense of safety and wellbeing.

Young people also expressed a high degree of satisfaction with the support and advocacy provided by their CV. In addition, half indicated that their CV has helped them with something in particular. Most commonly this help relates to obtaining material goods and resources that they need, such as clothes; achieving better contact arrangements with their families; and addressing issues that they have with their CSO or the department. This suggests that CVs are performing a valued function with respect to promoting and improving the safety and wellbeing of young people in residential care.

The survey findings suggest, however, that there is room for improvement. It is of concern that, while most young people report satisfaction with many aspects of their care, almost half do not feel they are better off since coming into their current living situation. The survey also reveals that certain groups of young people, such as those who are younger in age and those who are in the care of DChS, are more likely to have negative experiences and views of residential care. This suggests that support and care provided to young people in residential facilities needs to be sensitive and responsive to the particular needs and possible vulnerabilities of these subgroups.

In their work supporting young people in residential care, carers/facility staff and child protection practitioners should develop/maintain awareness of structural factors, including younger age and being in DChS care, that are associated with more negative experiences and views of being in residential care.

Understanding and meeting young people's needs

Stability of care

One of the most notable characteristics of young people in residential care highlighted by the survey is the instability of their alternative care experiences. For example, the four out of five respondents reporting a history of DChS care reported living in 2 residential facilities and 3 foster care placements on average while reporting a total of 3 years in DChS on average. Some residential care is only available on a short- to medium-term basis to provide young people with intensive therapeutic or behavioural support. This may contribute to the short average length of stay in

residential facilities. However, it is noteworthy that one in three young people said they are worried they will have to move to another place in the next few months and half do not know where they will be going after their current accommodation concludes.

These observations are important, given that stability and a sense of security have been identified as protective factors for children and young people in alternative care and, conversely, that instability in care and education are associated with negative long-term outcomes for this cohort (Cashmore & Paxman, 2006; Dearden, 2004; Simmel, 2007; Stein, 2006). In their research with care leavers in Australia, for example, Cashmore and Paxman (2006) found that a sense of security, stability, continuity and social support were strong predictors of better long-term outcomes for young people leaving care. Similarly Stein (2006) in the UK has observed that the most successful group of care leavers is characterised by having had more stability and continuity in their lives, including secure attachment relationships, than less successful groups of care leavers.

Many factors contribute to young people's instability in alternative care placements making this a complex issue to respond to at a policy level (see CCYPCG, 2006). Notwithstanding this, considerable effort has been directed at addressing this issue in Queensland in recent years. In particular, some of the strategies implemented by DChS are:

- amending the *Child Protection Act 1999* to specifically recognise the right of children in care to a safe and stable living environment
- amending the *Child Protection Act 1999* to stipulate that case plans must be developed for every child as soon as they enter the child protection system, to promote longer-term decision-making
- increasing the size and diversity of the carer pool to better match children and carers
- improving the preparation and training of carers to ensure that they understand the realities of foster care, and
- identifying ways to increase the availability of support to carers, including planned respite care (DChS, 2007; DChS, 2009).

In view of the survey findings, it is important to monitor the effectiveness of these and other strategies developed to improve stability of care and young people's sense of security.

Incorporate meaningful and valid measures of stability and security into performance reporting for the child protection system. Ideally these should include both subjective measures of young people's sense of security, such as that collected through the Commission's survey ("Are you worried that you will have to move to another place in the next few months?"), and objective measures of stability, such as the number of placements per year in DChS care and the number of schools attended per year of schooling, collected by DChS and DETA.

Education

The survey provides insights into the nature and extent of the educational challenges faced by young people in residential care. Instability in schooling is a common experience for these young people, with almost a third reporting attending 5 or more primary schools and a fifth reporting attending 4 or more secondary schools. Over half reported being excluded from school at least once and three in ten said they currently have a problem at school that they have not been able to get help with. In addition, one in five young people reported taking medication for ADHD, a condition associated with language, learning and social problems, while one in four reported having a disability, the most commonly cited of which are intellectual and learning disabilities.

In view of these factors, it is perhaps not surprising that almost half of respondents aged 16 years and over do not attend school, and of these two-thirds are not involved in any other training or education. Considering the long-term negative social and economic outcomes associated with low educational attainment, these reports are of concern. It is encouraging that young people in DChS care who are not attending school are more likely than young people not in DChS care to

report being involved in another form of training or education. This suggests that efforts to support this group of young people to continue with their education are having a positive impact. Also encouraging is the finding that one in two of those reporting having an Education Support Plan finds it helpful, suggesting that this initiative is going some way towards meeting the educational needs of these young people. Less encouraging, however, is the finding that fewer than half those attending school who are in the care of DChS are aware of having an ESP to help them achieve their educational goals. An ESP is more likely to be effective if the young person knows about their plan and is involved in it.

Incorporate measures from the Views surveys in child protection performance reporting for education to gauge the impact of strategies to address young people's educational needs, including the proportion of young people who are aware of having an ESP and the proportion who perceive their ESP to be of assistance to them.

The finding that young people with unresolved problems at school are more likely to report having a health problem of concern to them indicates the need to continue seeking more effective responses to the educational needs of young people in alternative care. One of the factors that has been attributed to the poorer educational outcomes of children and young people in care is traumatic experiences before coming into care that can result in a range of emotional, behavioural and physical health problems that affect performance at school (Veltman & Browne, 2001). The observed relationship between education and health problems in the present study may reflect this reality. Alternatively, it may suggest that stresses at school are affecting young people's physical and mental health. Either way, the observation lends weight to the suggestion made elsewhere – for example, by Cashmore et al., (2008) – that multi-agency and interdisciplinary cooperation are necessary to respond holistically to the educational needs of young people in alternative care.

Appreciate the complexity of young people's educational problems and pursue collaborative responses across service departments to address these holistically.

Evolve Interagency Services is a Queensland Government initiative that aims to respond holistically to the needs of young people in care. The service consists of teams of mental health professionals from Queensland Health (Child Safety Therapeutic Support Teams) and psychologists, speech and language therapists from Disability Services Queensland (Child Safety Behaviour Support Teams) who work in collaboration with school guidance officers and Child Safety Officers. A therapeutic plan and/or a behaviour support plan are implemented and monitored by the Child Safety Therapeutic Support Teams and Child Safety Behaviour Support Teams, together with the key people in the child's life, such as carers, family and school officers.

Another multidisciplinary initiative that is likely to be helpful in meeting the educational needs of young people is the introduction of dedicated education specialists in new therapeutic residential care services. These specialists will provide tailored education services to young people, either directly or through alternative education options.

Leaving care

Leaving care is an area in which it is crucial that young people receive adequate and appropriate support. Compared with peers who have not been in care, young people leaving care are at considerably greater risk of a wide range of negative outcomes, including homelessness, unemployment, poverty, early parenthood, substance abuse, poor mental and physical health, involvement in crime, imprisonment and juvenile prostitution (Cashmore & Paxman, 1996; Maunders et al., 1999; Mendes & Moslehuddin, 2006; Tweddle, 2007).

The importance of comprehensive, long-term planning for young people's eventual independence is increasingly acknowledged by governments in Australia and elsewhere through the formulation of legislation and policies to address the needs of care leavers (McDowall, 2008). DChS stipulates that transition from care planning is to commence in the month before a young person in care turns 15 years of age. The planning process is to involve a comprehensive assessment of the young person's strengths and needs, and the development of a leaving care case plan that identifies the young person's goals, along with the roles and responsibilities of the young person, their family, carers, friends and other support persons in achieving these goals (DChS, 2008a).

The survey's findings that less than three out of four young people aged 16 years or older can recall being spoken to about what will happen to their care situation when they turn 18, and that less than half those aged 16 years or older are aware of having a leaving care plan, suggest a shortfall between policy and practice in this area. In its recent *Report Card 2008: Transitioning from care*, CREATE Foundation observed across Australian states and territories similar shortfalls between leaving care policies and their implementation (McDowall, 2008); such shortfalls have also been noted internationally (Stein & Dixon, 2006). Given the seriousness of the risks and challenges facing care leavers, and the potential costs to the community of failing to support these young people adequately as they transition to independence, the survey's findings about transition from care planning are of concern. The survey does suggest, encouragingly, that some improvement is occurring, with an increase since 2007 in the proportion of young people reporting that they have been spoken to about what will happen to their care situation when they turn 18.

The department is currently reviewing its transition from care policy and procedures and has invited comments on how it can strengthen its responses to young people leaving care. The Commission has made a number of recommendations to the department as part of this review. Two that have relevance here are:

Adopt an ongoing focus on transitioning from care, supported by measures to enable CSOs to be more responsive in this area, including the possible establishment of dedicated transitioning from care positions.[49]

Take all reasonable steps to complete more leaving care plans earlier, to ensure that the needs and goals of individual young people approaching transition are matched with the services and supports they require in a timely way.

Moreover, to prevent transition from care planning being displaced by competing priorities, it is important to embed it in performance reporting processes:

Incorporate measures of transition from care planning, and the engagement of young people in this process, into child protection performance reporting.

Facilitating young people's participation

Young people's views about their care

Young people's views about what is working and not working in residential care are diverse and even contradictory at times, reflecting the different individual circumstances and experiences of respondents. Nevertheless, certain themes are evident that point to strengths and challenges of the residential care system. The two things that young people most commonly said they like best about residential care are the people in their residential facility – usually their workers and co-residents – and the resources provided to them. These resources include the facilities, equipment, pocket money, food and activities provided by the service. When asked what they would most like changed to make their current living situation better, at least one in four young people indicated they would like to have more flexible rules governing their behaviour and activities, enabling them

49 The suggestion of dedicated transition from care officers is in line with a proposal put forward by CREATE Foundation in its Report Card (McDowall, 2008).

greater independence and the option of doing what "normal" young people can do. This is often expressed in relation to participation in social activities, such as going out with friends or having "sleepovers". Multiple regression analysis confirms the importance of this issue to young people's sense of happiness in residential care. Being able to do what other young people not living in residential care can do is found to be a significant predictor of young people's happiness in their current living situation.

These views and analyses provide an important perspective on the strengths and challenges of the residential care system. While the system appears good at providing young people with a safe and supportive environment, it appears less effective in cultivating their sense of autonomy and social inclusion.

In their role of supporting and caring for young people in residential facilities, child protection and residential facility staff and management should be mindful of balancing young people's needs for social inclusion and a sense of normality with their needs for safety and security.

Young people's sense of being listened to and engaged in decision-making

In addition to giving young people a forum in which to have a say about their lives in residential care, the survey also explores young people's sense of being listened to and engaged in decisions related to their lives. This is in line with the participation rights of young people in policy and legislation framing the residential care and child protection systems in Queensland (see *Background*).

The survey's findings suggest that various factors are involved in young people's sense of being listened to or engaged in decisions. One factor appears to be the sphere of communication or decision-making. For example:

- four out of five young people feel they have a say in everyday household matters all or most of the time; however, only two out of three feel they have a say more generally in what happens to them all or most of the time
- almost all young people feel their CV listens to them all or most of the time and nearly nine out of ten feel their carers/workers listen to them all or most of the time; however, less than seven out of ten feel their CSO listens to them all or most of the time, and
- of the young people who indicated having a problem that they feel no one is listening to them about, the most common area of unheard concern relates to care and contact arrangements.

Another factor related to young people's sense of being heard or engaged in decision-making is their DChS care status: respondents in the care of DChS are more likely than those who are not in DChS care to report having a problem that no one is listening to them about, and they are less likely to report having a say all or most of the time in everyday household decisions or in what happens to them more generally. Moreover, many young people in DChS care indicated a lack of engagement in decision-making specifically related to their care in the child protection system. For example, just under half said they do not feel that decisions about them are explained to them all or most of the time, roughly a third reported that the reason they came into care has not been explained to them, and only three in ten could report knowing what is in their case plan.

Taken together, these findings suggest that young people are being listened to and engaged in decision-making more effectively at the "everyday" level (for example, decisions about choice of groceries or television programs), while their engagement in decisions about higher-order issues, such as care and contact arrangements and what happens to them more generally, appears to be less common. Satisfying young people's wishes in child protection decision-making is undoubtedly more difficult than in other spheres as it is more time consuming in an already heavily committed system, and there are potentially more serious consequences

to weigh. However, these should not prevent decisions being discussed with young people or explained to them; nor should it prevent young people being encouraged to voice their feelings and views about these decisions, and having their views recorded and genuinely considered. In addition to the argument that young people have a right to such participation, research by Leeson (2007) suggests that young people's perception of being listened to and engaged in these higher-order decisions reduces the sense of helplessness and anxiety commonly experienced by this cohort and builds young people's confidence and ability to make effective decisions in their lives.

DChS has taken various steps in recent years to improve its engagement of children and young people in decision-making related to their lives. It is important to monitor the effectiveness of these efforts by embedding young people's participation in decision-making within child protection performance reporting.

Incorporate measures of young people's participation in decision-making related to their care into child protection performance reporting.

Undertake qualitative research to explore the nature of the obstacles to young people's involvement in child protection decision-making.

The survey's findings about young people's communication with their CSOs deserve some attention. In addition to feeling listened to by their CSOs less commonly than by other significant adults in the residential care and child protection systems (such as CVs and workers/carers), one in three young people reported that they are never or not very often able to contact their CSO when they need to, and almost half indicated that they would like to see their CSO more often. These obstructions to communication may limit opportunities for young people to be heard and engaged in decision-making related to their lives. They also significantly influence young people's perception of their CSO's helpfulness: dissatisfaction with the amount that young people see their CSO was found to undermine their perception of their CSO's helpfulness, while having a CSO who is contactable all or most of the time was found to enhance the perception of helpfulness. While frequency of CSO visits may be determined by the department on the basis of individual needs and circumstances, it is interesting to note that those young people who reported seeing their CSO at least monthly were significantly more likely to express satisfaction with the amount of contact they have with their CSO than were those who reported seeing their CSO less often. These are valuable insights from the survey that point to directions for improving both young people's engagement in decision-making and their perception of statutory workers as helpful. They are also supported by recent research conducted in the UK with young people in care (Children's Rights Director for England, 2008). Of the 136 young people surveyed, two-thirds wanted to be visited by a statutory worker on a monthly basis. In addition, the most common response to the question "What rules should there be about social workers visiting children and young people in care?" was "Listen to the child".

Improve young people's access to CSOs, including provision for a minimum of monthly visits where this is desired by the young person.

The Commission's future work

This discussion of the survey findings has drawn attention to some of the notable strengths of the child protection and residential care systems. At the same time it has highlighted areas where improvements could and should be made in the interests of providing an alternative care system that genuinely meets the needs of young people, promotes their current and future wellbeing, and upholds their legislated rights. The Commission will continue to work closely with the Department of Communities (which, since March 2009, incorporates the functions and responsibilities of the former DChS) and other government and non-government agencies responsible for administering the child protection and residential care systems to improve the effectiveness and responsiveness of these systems. To gauge improvements in young people's care experiences, the Commission will repeat the residential care survey in 2010.

In the intervening period, the Commission will conduct its *Views of Children and Young People in Foster Care* survey for a third time. It will disseminate findings from its Views research as broadly as possible through presentations at conferences and other forums attended by child welfare and youth justice policy-makers, researchers and practitioners. Further analysis of survey data will be undertaken and published in various formats, including articles in scholarly journals. The Commission will pursue collaborative research on issues raised by its *Views* surveys. These activities will create greater public value by engaging the interest, expertise and resources of the broad range of individuals and human service agencies concerned with improving the life circumstances of vulnerable children and young people. The Commission's monitoring functions and the operations of the CV Program will continue to be informed by the survey findings and other information obtained through the Commission's range of work.

Finally, the Commission will continue its direct engagement with young people in residential care and other forms of alternative care and youth detention through monthly visits by CVs. Simultaneously with the publication of this report, the Commission will release a "young person–friendly" report of the survey findings, which will be presented to and discussed with each young person in residential care by their CV. This will allow young people to see that their voices have been heard and their views and perspectives genuinely represented. It will also demonstrate to them that they have a capacity to inform and influence the systems that care for them by participating in these surveys.

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Appendix

Responses to open-ended questions

This appendix presents the responses provided to the survey's open-ended questions and a handful of its 50 comments fields. The responses to the open-ended questions have been grouped into underlying themes, while the responses to comment fields have been grouped according to respondents' answers to the related question. Responses to open-ended questions have been duplicated where they cover multiple themes.

What is the best thing about living here?

There were 199 responses grouped into the following themes:

People in the household (62 responses, 3 sub-themes)

Workers (38 responses)

- [List of people's names – presumably workers and co-residents].
- [Particular worker named].
- 1. Sleeping (got a good bed) 2. Chillin' out with the workers on a weekend.
- All close-knit. Can talk to workers freely with no worries. Privacy respected.
- Being away from the kids that were trouble for me. The carers are fun and I get to see my sister a lot.
- Close to the city and close to transport. Other residents and the workers are nice.
- Getting everything and others. Workers who help you with stuff that not everyone can help you with and, most of all, driving you around. LOL.
- Getting to know different nurses and other kids and not getting angry as often.
- Good staff. A roof over my head.
- Good workers.
- Have got a good carer.
- Having fun. Not being on the streets. Meeting new friends. [Three names] – they are the best workers.
- Having my pet dog "Patchy" and nice people around me.
- Helping me get fit with workouts and giving me good food.
- How negotiable the staff at [facility/service provider name] are and how committed they are to their job.
- I don't get yelled at and they treat me the same as everyone else.
- I feel that I am cared for and am understood.
- I get cared for and respected by the people who work here.
- I get on with my carers and other clients.
- I got fun and exciting carers here.
- I have nice carers. I still see my family and my cat's allowed to live here too.
- Just having a bed to sleep in, fed meals, and that people actually help me sort out my life.
- Most of it (workers, food, activities).
- My friends [male name] and [male name]. All the carers except [female name].
- Staff – [male worker name].
- Staff are nice. Good social activities. Nice bedroom.
- Staff workers but one that is quinta.
- The affordability AND the youth workers.
- The carers – youth workers.

- The carers are good and care.
- The nurses are quite nice and it's reasonably comfortable.
- The staff are lovely and understanding.
- The workers understand me.
- Time alone with youth worker.
- Workers.
- Workers. Most of them.
- Youth workers' support.
- Youth workers.

Housemates/co-residents (15 responses)

- [List of workers and co-residents].
- [Co-resident]. 'Cause she is awesome and likes stuff (boys) that I like … .
- Close to the city and close to transport. Other residents and the workers are nice.
- Friends.
- Friends. Sport.
- Getting to know different nurses and other kids and not getting angry as often.
- Having fun. Not being on the streets. Meeting new friends. [Three names] – they are the best workers.
- Having people in my age group.
- I get on with my carers and other clients.
- My friends [male name] and [male name]. All the carers except [female name].
- Nice how you are around people the same age and the days are structured.
- Other girls here.
- People around my own age.
- The laughs, the food, some housemates.
- Two other young people in the unit.
- With my friends.

People in general (13 responses)

- [Male and female name listed], my toys.
- Food, social activities, nice people, PlayStation.
- Fun people, nice, clean, and I get privacy.
- Get to talk to someone.
- Good protection. Good food. Nice manners. Good people.
- Nice people. Activities, even if I am not here on a weekend. Heaps of games, PlayStation, Southport pool.
- People. Problems gone.
- Pool table – LOL. And meeting new people and making new friends.
- Safe, living healthy, fun and friendship every day.
- Support when needed to talk to someone.
- Taxi ride to school. Playing with [male name]. Watching TV.
- The company.
- We go for a drive, have good meals, have a room to yourself and nice people.

Resources provided (50 responses, 3 sub-themes)

Facilities, equipment, premises, pocket money (29 responses)

- 1. Sleeping (got a good bed) 2. Chillin' out with the workers on a weekend.
- AUSTAR [pay-TV].
- Clean and I get to go swimming when it's hot.
- Computer and [male name] takes us for games.
- Food, social activities, nice people, PlayStation.
- Get money.
- Horses, family-orientated, plenty of space, all-round living.
- I get money. Close to mum's. Sleeping over at Nan's.
- Internet.
- I've got furniture as kids (friend's).
- Money (pocket).
- Nice people. Activities, even if I am not here on a weekend. Heaps of games, PlayStation, Southport pool.
- Pay-TV, big rooms, big bathtub.
- PlayStation2.
- Pocket money, Foxtel, generally pretty good.

- Pocket money.
- Pool table – LOL. And meeting new people and making new friends.
- Pool, big garden.
- Staff are nice. Good social activities. Nice bedroom.
- Swimming pool.
- Taxi ride to school. Playing with [male name]. Watching TV.
- That the resi has Xbox.
- The nurses are quite nice and it's reasonably comfortable.
- The shed.
- The Xbox and the pool table.
- They get money for s**t.
- We get 20 bucks every week. If you do washing and stuff, you get five bucks. You can't watch TV in the mornings on school days.
- Xbox 360.
- You get money for doing chores and you get the responsibility to save up or not.

Activities, games, outings (22 responses)

- Activities – fun.
- Always something to do.
- Clean and I get to go swimming when it's hot.
- Computer and [male name] takes us for games.
- Do whatever I want. Get to go out.
- Fishing, freedom.
- Food and activities.
- Food, social activities, nice people, PlayStation.
- Friends. Sport.
- Get to go places on the weekends. Movies, Seaworld, shopping. With only some workers.
- Going out on trips and doing fun things.
- Helping me get fit with workouts and giving me good food.
- I like doing the same thing. Drawing, playing games, going out somewhere. My mother didn't really take me to cinema – thinks there are bad people there. I've just gone out to do some shopping.
- I really like going night fishing with the worker here.
- Most of it (workers, food, activities).
- Mum doesn't tell [me] to get off TV. Lot more movie time at cinemas.
- Nice people. Activities, even if I am not here on a weekend. Heaps of games, PlayStation, Southport pool.
- Outings.
- Staff are nice. Good social activities. Nice bedroom.
- Swimming, beach, backyard cricket, movies.
- We go for a drive, have good meals, have a room to yourself and nice people.
- You get to go places.

Food (9 responses)

- Food and activities.
- Food, social activities, nice people, PlayStation.
- Good protection. Good food. Nice manners. Good people.
- Helping me get fit with workouts and giving me good food.
- Just having a bed to sleep in, fed meals, and that people actually help me sort out my life.
- Most of it (workers, food, activities).
- That it is cosy and safe. And I have nice food.
- The laughs, the food, some housemates.
- We go for a drive, have good meals, have a room to yourself and nice people.

Personal space, privacy or autonomy (39 responses, 2 sub-themes)

Autonomy (28 responses)

- Able to go to a regular school. Being able to ride my bike around here. Being near my friends.

- Allowed freedom at this place, can visit friends.
- Can do whatever I want and it's peaceful. I like my quiet.
- Control of my life. Independent living with some youth worker support.
- Do whatever I want. Get to go out.
- Freedom and safety.
- Freedom. (2 responses)
- Freedom.
- Get to stay up.
- Going out doing whatever I like with no workers following me around town.
- Heaps of free time.
- I get a lot more independence here. I also don't have to put up with family.
- I get to sleep-in on weekends.
- Independence. More time for yourself. Here you can wake up at any time.
- Independent living.
- Independent.
- Living alone. No one bossing me.
- More freedom in the home.
- More freedom.
- Mum doesn't tell [me] to get off TV. Lot more movie time at cinemas.
- The freedom we get while we're living here.
- The opportunities I have to do things. I can eat when I want, whatever I want. I get to do what I want.
- We are independent and this house is situated in a good area.
- You don't have to cook.
- You get freedom.
- You get money for doing chores and you get the responsibility to save up or not.
- You get to lay on the bed and watch TV. You're not made to sit in a lounge chair.
- You get to put posters on the walls. Put horse pictures up too.

Space/privacy (11 responses)

- Fun people, nice, clean, and I get privacy.
- Horses, family-orientated, plenty of space, all-round living.
- I get more privacy.
- I get my own room.
- Like my own space and privacy.
- Living alone. No one bossing me.
- More room.
- My room. Like my house.
- No other kids live here.
- Pay-TV, big rooms, big bathtub.
- We go for a drive, have good meals, have a room to yourself and nice people.

Nothing (22 responses)

- Not much.
- Nothing much.
- Nothing. (16 responses)
- Nothing. I hate it.
- Nothing. There are no animals allowed.
- There is not anything.
- There's nothing I like.

Atmosphere in household (i.e. comfortable, fun, safe, peaceful, happy, stable, respectful) (21 responses)

- All close-knit. Can talk to workers freely with no worries. Privacy respected.
- Can do whatever I want and it's peaceful. I like my quiet.
- Everybody obeys the rules of this house.
- Everyone is at the same level (everyone living here).
- Freedom and safety.
- Fun.
- Get to have fun.
- Good protection. Good food. Nice manners. Good people.
- Having fun. Not being on the streets. Meeting new friends. [Three names] – they are the best workers.

- Horses, family-orientated, plenty of space, all-round living.
- I don't get yelled at and they treat me the same as everyone else.
- I know this is where I am staying.
- It feels more like my own place.
- It is good because I like who I am and I am with my culture.
- It's such a happy place.
- Not seeing my mum and getting hurt.
- Peace and quiet.
- Safe, living healthy, fun and friendship every day.
- Safer. Less stress.
- That it is cosy and safe. And I have nice food.
- The laughs, the food, some housemates.

Basic needs met (11 responses)

- A place to stay instead of the streets.
- A roof over my head.
- Apart from the fact that I have a roof over my head, I appreciate the fact that the house provides the essentials (food, drink, etc).
- Food. Kind of handy to have somewhere to live.
- Good staff. A roof over my head.
- Having fun. Not being on the streets. Meeting new friends. [Three names] – they are the best workers.
- I have a house to live in.
- Just having a bed to sleep in, fed meals, and that people actually help me sort out my life.
- Knowing that you have a bed every night of the week and food on the table.
- Roof over my head.
- Roof over your head.

Location (7 responses)

- Access to shops and bank.
- Being in the country.
- Close to school, city and [youth support service].
- Close to the city and close to transport. Other residents and the workers are nice.
- Like living in Brisbane. More things to do here.
- Living close to town.
- We are independent and this house is situated in a good area.

Maintaining contact with family (5 responses)

- Being away from the kids that were trouble for me. The carers are fun and I get to see my sister a lot.
- I am not separated from my brothers.
- I get money. Close to mum's. Sleeping over at Nan's.
- I have nice carers. I still see my family and my cat's allowed to live here too.
- Seeing my mummy. [Female name].

Don't know (13 responses)

- ?
- Don't know. (5 responses)
- I don't know.
- I don't know. Pretty everything is same rate.
- I don't know ... I am finding it a bit difficult here that I cannot focus on school or at home.
- I don't really know!! [young person been in placement for few days only]
- No idea.
- Not sure. (2 responses)

Other (9 responses)

- Able to go to a regular school. Being able to ride my bike around here. Being near my friends.
- Birthday, Xmas, Easter.
- Doing the gardening and going to school.
- Don't really know – everything.
- Everything.
- Heaps of stuff.
- I like everything.
- Keep out of trouble.

What do you most want to see improved or changed to make living here better?

There were 194 responses grouped into the following themes:

Changes to facility rules and management (i.e. fewer/more flexible rules; greater independence) (51 responses)

- Animals, birds, dogs.
- Bed times changed to 9pm or 9:30pm and rules not so strict.
- Bed times to later than 8:30pm.
- Being able to go and get drink at my sister's house.
- Being allowed to have animals.
- Change rule about playing "M" or "MA" games. Watching movies "M".
- Change the curfew on Friday and Saturday to later.
- Close the service down.
- Consequences for the other girls for being a bully.
- Curfew changes. Everyone treated equally, even upstairs.
- Curfew.
- Different waking up times.
- Everything. Going places on our own.
- Flexibility of leaving hours for [facility name]: 7am is logical and understandable, but still annoying when put into consideration the fact that I could put my time to better use.
- Go see friends and be able to go somewhere by myself.
- Have more friends and see people.
- I want more freedom.
- I would like more independent time on weekends with friends – for five hours.
- I would like to have more kids come and stay here.
- It would be cool if everything didn't need to go through a long process to organise, having a say in who moves in.
- Kids coming to stay here, more sports games. Going to the movies on weekends.
- Less rules.
- Less strict. You can explore the place with carers.
- Let us hang out with the people in the house.
- Letting friends visit, pets.
- Letting me go out more.
- Letting us listen to our own music including music with swearing.
- Me getting some time by myself at the shops with friends/boyfriends/girlfriends.
- More activities, internet, Foxtel, be allowed to have visitors overnight.
- More freedom within hospital. E.g. run the stairs by myself or with a friend, be allowed in kitchen.
- More freedom.
- More older kids, more freedom.
- More sleepovers at friends.
- Movie posters up around the house.
- My curfew time. LOL!!
- New TV and DVD player. Watch scary movies.
- Not enough freedom. Get stuck with bad kids.
- NOT SO MANY RULES. I know that rules are important but not when there are heaps of them!!!
- Not so strict.
- Reorganise the program to suit my timetable.
- So you can hang out with people you meet.
- Stay out more nights during the week.
- That we can watch MA movies.
- That we could wake up at 8:30am instead of 7:00am.
- They can make it better by not having two males on at night, because I rather talk to a female 'cause all the kids are male.
- This should be my bedroom – the largest room in the house – only joking! I want to be allowed to go out of the site to play.
- To be able to do what any kid can do.

- Unlocked fridges. No Perspex on TV. Air-conditioning. Later bedtimes.
- Wake up time at 8:30am.
- Wake up time changed to 8:30–9:00am. TV goes off at 11pm.
- Youth workers not taking money off me.

Improvements to resources provided (e.g. activities, food, facilities, equipment, premises, pocket money) (44 responses)

- [Service provider] to organise places to go on weekends. More activities on holidays.
- A better accommodation so I have more privacy.
- A larger pool.
- A new house.
- Add a games room, convert the garage.
- Another PlayStation.
- Bring Foxtel TV so the four young people can watch other shows and don't have to spend a lot of money going to the movies.
- Change the floors (they feel hard when I fall over).
- DVD player is not working.
- Everything. You can see the condition it's in already.
- Faster internet.
- Food. Workers who are always demanding f**king respect when they should try and gain it.
- Getting a washing machine, fire extinguisher, curtains, vacuum.
- Getting internet and Foxtel.
- Ha ha! Internet?
- I don't have a light in my room. I need a light.
- I want some footballs and a Frisbee.
- I want suitable [age-appropriate] videogames.
- I would like to see this place demolished.
- Internet access for jobs and housing. Gym, weights, bikes.
- Internet access.
- Internet and television in rooms. More space for belongings.
- Kids coming to stay here, more sports games. Going to the movies on weekends.
- Maybe have internet access for assignments.
- Me getting internet access.
- Me to go to the other residential house, as is full of special people. More money for the house.
- More activities, internet, Foxtel, be allowed to have visitors overnight.
- More excursions (Billabong Reef HQ, etc.).
- More kitchen appliances. Getting a vacuum.
- More KM and more shopping money.
- More pocket money.
- More recreational activities – gym, boxing bag, push bikes.
- New DVD player. Needs a shooting range.
- New TV and DVD player. Watch scary movies.
- New Xbox games, more movies.
- Not be so far out of town. More stuff to do.
- Not having to spend our entertainment money on every outing.
- One bed and room to a client.
- Recreational area, punching bag, internet.
- Service to provide better (newer) household goods – e.g. fridge.
- Swimming pool, tennis court.
- To get van back (in mechanics), sit around on hands.
- Transport to work provided.
- Unlocked fridges. No Perspex on TV. Air conditioning. Later bedtimes.

Nothing (42 responses)

- Can't think of anything.
- Everything is pretty good.
- It's all ok.
- It's pretty good here.
- Not a thing.
- Not much.
- Nothing really. (2 responses)

- Nothing stated [by respondent].
- Nothing, everything's fine.
- Nothing, I guess.
- Nothing. (29 responses)
- Nothing. Everything is alright.
- Nothing. It's good how it is now.

Changes to people in household (i.e. presence, behaviour or attitudes of workers/housemates) (27 responses)

- More [favourite worker].
- [Bring a?] boy in because of the back stabbing and taking sides and being mean.
- [Female name] going.
- [Particular worker] is the problem because she treats [co-res] as a pet.
- Better matched people and less people.
- Food. Workers who are always demanding f**king respect when they should try and gain it.
- For people who work here to get your permission before barging down the hallway and telling what to do.
- For the workers to get a root so they are not pissed all the time.
- Get other residents to stop teasing people.
- Get rid of [name].
- House mates.
- I don't want [co-resident] coming to skate park with me because he shows off to everyone.
- Me to go to the other residential house, as is full of special people. More money for the house.
- More older kids, more freedom.
- No [particular female worker], no [particular male co-resident]
- Not enough freedom. Get stuck with bad kids.
- People being a BITCH.
- People don't pick on me.
- People that are living here.
- Resident who is bullying me to leave.
- Seeing [particular male youth worker] more.
- That girl to stop hitting me.
- The arguments and bitchiness with the other girls.
- The respect between people.
- To trust us more.
- Worker to give you more respect.
- Would like to be sole resident.

More personal space or privacy (7 responses)

- A better accommodation so I have more privacy.
- I would like more independent time on weekends with friends – for five hours.
- I'd like to move into a flat.
- Locks on bedroom doors.
- One bed and room to a client.
- This should be my bedroom – the largest room in the house – only joking! I want to be allowed to go out of the site to play.
- Would like to be sole resident.

Don't know (16 responses)

- Don't know. (11 responses)
- Don't know and don't care.
- I don't know.
- I'm not sure.
- No idea.
- Uncertain.

Other (22 responses)

- Closer to the beach.
- Department visit.
- Do more work, like mowing lawns, gardening.
- Get more trusted out in the community.
- Get my "L"s
- Have more friends and see people.
- I get angry because I am sick of living here.
- Move me to Popy.

- My school. I would like to move schools.
- N/A. (2 responses)
- No comment.
- No. (6 responses)
- Not be so far out of town. More stuff to do.
- Shops closer to the house. Having to drive everywhere is a drag.
- To see my brothers.
- To see my mum more.

What would you most like to see improved or changed to make residential living better for young people?

There were 157 responses grouped into the following themes:

Nothing (32 responses)

- All good – no change.
- Can't think of anything.
- Don't know – nothing.
- Essentially, all the bases are covered. IMO.
- Everything is fine.
- Everything is pretty good.
- I think it's fine.
- I think it's pretty good these days. They have cool daily activities.
- It's ok.
- It's quite good. Strict rules – need rules to maintain place.
- Nil.
- Not a thing.
- Not really.
- Nothing needs to be changed.
- Nothing off the top of my head.
- Nothing really needs change.
- Nothing stated.
- Nothing, except what I just said about more female workers [rostered at night].
- Nothing, happy as it is.
- Nothing. (11 responses)
- Nothing. It's all good.
- Umm, well the place I'm at is great, so really nothing.

Improvements to resources provided (activities, food, facilities, equipment, premises, pocket money, etc.) (27 responses)

- A bigger TV and more games to play. Less restriction on sports and activities – they're worried we'll get hurt.
- Above [letting friends visit] and more pocket money.
- Activities to take your mind off your own situation.
- Better house. Better appliances.
- Bigger TVs.
- Curfew, internet, gym, weights, bikes.
- Get a computer for the kids.
- Getting out and being active like I am. No staying indoors watching TV all the time.
- Have a computer at residential site.
- I need an indoor pool.
- Improved internet and travel access.
- Internet – music we could download and games.
- Internet access.
- Internet and television … .
- Internet.
- Let young people have access to internet.
- More activities. (2 responses)
- More different foods like Aussie instead of Asian.
- More fun activities.
- More money and free smokes.
- More outings.
- New DVD player. Needs a shooting range.
- New remote and all of the channels.
- Put in a foster home – nowhere to play here.
- Sleepovers, take out dinners and going to different places for a visit.
- Two workers and two cars at all times.

Changes to rules, discipline or facility management (greater personal freedom, social opportunities, safety/wellbeing) (29 responses, 3 sub-themes)

Fewer restrictions on social and other activities (sleepovers, sport, playing with friends, going out) (14 responses)

- A bigger TV and more games to play. Less restriction on sports and activities – they're worried we'll get hurt.
- Above [letting friends visit] and more pocket money.
- Friends visit and same with the family too.
- Give chance to kids for sleepovers.
- Let us hang out with the people in the house.
- Longer phone calls, at least twenty minutes.
- Maybe to do more things with friends, e.g. sleeping over houses.
- More sleepovers at friends.
- Seeing people like going to [male name]'s place and having friends sleep over.
- Sleepovers, take out dinners and going to different places for a visit.
- So you can hang out with people you meet.
- That you're allowed to do stuff that your friends can do.
- The rules not as strict and you're actually allowed to do stuff like go late night shopping, go to friends' houses – younger kids aren't allowed, but I can because I'm a bit older.
- You are not allowed to go out and play from the site without a worker.

Fewer/more flexible house rules (e.g. curfews and bed/wake-up times, etc.) (11 responses)

- Bed times changed.
- Change the wake up time on Saturday to 9am.
- Curfew, internet, gym, weights, bikes.
- Curfew.
- Flexibility.
- Less rules.
- More chances [reference to "4 breaches and out" rule of shelter].
- Not so strict.
- Rule to be less harsh.
- That we could wake up at 8:30am instead of 7:00am.
- TV goes off at 11:00pm. Wake up at 8:30am.

Better or more consistent discipline/ management of residents' behaviour (4 responses)

- Behaviour.
- People being a BITCH.
- Stop bullying.
- The consequences are not fair for everyone.

Changes to staff (more staff, better skills, more support, understanding, respect, consistency) (14 responses)

- Better carers in all the houses, some carers shouldn't work with teenagers 'cause they make the problems we have worse.
- Everyone should have a decent Coordinator like [worker's name].
- Make more residentials family-orientated like this one.
- Make them feel more welcome.
- More females working in the residentials.
- More one-on-one times.
- Need more disability workers for the young people with disabilities.
- Nicer young people and more staff that trust you.
- Not so many youth workers.
- Nothing, except what I just said about more female workers [rostered at night].
- One to one support. Not sharing with others, especially with mental health issues.
- People to listen to my complaints instead of ignoring.

- They should listen and be kinder to the kids.
- Youth workers that care.

More personal space, privacy, freedom or opportunity to have a say/be heard (14 responses, 3 sub-themes)

Space/privacy (4 responses)

- ... More space for belongings.
- More space.
- Space to oneself.
- Would like to ring my mum and dad and see them without anyone else there.

Freedom (5 responses)

- I want more freedom.
- More free time.
- More freedom.
- More freedom. Can't leave the site without workers.
- You are not allowed to go out and play from the site without a worker.

Having a say in things/being listened to (5 responses)

- DChS taking more care with what kids say.
- Listen to the kids, otherwise one day you'll see that you can learn from us.
- People to listen to my complaints instead of ignoring.
- Selecting their own carer.
- They should listen and be kinder to the kids.

More accommodation options for young people/better publicity about options (6 responses)

- Change the three month length of stay to as long as you want.
- I wouldn't have known about it [youth shelter] if my friend hadn't told me. Put up signs at the train stations.
- More places like this one [youth shelter].
- More places that house 14 to 18 year olds.
- More shelters.
- More youth shelters!!

Don't know (22 responses)

- ?
- ?!
- Don't know – nothing.
- Don't know. (11 responses)
- I don't know. (2 responses)
- I'm not sure. (2 responses)
- Not sure. (2 responses)
- Ummmm, I don't know.
- Unsure.

Other (24 responses)

- [Female name] moving.
- [Lists residents he would like gone].
- Everything.
- Get a better approval process. Allow the Coordinator to sign stuff rather than your CSO. It's really annoying.
- Get out of here.
- Give clients to [provider name].
- It is all bulls**t [can't decipher].
- Learning to cook.
- Living with parents.
- Look out for the older people.
- N/A. (3 responses)
- Nicer young people and more staff that trust you.
- No comment. (2 responses)
- No ideas given.
- No. (2 responses)
- Not be here.
- Not in residential.
- Stay in one place for a while.
- Stay out of trouble.
- Us getting a job.

Is there anything that you want to have happen that no one is listening to you about? If yes, what is this?

Forty-nine of the 50 respondents who said they had such a problem elaborated on this. These responses are grouped into the following themes:

Issues with care or contact arrangements (19 responses)

- Bed times, sleepovers at Mum's. I want later bedtimes than 8:30pm and to have sleepovers with Mum.
- Go home and have a normal life like everyone else.
- Go home.
- Going home to live with Mum.
- I want to go home. HELP ME. Please.
- I want to know where my [younger brother and sister] are. I'm going to get them and bring them back home to Mum. She never sees them either.
- I want to move back to my Auntie's house.
- I want to move from this house but people keep telling me that there is nowhere else.
- I want to move out of the motel and into a proper home. The department say there are no carers for me.
- I would like to live with my older sister but no one is doing anything about it.
- Like to go into SILL (independent living).
- Live with my family.
- Me moving. I want to move into a home.
- More time with family.
- Stable accommodation – not moving around all the time. More kitchen appliances.
- That my brothers should go back to Nan's.
- To be sleeping over at Mum's house once a month. To spend more time with her.
- Would like to live here by myself with my workers. Find it hard to live with other boy who is high level ASD.
- Yeah, I'm not happy living a long way from my family.

Issues with facility management (including issues with staff, co-residents, house rules and the state of premises) (12 responses)

- [Particular worker] stop kissing and cuddling [co-resident] and to get [name] back.
- [Particular worker] to be gone with [particular co-resident].
- A girl to move out.
- Am not able to play with slingshots, and cap game.
- Bed times, sleepovers at Mum's. I want later bedtimes than 8:30pm and to have sleepovers with Mum.
- Free-time as I am in 24-hour care.
- I want to be able to see my friends more.
- Lawn mowing – if don't do it, I lose marks. Lawn is very big – rural area.
- Management doesn't listen to me at all.
- Replace the things that are stolen [young person has had things stolen].
- To be allowed to make friends with people you meet.
- Worried about being in present house: not safe.

Issues with provision of material goods and resources (11 responses)

- Get an Internet here.
- Get curtains, washing machine, fire extinguisher, vacuum.
- Get the net.
- Getting internet.
- Go to SugarWorld. (3 responses)
- Have my own TV and PlayStation in my room.
- MA 15+ movies and games.
- Stable accommodation – not moving around all the time. More kitchen appliances.
- Yes, I would like a road bike.

Issues with school or access to extracurricular educational opportunities (6 responses)

- Being removed from school.
- Country music and rap and hip hop dance lessons.
- I WANT TO MOVE SCHOOLS!!
- Kids stop teasing and bullying me at school.
- My school. I like school but not the school I go to. I want to go to [other school] as my cousins go there and I know some teachers there.
- Yes. But not really private. Singing lessons.

Other (3 responses)

- I literally can't go back to [name of city] or [name of country town] or I'm literally DEAD.
- I need to talk to you guys in-person or on the phone, so call me on [mobile phone number supplied].
- I want a new family.

Has your CV been able to help you with anything in particular? If yes, what is this?

Fifty-nine of the 68 respondents whose CV had been able to help them in a particular way elaborated on this. These responses are grouped into the following themes:

Obtaining material goods and resources (13 responses)

- Computer problems.
- Computer.
- Driving lessons.
- Get clothes. (2 responses)
- Getting a new bed.
- Getting more clothes.
- Getting my school uniform and heaps of other things.
- Glasses.
- Got phone connected.
- Helped me get more clothing … .
- Helped young person to get things needed in his residential house – e.g. fire blanket.
- She has helped me with getting clothes.

Improving family and community contact (11 responses)

- … Family contact.
- Community linking.
- Contact with my family.
- Family contacts.
- Going to see family.
- Information on locating my dad.
- More family contact.
- She's gonna try and help get me back to my family.
- Sister contact.
- Social activities. Family contact.
- Talking to Nan from the house phone.

Addressing issues with CSO/DChS (7 responses)

- Assistance when I was in foster care and hated it … .
- CSO.
- Helped Grandma get her money from Child Safety.
- … got CSO to come to court to support me.
- Problems with department and CSO.
- Stable placement.
- The Department of Child Safety and places to stay. She's been a big help.

Providing emotional support (7 responses)

- Changes.
- Good to talk to about certain issues.
- Good to talk to about certain issues.
- I like to talk to her when my anger builds up.
- Just general self-esteem.
- Listening to me.
- Listening to problems I have with [NGO service provider].

Providing information (4 responses)

- General advice.
- Get me to understand some rights that I did not have ideas about.
- Told me stuff.
- Understanding himself and position.

Addressing issues with facility management/co-residents (4 responses)

- Food.
- Listening to problems I have with [NGO service provider].
- Talking to Nan from the house phone.
- Talking to staff about things that I want changed.

Helping with lots of things (6 responses)

- [She] has contributed to helping me gain many things.
- Everything we spoke about really.
- Everything.
- Everything.
- Getting my school uniform and heaps of other things.
- Heaps of stuff.

Other (13 responses)

- Filling out the survey.
- General stuff.
- Getting employment.
- Help Grandma with things.
- Helped me work with my writing.
- I can't remember.
- I have forgotten, sorry.
- [name of facility] Gold Coast.
- New Zealand trip and whole other things. She's the best.
- School and stuff.
- TFC [Therapeutic Foster Care?].
- The Department of Child Safety and places to stay. She's been a big help.

Responses to selected comment fields

Are you better or worse off since moving here?

There were 42 comments recorded, grouped according to responses to the question:

Comments from those who responded "better" (19 responses)

- A little bit.
- Because I met [young person name].
- But I don't talk.
- But there are no kids.
- Get pocket money.
- I hate foster care so far.
- I have changed a lot.
- I like it because just to get away from my mum for a while so I won't listen to her talking to herself again.
- I'd rather be with my parents.
- I was picked up, off the street, so "better" is the inevitable answer.
- I've been under the department my whole life. I've been everywhere. This set up is better than foster care.
- I've started school with the support of my carers.
- Little bit more independent. Other place had everything. We would go to the beach, lots of girls … .
- Little bit.
- New town, new life.
- Only place I've got – where else am I going to live – on the streets?
- Probably better.
- Slightly.
- [Service name] has taught me a lot.

Comments from those who responded "worse" (11 responses)

- But I was in a good placement.
- I don't like this house or the other girls.
- I like it with my family.
- I preferred being out of the service.
- Never had a police record until moving here.
- No freedom – can't be by himself.
- Not living with Mum. A s**thole box in the middle of nowhere.
- Since moving here I have gained weight.
- Terrible.
- You don't hang out with people/friends – you become anti-social.
- Zulu.

Comments from those who responded "about the same" (6 responses)

- [CV comment: Young person didn't really know how to answer this question].
- [Respondent] doesn't know. Misses traditional community/activities.
- Better than living with Mum, although would like to live with other kids to socialise.
- Lately it has been not so good.
- Placement is good, troubles with residents.
- Still suffering illness deeply.

Comments from those who did not respond to the question (6 responses)

- [CV comment: N/A respite house]. (2 responses)
- A little bit bad and a little bit good?
- Depends. Some is better, some is worse.
- I don't know.
- Some of the time.

Have things got better for you over the last 12 months?

There were 48 comments recorded, grouped according to responses to the question:

Comments from those who responded "yes" (16 responses)

- [Service name] have helped me and supported me a lot.
- A little.
- Definitely.
- Doing a lot more free-time :-)
- Good and bad.
- I got a job.
- Last two months, yes.
- Learnt new things, gained access and awareness of resources around me.
- More time with Mum.
- My education. Not allowed to go out by myself.
- People/carers help me and are nice.
- Since I moved to current placement, eight months ago.
- Treated like a grown up.
- When Lizzie and Chris.
- With a few things.
- Worse.

Comments from those who responded "no" (18 responses)

- Didn't have anger issues or ticks until I got here.
- Health.
- I don't want to be here anymore and am leaving when I turn 16.
- I moved a lot. I'm sick of it.
- I wouldn't be here if things weren't bad.
- It's been hard.
- My life has gone downhill.
- My mum bl**dy shot herself.
- No, not really.
- Not really – got into more trouble.
- Not really. (3 responses)
- They have got a hell of a lot worse.
- They've gotten worse. Different people showed up in my life.
- Things were good until [worker] came with her pet [co-resident].
- Too many things happen in short amount of time.
- Worse.

Comments from those who responded "not sure" (5 responses)

- Due to current events.
- I wouldn't count on it.
- Just came here about two months ago.
- Sort of. (2 responses)

Comments from those who did not respond to the question (8 responses)

- A little bit.
- Haven't been here 12 months.
- I can't tell. Just finished court proceedings and on probation for 12 months.
- I've only been here for two or three days.
- n/a [regular weekend respite].
- Wasn't here.
- Yes and no.
- I stop hitting myself, at least, but I hate it here.

Are you able to see your family as much as you would like?

There were 58 comments recorded, grouped according to responses to the question:

Comments from those who responded "yes" (16 responses)

- [Respondent] sees dad every fortnight. Sees mum every fortnight and separate visits.
- Don't want to see family much.
- Except for some of my brothers.
- Have got into a routine now.
- I don't really want to see my mum.
- I don't want to see them.
- I prefer not to see them.
- I see them just enough – NEVER.
- I see them whenever I want.
- I've tried to ring Nan but no response.
- My brother, [name], every three weeks. All other brothers and sisters, monthly visits.
- See them every Saturday.
- See too much.
- They have no choice: I'll just take off.
- Three nights per week and Friday to Sunday.
- Weekends, during the week.

Comments from those who responded "no, I don't get to see them enough" (27 responses)

- After school Friday to 7. Sunday – to 7. Overnight Tuesday and after school.
- Am disappointed 'cause am not allowed to see grandmother any more.
- But [name] said it's ok to stay but doc said no.
- Contact has increased. DChS are arranging a sleepover at Mum's once a week now.
- Department.
- Don't see them at all. Their whereabouts is currently unknown.
- I haven't seen my little brother and sister for years. They were stolen from me during the night. When I woke up, they were gone.
- I want sleepover.
- I want to go home.
- I want to live with my dad but I can't. Only see my sister once a month.
- I want to see my dad.
- I was told if I see my mum and dad I might lose my room!!!
- I would like to see them more.
- I'd like to see them all the time.
- Living in a different state.
- Mother doesn't let me see the kids at all.
- Mother is looking after puppies at moment.
- Mum lives in Cairns [while respondent lives in Ipswich].
- My mum doesn't want to see me.
- Once every two weeks.
- Only had one family visit in two months.
- Sister – want to call and visit.
- They live 300km away.
- They live a distance away, out past Toowoomba.
- Three hours a fortnight is RAP.
- Would like more contact with brothers.
- Would like to spend more time with my sister.

Comments from those who responded "no, I have to see them more than I want" (1 response)

- To be honest, I don't see my family much, but it doesn't worry me.

Comments from those who did not respond to the closed question (14 responses)

- Don't want anything to do with them.
- Don't care.
- Don't want to.
- I don't see them, only my sister, once year. But I would love to see my brother.

- I don't want to answer these questions [about family contact].
- I don't want to see them. (2 responses)
- I want to see my siblings.
- Mum's in jail, sisters in whoop-whoop, brother and Dad in another f**king state.
- My mum is a BITCH.
- n/a [Respondent] attends weekend respite frequently.
- No family in this area.
- Occasionally.
- Yes and no. Complicated situation with mentally ill sister.

Are you able to do the same sort of things that your friends who aren't in a residential can do?

There were 48 comments recorded, grouped according to responses to the question:

Comments from those who responded "all the time" or "most of the time" (21 responses)

- And more which gives me more freedom.
- Apart from having friends over/parties.
- Apart from having friends/girls overnight.
- During the day.
- I can go to other friends' houses but they can't come here.
- I can't come and go as I please, can't just go anywhere without a carer.
- I do more than they do.
- I don't have a carer at all during the day; just make sure I'm back by 7.30.
- I even get to do more.
- I get to do more.
- I think so.
- I'm allowed to play and do things.
- Karate, soccer.
- No pocket money. Not able to work.
- Not allowed to have a girlfriend.
- Sleepover – having a friend sleep over here.
- Soccer, bowling.
- Some rules and obligations limit my options, but it's far from severe.
- Some.
- When I feel like it.
- Zulu.

Comments from those who responded "never" or "not very often" (21 responses)

- [CV comment: respite house].
- Can't go to friends' houses and stay. Can't go out with them.
- Can't sleep over at Dad's or friends.
- Can't sleep over or have them sleep over.
- Can't smoke in here. Going out.
- Curfew of 9:30pm is limiting.
- Curfew.
- Department red tape.
- Go out on weekends by themselves.
- I can go over to their houses and go to discos; that's it.
- I cannot have friends over as they do not have approval from Child Safety.
- I can't do nothing.
- I can't go out alone.
- I reckon someone should explain to me why my friends can't come and sleep over here, because that makes me feel different.
- Like hanging out with friends.
- Lots of things that are unable to do – play with friends.
- Need free-time.
- Need permission for everything.
- No MA-rated games. Very few age-appropriate games. I don't have enough money when I go out.
- No, only at school, but not at their places.
- Not allowed to leave the house without the carers and can't stay up late.

Comments from those who did not respond to the question (6 responses)

- No. (2 responses)
- No, I don't want to because I haven't made friends with anyone yet.
- N/A [regular weekend respite].
- Living independently.
- I don't have any friends.

When the department says you can do something, or have something, do you feel sure that it will happen?

There were 43 comments recorded, grouped according to responses to the question:

Comments from those who responded "yes" (8 responses)

- [CV comment: Service provider follows all of this up and advocates for her].
- [Worker name] (coordinator of service) makes sure it happens. He always follows up.
- At the moment I do because I have a good worker, but before I didn't.
- But it is usually slow.
- Only sometimes.
- Sometimes. (2 responses)
- When they think about it.

Comments from those who responded "no" (21 responses)

- Because sometimes it doesn't happen.
- Because they are a bunch of wankers.
- Broken my trust a lot.
- 'Cause they said in two years back with parents.
- Confused [by the question?].
- CSOs say they are going to do things all the time but mostly it never happens.
- Department never get back in time to give permission to camp.
- I don't like the department.
- I have been trying to have sleepovers for three months.
- It never does. They are lying scum.
- Lots of times it doesn't happen.
- Never. (4 responses)
- No contact with department.
- No, 'cause they are a bunch of f****ts.
- They are f**k heads.
- They are full of s**t. Said I would be in care six months and it's been much more.
- They don't do it anyway.
- They sux.

Comments from those who did not respond to the question (14 responses)

- Don't know. (3 responses)
- I don't even know who is my caseworker.
- I don't know. (2 responses)
- Maybe. (2 responses)
- Not sure.
- Sometimes. (4 responses)
- They never have contact with me.

Notes

Notes

Notes

Queensland Child Death Case Review Committee

Annual Report 2010–11

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The Queensland Child Death Case Review Committee respects the beliefs of the Aboriginal and Torres Strait Islander peoples and advises that there is information regarding Aboriginal and Torres Strait Islander deceased people in this report.

Suggestions:
The CDCRC welcomes suggestions on the information contained in this publication. Please direct your suggestions to the CDCRC at the above mailing address.

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31 October 2011

The Honourable Karen Struthers MP
Minister for Community Services and Housing
and Minister for Women
Parliament House
George Street
BRISBANE QLD 4000

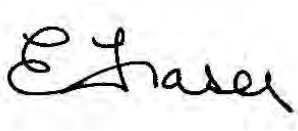
Dear Ms Struthers

I submit the annual report for the Child Death Case Review Committee (the CDCRC) for the 2010–11 financial year.

The report is produced in accordance with section 141(1) of the *Commission for Children and Young People and Child Guardian Act 2000* (Qld). It outlines the CDCRC's roles, key activities and performance for 2010–11.

I draw your attention to section 141(3) of the *Commission for Children and Young People and Child Guardian Act 2000*, which requires you to table this report in Parliament within 14 sitting days of receipt.

Yours sincerely



Elizabeth Fraser
Chairperson
Child Death Case Review Committee

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Contents

Message from the Chairperson

The Queensland Child Death Case Review Committee (CDCRC) is an independent, multidisciplinary committee that provides a second tier review of deaths of children who were known to the Department of Communities – Child Safety Services (Child Safety Services) within three years of their death. During the 2010–11 reporting period, the CDCRC considered the deaths of 65 children and young people.

This is the seventh annual report of the CDCRC.

On behalf of the CDCRC, I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths were considered by the CDCRC during the reporting period.

The death of a child is always emotional. Each one touches the lives of the child's family, friends, those who worked with the child and the broader community. Many of the children to whom this report refers are from complex family circumstances that may include parental substance misuse, domestic violence and mental illness. These circumstances are often the reason the child becomes part of the child safety service system and once known, the system must appropriately respond and minimise risk to the child.

When a child dies who was known to Child Safety Services, there is a legislative requirement and public expectation that the death will be comprehensively reviewed and that services provided to the child will be evaluated in a manner which promotes learning, transparency and accountability. The review process is also compelled by a deeply entrenched moral imperative to act to protect young lives by identifying and addressing risks and making recommendations for reform.

The child death case review jurisdiction in Queensland was established in 2004 upon the recommendation of two independent reports in relation to the former Department of Families. Since its inception the child death case review framework has evolved into what is recognised nationally as a robust review process. In this period, the CDCRC has reviewed the deaths of 383 children and young people within its jurisdiction and all recommendations made to Child Safety Services by the CDCRC have been implemented or are in the process of being implemented.

The CDCRC's process and annual report aims to promote the transparency of the child death case review jurisdiction by ensuring all cases are scrutinised by an independently appointed committee with expertise in child protection, health, youth justice and a range of other areas. The review process acknowledges public interest and aims to ensure that the outcomes of the CDCRC's work are available for all to access. In determining the level of information released, the CDCRC is currently guided by Article 16 of the United Nations Convention on the Rights of the Child which states:

> *Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.*[1]

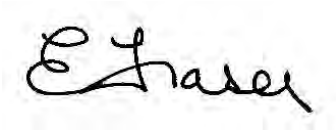
[1] http://www.unicef.org

The children and young people reviewed by the CDCRC have child protection histories, surviving relatives and friends, and the information reviewed is highly personal. When assessing what information is made available to the public, we should always ensure that the welfare and best interests of the child remain paramount. Balancing the rights of children with the public's right to information will, nonetheless remain an ongoing challenge for the CDCRC, as will providing sufficient context for the public to understand the assessment and recommendations made.

This year marked an important milestone for the CDCRC with the appointment of new community members in November 2010, after a completion of the three-year term of the previous members.

I would like to take this opportunity to sincerely thank the members of the outgoing CDCRC for their invaluable contribution to the child death case review process and for their commitment to improving service delivery to Queensland's most vulnerable children. I would also like to thank the current members and the secretariat, who have brought a diverse wealth of relevant experience to the child death review process, and express my gratitude for their contribution this year.

In conclusion and on behalf of the CDCRC, I would like to thank Child Safety Services and its staff for the support they have given to the CDCRC's review function throughout 2010–11. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing in the same way previous processes have assisted to advance reforms.



Elizabeth Fraser
Chairperson
Child Death Case Review Committee

Executive Summary

Background

The Queensland child death case review jurisdiction consists of a two-tiered system for reviewing deaths of children known to Child Safety Services in the three years prior to their death. The first tier is a review conducted by Child Safety Services about its involvement with the child or young person (the original review). The original review is then assessed by the CDCRC (the second tier) against a set of review criteria.

The CDCRC acts independently when performing its functions and is not under the control or direction of any other entity.

This system ensures that Queensland has a strong and independent child death case review jurisdiction. It provides the Queensland public and government with a strong accountability framework, ensuring that Child Safety Services conducts reviews of all child deaths where the child had involvement with the agency within the three years prior to their death, and rigorous and independent scrutiny is applied to all cases.

The level of Child Safety Services' involvement with the children reviewed by the child death case review jurisdiction ranges from minimal contact (responding to the death incident) to significant involvement over many years. The trigger for a child death case review is not alleged negligence of Child Safety Services but rather its involvement (no matter how minimal) in the child's life.

The actions or inactions of the child safety service system were not linked to any of the deaths reviewed by the CDCRC in 2010–11.

Children and young people reviewed in 2010–11

In the 2010–11 reporting period, the CDCRC considered Child Safety Services' reviews of the deaths of 65 Queensland children and young people.

Of the 65 children reviewed, 55% were male (36 children) and 45% were female (29 children).

The majority of children reviewed by the CDCRC in 2010–11 (63%, 41 children) were aged between birth and 4 years at the time of death. Twenty-eight children (43%) were under 1 year of age. Twelve young people (18%) were aged 10–14 years, nine (14%) were aged 15–17 years and three were aged 5–9 years, at the time of their death.

Of the 65 children and young people whose deaths were reviewed, 17 (26%) identified as Aboriginal. There were no Torres Strait Islander children reviewed in the 2010–11 reporting period.

Almost half of the children and young people reviewed (43%, 28 children) were identified as having a physical medical condition, intellectual impairment, developmental delay or a mental health condition.

Forty-eight children and young people (74%) were residing at home at the time of their death. A further twelve (18%) were residing in hospital and three were living with foster carers. Two young people, aged 15 and 17 years respectively, had self-placed.

Many of the families of the children and young people whose deaths were reviewed faced complex family and parental issues, such as substance misuse, domestic violence, high mobility of lifestyle (transience), mental health conditions of the parents, parental involvement in the criminal justice system and parental child protection history. In 63 families (97%), one or more of these family issues were identified as present

Forty-one children (63%) were from families where domestic violence was an issue and the co-existence of this issue with parental substance misuse was identified in 28 reviews (43%).

The prevalence of multiple family and parental issues, combined with the complex needs of the children, highlights the challenge faced by the child safety service system in responding to complicated family situations and the need for an effective, coordinated multi-disciplinary response.

Cause of death for children reviewed in 2010–11 and associated risk factors

In relation to 5 deaths, the official cause of death was pending and could not be readily classified into a research category at the time of reporting.

Of the 65 deaths considered in the 2010–11 reporting period, 32 (49%) were due to diseases and morbid conditions.

Five children died as a result of sudden infant death syndrome (SIDS) and undetermined causes.

Drowning was the leading external cause of death, accounting for 30% (seven deaths).

Six young people suicided.

Four children and young people died in transport incidents and four died due to other non-intentional injury-related causes.

One death considered in the 2010–11 reporting period was due to a fatal assault and one was fire-related.

Consideration of reviews

The CDCRC endorsed 76 recommendations made by Child Safety Services, and made an additional 17 recommendations to better focus actions and further strengthen the responsiveness of the system through training, professional development and policy reform.

In 12 of Child Safety Services' reviews, issues were referred to other government agencies for consideration of options to strengthen their involvement in areas relevant to improving service responses for children and young people. Child Safety Services advised the CDCRC of actions taken as a result of the original review process.

In relation to the 17 Aboriginal children and young people whose deaths were reviewed, the relevant Aboriginal member of the CDCRC was present in all 17 cases in accordance with legislative requirements.

In the 2010–11 reporting period, the CDCRC completed its considerations of all Child Safety Services' reviews within the legislated timeframe.

During the reporting period, the CDCRC developed a framework to guide its assessment of its recommendations and referrals. The framework identifies activities that may reveal the impact these recommendations and referrals have on the child safety service system.

Service system issues

In 2010–11 the CDCRC identified the following service system areas may be strengthened:

- assessments of initial allegations of harm, and
- services provided to pregnant women and their unborn children.

In addition, the CDCRC noted positive service delivery elements in the support provided to children and young people who were under Child Protection Orders.

The CDCRC also examined service system issues that were found in the reviews where children and young people died as a result of suicide or fatal assault.

Intake – a critical decision-making process

In the 2010–11 reporting period, opportunities to improve information gathering at Intake were identified in relation to 27 children and young people whose deaths were reviewed.

Issues regarding assessment and screening decisions at Intake were identified in relation to 25 children. In relation to six children and young people, it was found that information recorded as a case note or Intake Enquiry, should have been recorded as either a Child Concern Report or Notification due to the information containing allegations of harm or risk of harm.

Unborn Child Notifications – opportunities for healthier and safer children

Of the 65 children and young people whose deaths were considered by the CDCRC in the 2010–11 reporting period, 15 (23%) involved service delivery to pregnant women and their unborn children.

The families of these 15 children had complex family issues impacting the safety and wellbeing of the unborn child as well as the parents' ability to care for the baby after birth, including:

- the mother's own child protection history as a subject child
- parents' criminal history
- domestic violence, and
- substance misuse.

In reviewing the cases, the following key areas were identified as requiring strengthening:

- timeliness of actioning Unborn Child Notifications, and
- development and implementation of support service plans.

Children and young people under Child Protection Orders

In relation to the six children and young people who were under Child Protection Orders at the time of their death, the CDCRC observed that the following factors promoted positive service delivery outcomes:

- strong engagement between case workers and child, family and carers
- child-focused, considered and planned case work
- cross-agency communication, collaboration and planning, and
- stable placements that meet the individual needs of the child.

Children reviewed in 2010–11 who died as a result of suicide or fatal assault

The following areas of Intake were identified as areas where there were opportunities for improvement:

- information gathering/sharing
- screening decisions
- timeliness of recording concerns
- recording cultural heritage of family members, and
- recording concerns as an Intake Enquiry.

Report structure

This report is structured as follows:

Chapter 1 provides an overview of the children whose deaths were reviewed by the CDCRC in 2010–11, including the level of involvement with Child Safety Services at the time of their death.

Chapter 2 provides a summary of the causes of death and associated risk factors for the children whose deaths were reviewed by the CDCRC in 2010–11.

Chapter 3 outlines the review process and provides a summary of the original reviews and CDCRC reviews conducted in 2010–11.

Chapter 4 contains a discussion of key service system issues that may be strengthened, namely assessments of initial allegations of harm, and services provided to pregnant women and their unborn children. It also contains an analysis of positive service delivery elements in the support provided to children and young people who were under Child Protection Orders and an analysis of service delivery to children and young people who died as a result of suicide or fatal assault.

Chapter 1

Overview of children and young people reviewed in 2010–11

Key findings and messages

- In 2010–11 the CDCRC considered Child Safety Services' reviews of the deaths of 65 Queensland children and young people.
- Of the 65 children reviewed:
  - thirty-six were male (55%) and 29 were female (45%)
  - the majority (63%, 41 children) were aged between birth and 4 years at the time of death
  - almost half (43%, 28 children) were identified as having a physical medical condition, intellectual impairment, developmental delay or a mental health condition
  - thirty-two (49%) were hospital inpatients at the time of their death, and
  - forty-one (63%) were from families where domestic violence was an issue and the co-existence of this issue with parental substance misuse was identified in 28 (43%) reviews.

In the 2010–11 reporting period, the CDCRC considered Child Safety Services' reviews of the deaths of 65 Queensland children and young people. The CDCRC reviewed these cases as the children and young people concerned were known to the child safety service system within three years prior to their death.

This chapter provides an overview of the children and young people reviewed, their families and involvement with the child safety service system.

Throughout this chapter and those that follow, information about recommendations and actions undertaken by the CDCRC in response to specific cohorts of children and service system issues is included in order to highlight learnings and possible service delivery improvements. The CDCRC acknowledges that any observations made are based on the reviews of children who died, and these are not necessarily representative of issues across the whole child safety service system.

Characteristics of children and young people reviewed

Age and gender

As shown by Table 1.1, the majority of children reviewed (63%, 41 children) were aged between birth and 4 years at the time of death. Twenty-eight children (43%) reviewed by the CDCRC in 2010–11 were under 1 year of age.

Twelve young people (18%) were aged 10–14 years, nine (14%) were aged 15–17 years and three were aged 5–9 years, at the time of their death.

Of the 65 children reviewed, 55% were male (36 children) and 45% were female (29 children).

Table 1.1 Child deaths by gender and age category, 2010–11

Age category	Female *n*	Male *n*	Total *n*	Total %
Under 1 year	12	16	28	43
1–4 years	7	6	13	20
5–9 years	1	2	3	5
10–14 years	4	8	12	18
15–17 years	5	4	9	14
Total	**29**	**36**	**65**	**100**

Aboriginal and/or Torres Strait Islander status

Of the 65 children and young people, 17 (26%) identified as Aboriginal. There were no Torres Strait Islander children reviewed in the 2010–11 reporting period.

CDCRC actions – Recording of cultural status

Accurate identification and recording of a child and family's cultural status is essential to the provision of culturally appropriate service delivery. The Child Safety Practice Manual requires Child Safety Services staff to record the Aboriginal and/or Torres Strait Islander status of all clients at the Intake stage.

In relation to two Aboriginal children whose deaths were considered by the CDCRC during the reporting period, the cultural status of the subject child and their family had not been identified in Child Safety Services' records.

The CDCRC recommended that Child Safety Services update its records to appropriately reflect the subject child's cultural status and the cultural status of other family members (where necessary) in order to ensure future service delivery to the family is culturally appropriate. In making any updates or amendments to its records, the CDCRC recommended that Child Safety Services clearly document that such updates and/or amendments were being made as a result of the child death review process.

Child Safety Services accepted both recommendations and have amended its records appropriately.

Initiatives to improve child safety – Child Safety Services: Support for Aboriginal and Torres Strait Islander children and their families

Blueprint for Implementation Strategy
In December 2010 the Minister for Child Safety released the Blueprint for Implementation Strategy (the Blueprint Strategy) as the Queensland Government's response and commitment to reducing the over-representation of Aboriginal and Torres Strait Islander children within the child safety service system.

The Blueprint Strategy has been developed on the premise that the care, safety and wellbeing of Aboriginal and Torres Strait Islander children is our shared responsibility and that all children have the right to grow up in a safe and supportive family environment.

Implementation of the Blueprint Strategy has commenced and will continue over the next 12 months. In December 2011 the Blueprint Strategy's progress will be considered and priorities to achieve better outcomes for Aboriginal and Torres Strait Islander children and families will be determined and continued in 2012.

The Blueprint Strategy is consistent with the Government's refocused investment of $20.2 million in 2011–12 in Aboriginal and Torres Strait Islander child protection services to increase family support and early intervention for Indigenous families and supporting 190 staff for both services across Queensland.

Funding reforms for Recognised Entities and Indigenous Family Support Services
In 2011–12, $10.1 million will be invested to support the 11 Recognised Entities across Queensland and $10.1 million will be invested to support the 11 Indigenous Family Support Services.

Extra funding has been approved to facilitate specialist training in the Triple P Parenting program and family and domestic violence training for the staff of Indigenous Family Support Services. These funding reforms are helping to deliver jobs and key services to Aboriginal and Torres Strait Islander peoples.

Safe houses
Over the next four years, $45 million will be invested to establish safe houses in 11 Indigenous communities. These safe houses enable Indigenous children to remain with appropriate care and support in their communities while Indigenous Family Support Services help families address the issues that brought them to the department's attention in the first place.

The safe house facilities will provide up to 66 additional placements in total for Aboriginal and Torres Strait Islander children.

Children with complex medical needs

Almost half of the children and young people reviewed (43%, 28 children) were identified as having a physical medical condition, intellectual impairment, developmental delay or a mental health condition.

A number of children had co-morbid conditions where they identified with more than one complex medical need. These data highlight the challenges of the child safety service system in providing appropriate service delivery to children and families with diverse social and medical challenges.

Responding to these children and young people provides additional challenges for Child Safety Services, including the management of multi-agency service provision, identification of additional supports to provide respite, practical assistance and emotional support for families, and identification of appropriate placement options for children in out-of-home care.

CDCRC actions – Complex medical needs

The CDCRC recognises the positive difference that strong community supports provide to children and young people with complex medical needs, their families and carers.

In one case reviewed during the reporting period, the CDCRC observed that the subject child's school provided a high standard of support to the subject child during their illness, including staff visiting the subject child in hospital.

The CDCRC acknowledged the school's significant support and excellent service delivery by providing feedback to the Department of Education and Training representative of the Child Safety Directors' Network.

Geographical distribution

As illustrated in Table 1.2, the majority of children reviewed (60%, 39 children) resided in regional areas. The remaining 26 children and young people (40%) resided in metropolitan areas. In the 2010–11 reporting period, there were no children and young people reviewed by the CDCRC who resided in remote areas.

Table 1.2 Child deaths by geographical distribution, 2010–11

ARIA+[2] Classification	Female *n*	Male *n*	Total *n*
Regional	18	21	**39**
Metropolitan	11	15	**26**
Remote	0	0	**0**
Total	**29**	**36**	**65**

Living arrangements

As shown in Table 1.3, 48 children (74%) were residing at home at the time of their death. 'Home' for the purpose of this report means the usual family residence, and includes residing with the biological parent or parents, step-parents, partners of the biological mother or father, and extended family.

Twelve of the children and young people (18%) resided in hospital at the time of their death. Eleven of these children were under the age of 1 year, with one child aged 1–4 years.

The CDCRC classifies the child's residence as 'hospital' in cases where the child never left hospital after their birth or in cases where the child spent the majority of their life in hospital care due to complex and often terminal medical conditions. In these cases, the child or young person remained in hospital care until their death. This category is not so broad that it captures all children who were hospital inpatients at the time of their death (see discussion below).

Three children and young people were in out-of-home care at the time of their death. All three children were living with foster carers. Two young people, aged 15 and 17 years respectively, had self-placed.

Table 1.3 Living arrangement category, 2010–11

Residential status at time of death	Total *n*	Total %
Home	48	74
Hospital	12	18
Foster Care	3	5
Self-placed	2	3
Total	**65**	**100**

[2] Accessibility/Remoteness Index of Australia

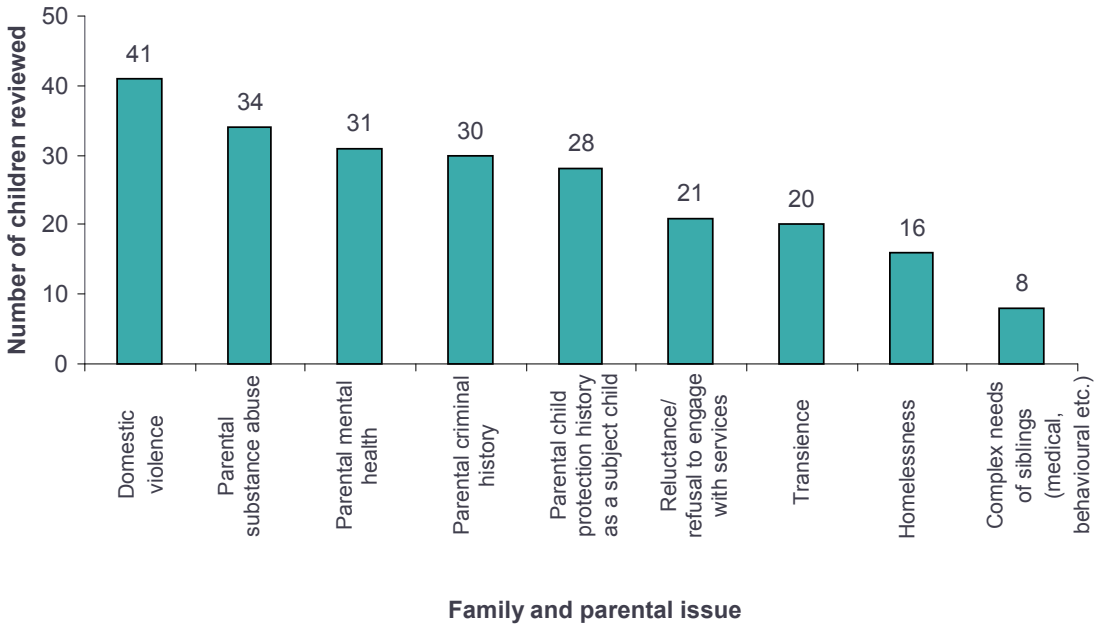
Almost half of the 65 children and young people (49%, 32 children) were hospital inpatients at the time of their death. 'Hospital inpatient' means that the child or young person had been admitted to a hospital ward for treatment. In some cases the child was only an inpatient for a short period after the onset of sudden illness or injury, while other children spent extensive periods of time in hospital because of a serious illness. The majority of children were aged under 1 year (15 children). Five children were aged 1–4 years, one child was aged 5–9 years, eight children and young people were aged 10–14 years, and three young people were aged 15–17 years.

Family issues

Many of the families of the children and young people whose deaths were reviewed faced complex family and parental issues, such as substance misuse, domestic violence, high mobility of lifestyle (transience), mental health conditions of the parents, parental involvement in the criminal justice system and parental child protection history.

Figure 1.1 shows the presence of these family issues in the families of the 65 children and young people reviewed by the CDCRC.

Figure 1.1 Family and parental issues, 2010–11



As in previous years, there was a high proportion of domestic violence, occurring in 41 families (63%). Parental substance misuse was the second most common family and parental issue occurring in 34 families (52%). Parental mental health and parental criminal history were noted in 31 families (47%) and 30 families (46%) respectively.

As shown in Table 1.4, 62 families (95%) had one or more family issues present. The majority of families (37%, 23 families) had between one and three of the family issues listed in Figure 1.1. Fifteen families (25%) had between four and six issues present and 17 families (26%) had between seven and nine family issues present. Seven families (14%) had greater than nine family issues present.

Table 1.4 Prevalence of family issues, 2010–11

Number of issues present	Total *n*	Total %
None	3	5
Between 1 and 3	23	35
Between 4 and 6	15	23
Between 7 and 9	17	26
Greater than 9	7	14
Total	**65**	**100**

Domestic violence was found to have a high rate of co-existence with substance misuse (43%, 28 families), parental mental health problems (38%, 25 families) and parental involvement in the criminal justice system (37%, 24 families). Of the 21 families where refusal/reluctance to engage with services was identified as a family issue, 19 (90%) noted the co-existence of domestic violence.

Mental health problems and its co-existence with substance misuse was noted in 21 families (32%).

The prevalence of multiple family and parental issues, combined with the complex needs of the children, highlights the challenge faced by the child safety service system in responding to complicated family situations and the need for an effective, coordinated multi-disciplinary response.

Initiatives to improve child safety – Child Safety Services: Helping Out Families Initiative

In line with the *National Framework for Protecting Australia's Children 2009–2020*, the Queensland Government's Helping Out Families Initiative is focussed on re-orienting and realigning the child safety service system with a focus on investments in the secondary service system. The aim of the Helping Out Families Initiative is to provide services to vulnerable families to provide appropriate early support to vulnerable families who are at risk of entering/re-entering child safety services. By responding to families' needs earlier, the longer term outcomes expected include a reduction in the volume of reports to Child Safety Services and the number of children in out-of-home care.

Funding of $55 million over four years for Helping Out Families comprises:

- more efficient Child Safety Regional Intake Services
- three Family Support Alliances
- three Intensive Family Support Services
- universal and targeted Health Home Visiting services, and
- enhanced domestic and family violence services.

In the south east region, the Family Support Alliance (FSA) service is the central and visible referral pathway from Child Safety Services to the secondary service system. The Family Support Alliance service works together with an alliance of other government and community based service providers known as the Alliance, to plan and co-ordinate a range of services to meet the specific needs of individual families.

The Helping Out Families Initiative is being evaluated over four years. Between October 2010 and 30 June 2011, the Child Safety South East Regional Intake Service (RIS) referred almost 1500 families to the three FSA services. Combining the child safety referrals through the RIS and direct referrals to the FSA services, almost 1600 referrals to the Helping Out Families Initiative have been made during this period.

Families referred to the FSA services present with a range of challenges and needs, including a substantial number where domestic and family violence is an issue. In order to respond effectively to those needs, a range of domestic and family violence services have been funded under the Helping Out Families Initiative to assist all members of families affected by domestic and family violence. These include:

- a new regional Domestic and Family Violence Service for the Eagleby, Beenleigh and Nerang areas
- enhancement to existing services in Logan
- counselling and support services for victims
- children's domestic and family violence counselling services
- men's perpetrator behaviour change programs, and
- court support services.

The services specifically funded under the Helping Out Families Initiative complement and strengthen the existing domestic and family violence services in the identified catchment areas.

Youth Justice System

Involvement in the youth justice system may range from being charged with a criminal offence by Queensland Police Service to being detained in youth detention.

Five young people reviewed had involvement with the youth justice system during their lifetime. One young person had spent time in youth detention.

Four young people were aged 15–17 years at the time of their death, while one young person died aged 10–14 years.

Four of the young people involved in the youth justice system were male and one was female.

CDCRC actions – Youth Justice Services

The CDCRC seeks to promote the learnings identified as a result of child death case reviews across the whole child safety service system by engaging with service providers other than Child Safety Services wherever possible.

In the case of two young people who were known to the Department of Communities, Youth Justice Services, the CDCRC referred the cases to Youth Justice Services for consideration of possible learnings around the issue of collaboration between Child Safety Services and Youth Justice Services.

In the case of another young person, the CDCRC referred the case to Youth Justice Services for its review and consideration of issues identified by the CDCRC in relation to the subject child's mental health.

Involvement with Child Safety Services

The trigger for a child death case review is not alleged negligence of the child safety service system but rather its involvement (no matter how minimal or extensive) in the child's life.

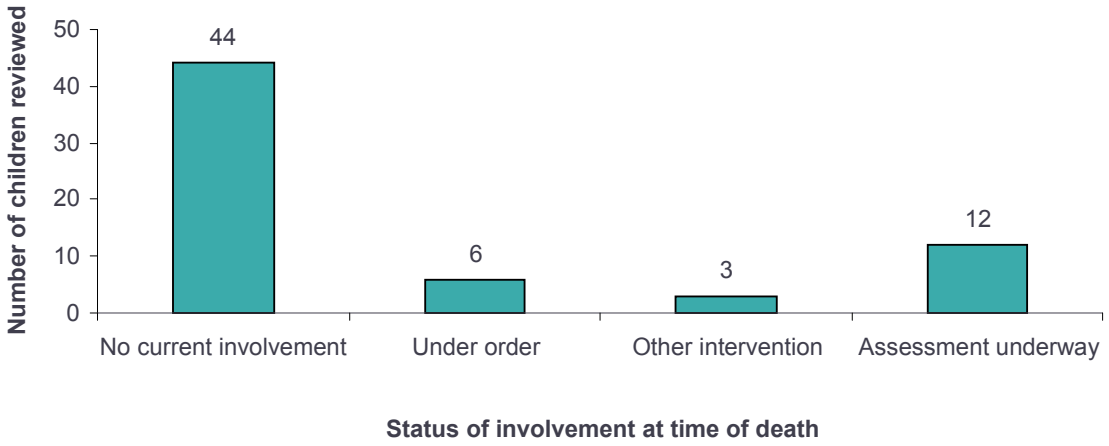
The following section examines Child Safety Services' level of involvement with the child both at the time of death and during the child's lifetime.

The first review criterion of the CDCRC considers whether any service system actions or inactions were linked to the child's death. The CDCRC found that actions or inactions of the child safety service system were not linked to any of the deaths of children and young people reviewed by the CDCRC in 2010–11.

Involvement at the time of death

Figure 1.2 illustrates the nature of Child Safety Services' involvement with the children and young people at the time of their death.

Figure 1.2 Category of Child Safety Services' involvement at time of death



'No current involvement' refers to those cases where Child Safety Services had no involvement with the child or their family at the time of their death. In the majority of cases (68%, 44 children), there was no current involvement of Child Safety Services with the children and young people or their families at the time of their death.

'Under an order' refers to cases where an order under the *Child Protection Act 1999* had been granted to the Chief Executive, Department of Communities in relation to the child or young person at the time of their death, including a short or long-term custody or guardianship order, or an assessment order. In six cases, the children were under an order at the time of their death.

Chapter 4 of this report includes a discussion of service delivery to children who were subject to Child Protection Orders, including: three children who were placed in foster care; one child who was a long-term hospital inpatient (due to a complex medical needs); and two young people who had self-placed.

'Other intervention' refers to cases where at the time of their death the child or their siblings were subject to ongoing intervention by Child Safety Services in a voluntary capacity, for example, Intervention with Parental Agreement and Support Service cases. Three children were subject to other interventions at the time of their death.

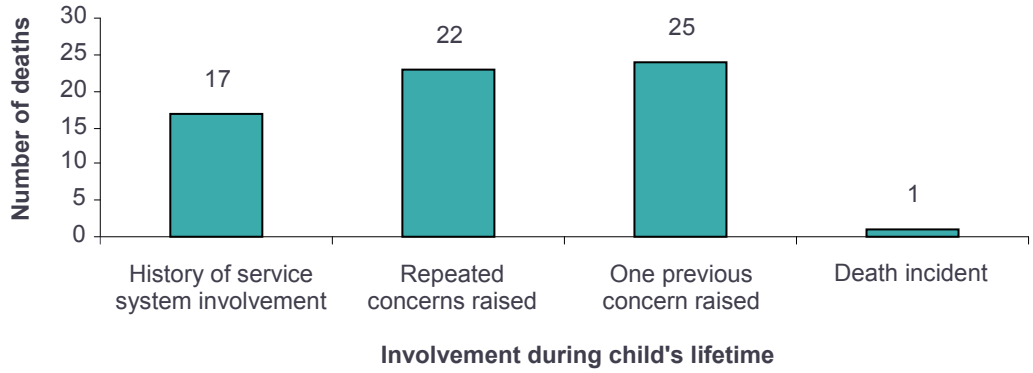
'Assessment underway' refers to those cases where Child Safety Services was in the process of assessing concerns received in relation to the child or their family. In relation to 12 children and young people (18%), assessments were underway at the time of their death.

Involvement during the child's lifetime

In addition to recording involvement of Child Safety Services at the time of the child's death, the CDCRC considers the extent of involvement with Child Safety Services during the child's lifetime.

Figure 1.3 illustrates the nature of Child Safety Services' involvement with the children and young people during their lifetime.

Figure 1.3 Involvement of Child Safety Services during child's lifetime



To assist in analysing the level of involvement of Child Safety Services in each case, the CDCRC has categorised the level of involvement into four groups as outlined below.

'History of service system involvement' refers to cases where the deceased child or their family had significant involvement with the child safety service system, with at least one Notification having been substantiated. Seventeen children and young people (26%) had a history of service system involvement.

'Repeated concerns raised' refers to cases where child protection concerns had been repeatedly raised in relation to the deceased child or siblings of the deceased child, but where such concerns were assessed as not meeting the threshold for recording a Notification, or where a Notification was not substantiated. Twenty-two children and young people (34%) had repeated concerns raised that either did not meet the threshold for a Notification or were not substantiated.

'One previous concern raised' refers to cases where Child Safety Services had been notified about child protection concerns for the child or their siblings, on one occasion prior to the death of the child, and where the concerns either did not meet the threshold for a Notification or were unsubstantiated. Twenty-five children and young people (38%) had one previous concern raised about them prior to their death.

'Death incident' refers to cases where the involvement by Child Safety Services with the family was only in response to the incident causing the death of the deceased child. One child was known to Child Safety Services through the death incident.

Chapter 2

Cause of death for children reviewed in 2010–11 and associated risk factors

Key findings and messages

- Thirty-two children and young people reviewed died from diseases and morbid conditions. Deaths from diseases and morbid conditions were most common in children aged under 1 year (25%, 16 deaths).
- Drowning was the leading external cause of death (seven deaths).
- Six children and young people suicided. They all experienced stressful life events prior to their deaths.
- Five children died from sudden infant death syndrome and undetermined causes.
- Five children died from causes unknown – pending test results.
- Four children and young people died due to other non-intentional injury-related causes.
- Four children and young people died in transport incidents.
- One child died as a result of a fire.
- One child was fatally assaulted.

Overview of deaths

This chapter examines in detail the circumstances of death of the children and young people whose deaths were reviewed in 2010–11 by the following research categories:

- diseases and morbid conditions
- sudden infant death syndrome (SIDS)and undetermined causes
- accidental external causes (drowning, transport, fire and other non-intentional injury-related deaths)
- suicide, and
- fatal assault.

The data in this chapter are sourced from the original reviews conducted by Child Safety Services, CDCRC reports and the Queensland Child Death Register, which is maintained by the Commission for Children and Young People and Child Guardian (the Commission). To assist with comparative research regarding the prevention of child deaths, the Queensland Child Death Register classifies cause-of-death data into research categories according to the circumstances of each death, as agreed upon by the Australian and New Zealand Child Death Review and Prevention Group.[3] Information about the Queensland Child Death Register classifications is presented in this chapter before the relevant analysis to aid understanding of findings and risk factors associated with specific causes of death. Information on child safety service system initiatives is also provided.

This chapter aligns with the CDCRC's second review criterion, which requires the CDCRC to consider whether any risk factors were relevant to the child's death.

Cause of death

Table 2.1 provides an overview of the causes of death for the 65 children and young people reviewed by the CDCRC in 2010–11.

Table 2.1 Cause of death by research category, 2010–11

Primary research category	Total *n*	Total %
Unknown – pending test results	**5**	**8**
Diseases and morbid conditions	**32**	**49**
SIDS and undetermined causes	**5**	**8**
External causes of death	**23**	**35**
Drowning	7	11
Suicide	6	9
Transport	4	6
Other non-intentional injury-related	4	6
Fatal assault	1	2
Fire	1	2
Total	**65**	**100**

[3] Commission for Children and Young People and Child Guardian, Annual Report: Deaths of children and young people, Queensland, 2009–10, page 187.

Unknown – pending test results

There were five deaths of children and young people reviewed by the CDCRC in 2010–11 in which an official cause of death was pending and which could not be readily classified into a research category at the time of reporting.

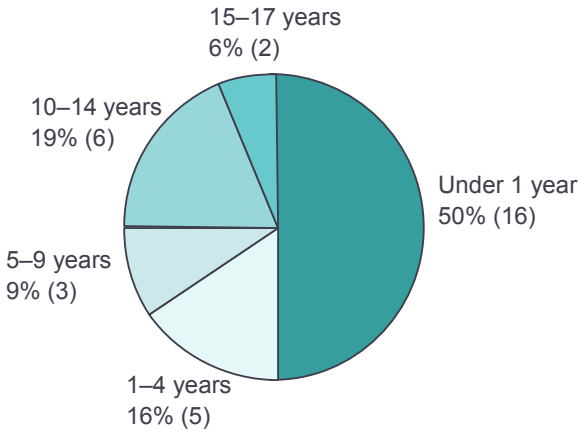
Where a cause of death is pending, the CDCRC monitors the Queensland Child Death Register to identify when an official cause of death has been established. In cases where the CDCRC has already completed its review of the child, the review is re-considered by the CDCRC to ensure that findings and recommendations remain accurate and appropriate in light of the cause of death.

Diseases and morbid conditions

Diseases and morbid conditions are those deaths for which the underlying cause is an infection, disease or other naturally occurring condition. Deaths from diseases and morbid conditions are often due to factors such as perinatal conditions and congenital malformations, deformations and chromosomal abnormalities.[4]

As illustrated in Figure 2.1, there were 32 children (49%) who died from diseases and morbid conditions. Children in their first year of life are particularly vulnerable to diseases and morbid conditions.[5] Deaths from diseases and morbid conditions were most common in children under 1 year of age (50% of deaths due to diseases and morbid conditions, 16 deaths).

Figure 2.1 Deaths due to disease and morbid conditions by age category, 2010–11



An equal number of males and females died as a result of diseases and morbid conditions (16 males, 16 females).

Of the 32 children who died from diseases and morbid conditions, nine (28%) were Aboriginal.

[4] Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people, Queensland, 2009–10*, page 27.
[5] Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people, Queensland, 2008–09*, page 42.

SIDS and undetermined causes

SIDS is defined as the sudden, unexpected death of an infant under 1 year of age, the cause of which remains unexplained after a thorough investigation—including review of the death scene, clinical history and complete autopsy.[6]

Five children died as a result of SIDS and undetermined causes in 2010–11.

The CDCRC noted three children who died from SIDS. Two of the children who died from SIDS were male, one was female. One of the children was Aboriginal.

Two children aged under 1 year of age died as a result of undetermined causes.

Drowning

Drowning was the leading external cause of death accounting for 30% (seven deaths).

Four female children drowned, compared with three males.

Table 2.2, illustrates the different types of drowning related deaths by age and gender. Three of the seven drowning deaths occurred in private swimming pools. Four drownings occurred in non-pool locations. Drowning occurred most frequently in the 1–4 year age group (six deaths). One drowning occurred in the 10–14 year age group.

Table 2.2 Drowning deaths by age and gender category, 2010–11

Type of drowning	Age group	Female *n*	Male *n*	Total *n*
Swimming pool drownings	1–4 years	2	1	**3**
Non-pool drownings		2	2	**4**
Dam	1–4 years	1	1	**2**
Transport incident	10–14 years	0	1	**1**
Other	1–4 years	1	0	**1**
Total		**4**	**3**	**7**

None of the non-pool drowning deaths reviewed by the CDCRC in 2010–11 were linked to the major Queensland flood events of January 2011.

The CDCRC noted inadequate supervision was a risk factor in almost all of the toddler drownings reviewed in 2010–11 (five deaths). That is, the children were not within the direct line of sight of an adult at the time of the incident.

A risk factor identified in two of the three drownings that occurred in private swimming pools was pool fencing that was non-compliant with council regulations governed by the Australian safety standards. In these cases, there was either a defect with fencing rendering the fence non-complaint with regulations, or no fence at all. A further risk factor identified in one of the drownings was a moveable object in the vicinity of the pool fence.

All drownings occurred in regional areas.

[6] Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people, Queensland, 2008–09*, page 160.

Suicide

In Queensland, a high standard of proof is generally needed for a suicide to be labelled as such. The substantial evidence required for suicide classifications often results in deaths that would ordinarily, in clinical or research situations, be categorised as suicides not meeting the threshold for a legal classification.

Consequently, in cases where a suicide is suspected but intent is unclear (that is, the deceased did not leave a suicide note and did not state their intent before death), the cases are often coded as accidents. This has resulted in childhood and adolescent suicide being under-reported in official statistics, with a large proportion mistakenly recorded as accidental deaths.

The Commission has endeavoured to reduce the likelihood of suicides being undercounted by examining all cases where police have indicated that a death is a suspected suicide. In addition, to enable further categorisation of these deaths, the Commission has developed a suicide classification model (see Appendix 4). This model includes consideration of whether the method of death has a high likelihood of being a suicide (e.g. hanging). The suicide deaths reviewed by the CDCRC have been classified using this model. [7]

Suicide was the second leading external cause of death for children and young people reviewed during the 2010–11 reporting period. Six children and young people were suspected of suiciding.

Age and gender

Three of the young people who took their own lives were aged 10–14 years. Three were aged 15–17 years.

Of the six suicide cases, four were male and two were female.

Table 2.3 illustrates the gender and age breakdowns for all of the suicide deaths.

Table 2.3 Suicide deaths by age and gender category, 2010–11

Age at death	Female *n*	Male *n*	Total *n*
13 years	1	1	**2**
14 years	0	1	**1**
15 years	1	0	**1**
17 years	0	2	**2**
Total	**2**	**4**	**6**

[7] Commission for Children and Young People and Child Guardian, *Annual Report: Deaths of children and young people, Queensland, 2009–10*, page 107.

Aboriginal and/or Torres Strait Islander status

Three of the six young people who took their own lives identified as Aboriginal. All three of these young people were male.

Method of death

Hanging was the method for five of the six deaths due to suicide reviewed by the CDCRC in 2010–11. A gun was the method of suicide used by one young person.

Place of incident

Four of the young people took their own life at home. The other two young people suicided in a public place.

Intent stated or implied (orally or written)

Four of the young people who suicided either expressly stated or implied an intention of suicide before their death.

Of the six young people who took their own life, one young person left a suicide note. This young person had not previously stated or expressed any intention of suicide.

Risk factors

This section examines the risk factors, where known, that may have been associated with the six children and young people who suicided. The information used is sourced from original review reports and relevant documents provided to the CDCRC by Child Safety Services in accordance with the *Child Protection Act 1999* and the Queensland Child Death Register.

Table 2.4 shows the risk factors present in the children and young people who suicided. As shown, many of the young people experienced multiple factors that place individuals at a higher risk of suicidal behaviours.

Table 2.4 Significant factors identified in suicide deaths, 2010–11

Demographics					Known risk factors						
Gender	Age	Aboriginal and/or Torres Strait Islander	Regional/remote	Low SES[8]	Mental health problems	Previous suicidal thoughts and/or behaviours	History of childhood abuse	Precipitating incident	Involvement with the youth justice system	Substance misuse	Contagion
Male	13				✓	✓	✓				
Female	13		✓								
Male	14	✓	✓	✓	✓	✓		✓	✓	✓	
Female	15		✓	✓	✓	✓	✓	✓			
Male	17	✓		✓	✓	✓		✓	✓	✓	
Male	17	✓		✓	✓	✓	✓	✓	✓		✓
Total		**3**	**3**	**4**	**5**	**5**	**3**	**4**	**3**	**2**	**1**

Mental health and behavioural problems

Five of the young people who suicided are recorded in the Queensland Child Death Register as having suspected or diagnosed mental health conditions. Depression was noted or suspected for four of these young people. One young person was suspected to have co-morbid conditions of depression and schizophrenia. Two of the young people with mental health conditions also misused substances.

Three of the young people who suicided are recorded as demonstrating behavioural issues such as refusal to attend school, truanting, aggressive behaviours and violence and/or destruction of property.

Previous suicidal thoughts and/or behaviour

Five of the six young people who suicided had experienced suicidal ideation and two of these young people had a history of self-harming behaviours (one young person self-harmed by cutting and the other self-harmed by unknown means). One of the five young people with a history of suicidal ideation had previously attempted suicide.

[8] 'Low SES' refers to children and young people who have been classified as residing in either a low or a very low socio-economic region.

History of childhood abuse

Three of the six young people who suicided had a history of alleged child abuse. All three of these young people had been the subject of a Notification on more than one occasion during their lifetime. The alleged concerns included physical abuse (of two young people), emotional abuse (of all three young people) and neglect (of one young person). In all cases, the alleged perpetrator was a parent or step-parent.

Child Safety Services' involvement with two young people consisted of recording one previous concern that did not meet the threshold for recording a Notification. One young person was known to Child Safety Services only as a result of the suicide incident.

Precipitating incidents and stressful life events

A precipitating incident or incidents before the death was identified as a factor in four of the suicides. Two young people experienced an argument with a significant other the day prior to their death. One of these young people also experienced a relationship breakdown with a significant other in the weeks prior to their suicide. Another young person was due to appear in court on the day of their death. A further young person was withdrawing from drugs and alcohol.

Stressful life events were identified as a risk factor for all six of the children and young people who took their own lives. These stressful events included: bereavement as a result of a parent's death, contact with the police and the youth justice system, being a victim of crime, family conflict, homelessness and/or transience, disengagement from the educational system, emigration, depression, and re-engagement with the education system after a period of absence.

Involvement with the youth justice system

Three young people were involved with the youth justice system. All three young people were male and identified as Aboriginal.

Substance misuse

Of the suicides reviewed during the reporting period, two young people identified as misusing one or more of a combination of alcohol, illicit drugs and volatile substances.

Contagion

Contagion was identified as a risk factor in one of the suicide cases considered during the reporting period. Specifically, familial contagion was identified in this case.

CDCRC actions – Engaging young people at high risk

The CDCRC Annual Report 2009–10 highlighted the service delivery challenges in responding to young people at high risk due to the complex behaviours and characteristics that define the cohort and the need for cross-agency service delivery.

One challenge often present in the case of young people at high risk is refusal or reluctance to engage with support services.

In one case considered in 2010–11, the CDCRC noted Child Safety Services staff were flexible and responsive to the young person's needs and found ways to engage with the subject child despite the young person's reluctance at times.

The CDCRC identified that the case evidenced significant learnings for staff engaging with children and young people who do not want to work voluntarily with Child Safety Services and who are engaging in risk taking behaviour.

Child Safety Services supported this recommendation and proposed learnings from this case be provided as a working tool to be used at the senior management level across the region to assist Child Safety Officers who are working with young people transitioning from out of-home-care.

CDCRC actions – Mental health service providers

The CDCRC seeks to promote the learnings identified as a result of child death case reviews across the whole child safety service system by engaging with service providers other than Child Safety Services wherever possible.

In one case concerning a young person who took their own life, who had previously been engaged with mental health services, the CDCRC considered that the case offered important potential learnings for Queensland Health, in particular the Child and Youth Mental Health Service. Accordingly, the CDCRC referred the key learnings it identified from the case to Queensland Health for it to consider whether the learnings could be utilised to improve future service delivery options to young people who engage with their service.

CDCRC submission – Reducing Youth Suicide in Queensland project

In the 2010–11 reporting period, the CDCRC made a submission to the Commission's Reducing Youth Suicide in Queensland (RYSQ) project team.

The submission shared important learnings identified through the Queensland child death case review process, particularly in relation to 19 suspected suicide deaths which were considered by the Committee between 2008 and 2010.

The submission analysed the 19 deaths as a group and provided key observations and learnings identified in the cases from a collective perspective.

The submission offered a point of comparison with the RYSQ project's preliminary findings and an insight into the profile of young people known to the child safety service system who suicide.

CDCRC submission – Youth at Risk Initiative

In the 2010–11 reporting period, the CDCRC made a submission to the Department of Communities Youth at Risk Initiative.

The Youth at Risk Initiative combined 11 existing funded youth initiatives into a single initiative. This will improve services to vulnerable young people by specifying expected outcomes, prioritising services to the most vulnerable young people, and streamlining administrative processes.

The CDCRC provided information from the 2009–10 reporting period in relation to the young people at high risk it reviewed. The CDCRC submission addressed specific consultation questions and identified the principles of prevention and early intervention and co-ordinated services for inclusion within the initiative's framework.

The CDCRC submission also highlighted important learnings regarding the service delivery requirements and service delivery challenges to young people at high risk reviewed by the CDCRC.

Transport

Four children and young people reviewed by the CDCRC in 2010–11 died in transport incidents.

Age and gender breakdowns for transport fatalities are illustrated in Table 2.5.

Table 2.5 Transport deaths by age and gender category, 2010–11

Age group	Female *n*	Male *n*	Total *n*
Under 1 year	1	0	**1**
1–4 years	0	1	**1**
10–14 years	0	1	**1**
15–17 years	1	0	**1**
Total	**2**	**2**	**4**

Motor vehicle incidents

Of the four children and young people who died in transport incidents, two died as a result of motor vehicle incidents. Both children and young people were passengers of the motor vehicle.

In one of the incidents, road trauma elements such as dangerous driving; inexperienced driver; late night driving; and peer passengers were identified as risk factors relevant to death.

Pedestrian incidents

Two children and young people who died as a result of transport incidents were pedestrians.

One child was under 1 year of age and died as a result of a low-speed run-over in a driveway.

One young person was in the 10–14 years age category and died as a result of being struck after entering a roadway.

Other non-intentional injury-related deaths

During the reporting period, the CDCRC considered Children Safety Services' review of four accidental deaths.

One death was attributed to head injuries, where a child who was in the 1–4 years age group died after falling from a height.

One accidental death of a young person in the 15–17 years age category was as a result of morphine toxicity. A second young person in the 15–17 years age category died as a result of electrocution.

A further death of a child under 1 year of age was a result of a sleep accident.

Fatal assault

In 2010–11 the CDCRC considered Child Safety Services' review of the death of one child who was fatally assaulted. The child was male and under 1 year of age.

This is the lowest number of fatal assaults considered by the CDCRC in a reporting period since its inception in 2004.[9]

The one child who was fatally assaulted died of a gunshot wound during a domestic homicide, perpetrated by a parent. The parent was not charged in relation to the fatal assault due to the parent's death shortly after the incident.

Service delivery to this child who was fatally assaulted is discussed at Chapter 4 of this report.

Fire

During the reporting period, the CDCRC considered Child Safety Services' review of one young person whose cause of death was fire-related. The young person was female and in the 15–17 years age category.

[9] The 2004–05 reporting period identified three deaths due to fatal assault and neglect; 2005–06 reported six, 2006–2007 reported seven, 2007–08 reported nine, and 2008–09 and 2009–10 reporting periods both identified five deaths due to fatal assault and neglect.

Chapter 3

Consideration of reviews

Key findings and messages

- The reviews conducted by Child Safety Services were generally of a high quality. Child Safety Services engaged broadly with stakeholders in conducting the reviews.
- In addition to endorsing the 76 recommendations of the original reviews, the CDCRC made a further 17 recommendations to better focus actions and further strengthen the responsiveness of the system through training, professional development and policy reform.
- The actions or inactions of the child safety service system were not linked to any of the deaths reviewed by the CDCRC in 2010–2011.
- In 12 of Child Safety Services' reviews, issues were referred to other government agencies for consideration of options to strengthen their involvement in areas relevant to improving service responses for children and young people.
- Child Safety Services advised the CDCRC of actions taken as a result of the original review process. The CDCRC supports the development of initiatives during the review process and considers that this demonstrates a willingness by Child Safety Services to be proactive in implementing changes to improve service delivery to children and young people in the child safety service system.
- In relation to the 17 Aboriginal children and young people whose deaths were reviewed, the relevant Aboriginal member of the CDCRC was present in all 17 cases in accordance with legislative requirements.
- In the 2010–11 reporting period, the CDCRC completed its considerations of all Child Safety Services' reviews within the legislated timeframe.
- In the 2010–11 reporting period, the CDCRC developed a framework to guide its assessment of its recommendations and referrals. The framework identifies activities that may reveal the impact these recommendations and referrals have on the child safety service system.

This chapter provides information about the CDCRC's consideration of Child Safety Services' original reviews relating to the deaths of 65 children and young people.

The Queensland child death case review jurisdiction consists of a two-tiered system for reviewing deaths of children known to Child Safety Services in the three years prior to their death. The first tier is a review conducted by Child Safety Services about its involvement with the child or young person (the original review).

The original review is then assessed by the CDCRC (the second tier) against a set of review criteria (see Appendix 2) which consider:

1. service system actions/inactions linked to the child's death (addressed in this chapter)
2. risk factors relevant to the child's death (addressed in Chapter 2 of this report)
3. service system issues identified as adversely affecting the deceased child (addressed in Chapter 4 of this report)
4. recurring risk factors and service system issues (addressed in Chapter 4 of this report), and
5. the quality of the original review (addressed in this chapter).

In 2010–11 the CDCRC considered the original reviews for 65 children and young people, against the review criteria, and a report of the CDCRC findings was delivered to the Chief Executive, Department of Communities.

The CDCRC acts independently when performing its functions and is not under the control or direction of any other entity.

This system ensures that Queensland has a strong and independent child death case review jurisdiction. It provides the Queensland public and government with a strong accountability framework, ensuring that Child Safety Services conducts reviews of all child deaths where the child had involvement with the agency within the three years prior to their death, and rigorous and independent scrutiny is applied to all cases.

The level of Child Safety Services' involvement with the children reviewed by the child death case review jurisdiction ranges from minimal contact (responding to the death incident) to significant involvement over many years. The trigger for a child death case review is not alleged negligence of Child Safety Services but rather its involvement (no matter how minimal) in the child's life.

The actions or inactions of the child safety service system were not linked to any of the deaths reviewed by the CDCRC in 2010–11.

This chapter outlines the key factors considered by the CDCRC when considering Child Safety Services' original reviews including:

- quality of original reviews
- timeliness of original reviews
- engagement with service providers
- recommendations, and
- actions arising from original reviews.

This aligns with the fifth review criterion of the CDCRC, which requires the CDCRC to consider whether the original review was of sufficient quality to enable timely responses to any relevant risk factors or service system issues, and to identify whether any further action is required.

This chapter also provides an overview of the CDCRC's actions in response to the original reviews including:

- review process
- timeliness
- cultural considerations
- recommendations, and
- referrals.

Child Safety Services' original reviews

Quality of original reviews

In considering the quality of original reviews, the CDCRC assesses the following elements:

- comprehensiveness of the original review
- timeliness in which the original review is provided to the CDCRC
- engagement of Child Safety Services with service providers in conducting the original review
- appropriateness of recommendations
- appropriateness of actions taken by Child Safety Services in response to the original review, and
- cultural consideration.

Each of these elements are discussed in further detail below.

Comprehensiveness

As noted in previous annual reports, the CDCRC has observed an overall improvement in the quality of reviews conducted by Child Safety Services.

The CDCRC continues to monitor the quality of each original review. In particular, the CDCRC considers whether the original review identified and assessed significant service system issues or risk factors present in the case to enable Child Safety Services to respond to the service system issues and risk factors in an appropriate and timely manner.

In the event that the CDCRC identifies ways in which the quality of original reviews may be enhanced, it shares such learnings with Child Safety Services. This includes: ensuring all service system issues are identified and addressed; identifying opportunities for consultation with external agencies to add further value and learnings to the review process; and appropriately considering whether service delivery was culturally appropriate.

Timeliness of original reviews

Under the *Child Protection Act 1999,* the Chief Executive of the Department of Communities must complete the original review and provide a copy of the report, as well as any documents used in conducting the review, to the CDCRC within six months of the Chief Executive becoming aware of the child's death.[10]

During the 2010–11 reporting period, one original review and accompanying documents were not provided to the CDCRC within the six-month timeframe due to an administrative error. In this case, the CDCRC commended Child Safety Services for its prompt action once the error was identified.

[10] Section 246D of the *Child Protection Act 1999.*

Initiatives to improve child safety – Child Safety Services: Procedures following the death of a child

In conducting an original review, Child Safety Services identified a breakdown of communication between Child Safety Service staff upon becoming aware of a child's death about the need to conduct a review of the child's death. The original review made a recommendation and proposed changes to policy to ensure that all Child Safety Services staff are aware of the processes to be followed once Child Safety Services becomes aware of a child's death.

This recommendation was implemented, and changes to Child Safety Services' policy have been effected.

Engagement with service providers

Both Child Safety Services and the CDCRC acknowledge the importance of identifying and addressing across-government child protection issues.

When conducting original reviews, Child Safety Services may seek to engage with other government and/or non-government entities that were involved with the deceased child or their family.

Engagement may be conducted by way of request for written documents, informal interviews with individual officers or group discussions with officers of the external entity.

In relation to 46 original reviews, Child Safety Services engaged with external entities, including:

- Queensland Police Services
- Queensland Health
- Disability and Community Care Services
- Recognised Entities
- Youth Justice Services, and
- non-government service providers.

Recommendations

Child Safety Services made 76 recommendations in its original reviews, all of which were endorsed by the CDCRC. The recommendations have been categorised as follows:

- learnings for departmental officers
- referrals to other agencies
- localised action (Child Safety Services)
- training and professional development, and
- policy and research development.

Table 3.1 categorises the types of recommendations made in the original reviews.

Table 3.1 Original review recommendations by type category, 2010–11

Type of recommendation	Total *n*
Learnings for officers	55
Referrals to other agencies	7
Localised action (Child Safety Services)	3
Training and professional development	7
Policy and research development	4
Total	**76**

Actions arising from original reviews

Child Safety Services took action as a result of the original review process in response to cases regarding the following areas of concern:

- review and/or development of policies, practice and procedures
- staffing and recruitment
- training and professional development
- monitoring of practice
- managing workloads
- interagency communication, collaboration and relationship building, and
- professional supervision.

The CDCRC commends initiatives aimed at improving service delivery to children and young people. In particular, the CDCRC considers that the development of the initiatives during the review process, rather than waiting for recommendations to be made, demonstrates a willingness by Child Safety Services to be proactive in implementing changes to service delivery to children and young people in the child safety service system.

Cultural consideration

In the 2010–11 reporting period, the CDCRC identified that all original reviews relating to Aboriginal children appropriately engaged cultural consultants in the review process. As noted in Chapter 1 of this report, there were no Torres Strait Islander cases reviewed in the 2010–11 reporting period.

Initiatives to improve child safety – Child Safety Services: Monitoring and implementation of recommendations

Child Safety Services' Practice Improvement (CSPI) Branch and each Child Safety Services' region, receive systemic recommendations arising out of various internal and external reviews, including Child Safety Services' original reviews about child deaths, Matters of Concern, Complaints, CDCRC reports, and investigations conducted by the Commission for Children and Young People and Child Guardian and the Office of the Queensland Ombudsman.

CSPI is committed to the following initiatives for 2011–12, to ensure a systemic understanding of and approach to the recommendations:

- development and maintenance of a tracking system to monitor the implementation of systemic recommendations
- quarterly reporting to the Regional Directors' Forum to highlight the current trends and hot issues arising from recommendations
- the Regional Directors' Forum has a standing agenda item each quarter to determine ways to implement and embed recommendations to facilitate best practice, and
- creation of the Annual Regional Report Card of Best Practice initiatives arising out of the systemic recommendations.

In addition to these initiatives, it is CSPI's intention to collate the recommendations in a way that allows:

- summarising practice trends
- assessing if recommendations are being addressed through current projects or activities, and
- focus on strategic planning and implementation of practice improvement via regional staff Forums on a quarterly basis.

CSPI's primary responsibility for tracking recommendations and highlighting trends will allow a coordinated systemic response. Additionally, collaboration with the regions will assist in creating efficacies in implementing recommendations.

Child Death Case Review Committee reviews

The CDCRC constitutes the second tier in the child death case review process. The CDCRC consists of the Commissioner for Children and Young People and Child Guardian (the Commissioner) who is the Chairperson, the Assistant Commissioner and seven appointed members.

The CDCRC members are appointed by the Minister for a term of three years. During the 2010–11 reporting period, the previous members completed their term of appointment, with the current members being appointed in November 2010.

Of the 65 deaths reviewed by the CDCRC, 25 were considered by the former CDCRC members and 40 were considered by the current members. (Appendix 1 details the biographies of the current CDCRC members, and also provides a list of the former members whose appointment expired during the 2010–11 reporting period).

The members bring a wealth of multi-disciplinary expertise to the CDCRC. The 2010–2013 CDCRC is comprised of specialists in the fields of mental health, paediatrics, youth justice and social work, as well as representatives from the Queensland Police Service and Aboriginal and Torres Strait Islander cultural representatives.

The Commission, in its role of providing secretariat support to the CDCRC, facilitated the induction of new members, including detailed briefings on the outcomes of the CDCRC's work undertaken during the last six years.

As has been the case with previous members, the new CDCRC is committed to utilising the breadth of their expertise where appropriate to enhance and promote learning among Child Safety Services staff and to further strengthen the responsiveness of the system through professional development and policy reform.

The extent of the review conducted by Child Safety Services and the terms of reference of its original review are at the discretion of the Chief Executive of the Department of Communities. The CDCRC review process applies a set of review criteria (Appendix 2) and critically assesses every original review to obtain learnings about service system issues and risk factors relevant to each child.

Timeliness

Under the *Commission for Children and Young People and Child Guardian Act 2000,* the CDCRC must review Child Safety Services' original review within three months after receiving a copy of the original review.[11]

In the 2010–11 reporting period, the CDCRC completed all reviews within the legislated timeframe.

Cultural considerations

Under the *Commission for Children and Young People and Child Guardian Act 2000* when considering the death of an Aboriginal child, the CDCRC's Aboriginal representative must be present. When considering the death of a Torres Strait Islander child, the CDCRC's Torres Strait Islander member must be present.[12]

In relation to the 17 Aboriginal children and young people whose deaths were reviewed in 2010–11, the Aboriginal representative of the CDCRC was present during all reviews. As noted previously, no deaths of Torres Strait Islander children were reviewed in the 2010–11 reporting period.

Recommendations

As well as endorsing the 76 recommendations made by the original reviews, the CDCRC made a further 17 recommendations to better focus actions and further strengthen the responsiveness of the system through training, professional development and policy reform.

As illustrated in Table 3.2, seven of the recommendations requested policy development and research to improve service delivery areas. Two recommendations were aimed at providing training to staff members to improve practice in specific areas.

[11] Section 135 of the *Commission for Children and Young People and Child Guardian Act 2000.*
[12] Section 128(2) of the *Commission for Children and Young People and Child Guardian Act 2000.*

Eight recommendations requested that action be taken by the respective specific Child Safety Service Centres including updating of records, disseminating learnings and informing staff of the CDCRC's positive feedback and acknowledgement of staff efforts in working with the subject child and their family. No recommendations were made in relation to disciplinary action in the 2010–11 reporting period.

Table 3.2 CDCRC recommendations by type category, 2010–11

Type of recommendation	Total *n*
Policy and research development	7
Training and professional development	2
Localised action (Child Safety Services)	8
Disciplinary action	0
Total	**17**

The CDCRC closely monitors the implementation of its recommendations and has determined that all recommendations made by the CDCRC in the 2010–11 reporting period have been implemented. The CDCRC is confident that the recommendations made and learnings identified in the reporting period will lead to improved service delivery to children and young people in Queensland.

Referrals

In addition to making formal recommendations under the *Commission for Children and Young People and Child Guardian Act 2000*, the CDCRC where appropriate:

- tests the willingness of other agencies to voluntarily participate in the review process
- makes referrals directly to the Child Safety Directors' Network and/or individual line agencies for action, and monitors responses to those referrals
- requests the Commission to undertake specific areas of research (for example, relevant to particular classes of cases)
- refers issues to the Commission for monitoring and/or investigation, and
- refers any child protection concerns for the surviving siblings of the deceased child to Child Safety Services for its consideration and action.

In 12 of Child Safety Services' reviews considered by the CDCRC in the reporting period, issues were referred to other government agencies for consideration of options to strengthen their involvement in areas relevant to improving service responses for children and young people. Efforts aimed at improving cross-agency collaboration highlight the complexity and multidisciplinary nature of implementing an effective child protection response.

CDCRC action – Sibling safety

Upon considering an original review conducted by Child Safety Services, the CDCRC identified concerns regarding the safety and wellbeing of the deceased child's siblings. The CDCRC referred its concerns to Child Safety Services and requested advice as to measures being taken to address relevant risk factors.

Child Safety Services provided advice to the CDCRC about the services being provided to the siblings to ensure their current and ongoing safety and wellbeing.

Refining the role of the Child Death Case Review Committee

In addition to its core functions, the CDCRC undertakes ongoing reflection and assessment of its role to ensure that it remains effective and relevant. Current activities for 2011–12 may include:

- implementing a framework for assessing effectiveness of recommendations and referrals, and
- identifying opportunities to enhance its review practice.

Development of a framework for assessing effectiveness of recommendations and referrals

Since its establishment in 2004, the child death case review jurisdiction (the jurisdiction) has reviewed 383 child deaths. In 2009 officers from Child Safety Services and the CDCRC Secretariat formed a working group to facilitate the discussion of issues relevant to the legislative processes including the implementation of CDCRC recommendations.

The child death jurisdiction working group (the working group) has recognised the evolution of the jurisdiction from focusing predominantly on compliance and capacity building to influencing policy and procedures that improve service delivery to children and young people while holding the child safety service system to account.

The working group refined a process that tracks recommendations once they have been made by the CDCRC through to their implementation by Child Safety Services. A Monthly Recommendation Implementation Report has been an important tool for the CDCRC to be satisfied that the actions taken by Child Safety Services to implement the CDCRC's recommendations are appropriate and thorough.

With the CDCRC having capacity to monitor the implementation of its recommendations through the Monthly Recommendation Implementation Report, it is important to review the impact its recommendations have on the child safety service system.

The approach suggested identifies activities that may reveal the impact these recommendations and referrals have on the child safety service system.

The framework breaks down CDCRC recommendations into categories. For each recommendation category, there are key indicators that provide guidance in reporting what the recommendation has achieved.

The following table details the framework, including proposed activities for the CDCRC in the 2011–12 reporting period, for the following recommendation and referral categories:

- training and professional development
- policy and research
- localised action (Child Safety Services), and
- referrals to other agencies.

Each recommendation category aligns with: implementation indicators that allow assessment of the CDCRC's recommendations and referrals; and proposed activities for the 2011–12 reporting period.

Table 3.1 Framework – Examining effectiveness of recommendations and referrals 2011–12

Recommendation category	Implementation indicators	Proposed activities 2011–12
Policy and research	• Policy review occurs • Consideration of issue raised by CDCRC is documented in review process • The CDCRC's input is valued • Policies are amended • CDCRC findings inform research	• Collect detailed information (aligning with outcome indicators) about the seven policy recommendations made by the CDCRC in 2010–11
Training and professional development	• Training reinforces good practice • Training improves professional knowledge base • Training improves individual practice	• Incorporate a requirement for a feedback process about training and professional development (aligning with the outcome indicators) in recommendations made by the CDCRC in 2011–12
Localised action (Child Safety Services)	• Child Safety Service Centre uses recommendation as an opportunity to implement strategies to improve practice	• Identify relevant recommendation to use as a trial. Follow up with the relevant Child Safety Service Centre six months after implementation occurs
Referrals to agencies other than Child Safety Services	• Agencies action referral	• Create a questionnaire for agencies to provide feedback to the jurisdiction about: the value of referrals, and if there is a further role the jurisdiction can play in informing child protection policy

The outcome of the proposed activities outlined in the table above will be reported in the CDCRC's 2011–12 annual report.

Identifying opportunities to enhance review practice

During 2011–12 the CDCRC will use a sample of reviews it had undertaken during 2009–10 reporting period to reflect on its own review process. This will allow the CDCRC to affirm the strengths of its process and look at developing opportunities to improve its role.

Chapter 4

Service delivery provision

Key findings and messages

- None of the service system issues discussed in this chapter were linked to the death of children reviewed by the CDCRC.
- In 2010–11 the CDCRC identified that assessments of initial allegations of harm and services provided to pregnant women and their unborn children may be strengthened.
- In addition, the CDCRC noted positive service delivery elements in the support provided to children and young people who were under Child Protection Orders.
- The CDCRC acknowledges that the service system issues discussed in this chapter are based on the children reviewed, which is not necessarily representative of service delivery trends across the entire system. However, the identification of these issues enables the child safety service system to examine and monitor these areas to foster a better understanding and promote learning about the complex interplay of factors relevant to child protection.

Key findings and messages (cont.)

Intake processes

- In the 2010–11 reporting period, opportunities to improve information gathering at Intake were identified in relation to 27 children and young people whose deaths were reviewed.
- Issues regarding assessment and screening decisions at Intake were identified in relation to 25 children.
- In relation to six children and young people, it was found that information recorded as a case note or Intake Enquiry, should have been recorded as either a Child Concern Report or Notification due to the information containing allegations of harm or risk of harm.

Unborn Child Notifications

- Of the 65 children and young people whose deaths were considered by the CDCRC in the 2010–11 reporting period, 15 (23%) involved service delivery to pregnant women and their unborn children.
- The families of these 15 children had complex family issues impacting on the safety and wellbeing of the unborn child as well as the parents' ability to care for the baby after birth, including:
  - the mother's own child protection history as a subject child
  - parents criminal history
  - domestic violence, and
  - substance misuse.
- In reviewing the cases, the following key areas were identified as requiring strengthening:
  - timeliness of actioning Unborn Child Notifications, and
  - development and implementation of support service plans.

Children and young people under Child Protection Orders

- In relation to the six children and young people who were under Child Protection Orders at the time of their death, the CDCRC observed that the following factors promoted positive service delivery outcomes:
  - strong engagement between case workers and child, family and carers
  - child-focused, considered and planned case work
  - cross-agency communication, collaboration and planning, and
  - stable placements that meet the individual needs of the child.

Key findings and messages (cont.)

Children and young people who died as a result of suicide or fatal assault

- At the time of their death, Child Safety Services had no service involvement with any of the young people reviewed by the CDCRC in 2010–11 who suicided.
- In relation to the child who was fatally assaulted, Child Safety Services had no current involvement at the time of their death.
- The following areas of Intake were identified as areas where there were opportunities for improvement:
  - information gathering/sharing
  - screening decisions
  - timeliness of recording concerns
  - recording cultural heritage of family members, and
  - recording concerns as an Intake Enquiry.

As discussed in Chapter 2 of this report, in considering the reviews conducted by Child Safety Services, the CDCRC examines service delivery provided by Child Safety Services to children and young people. In addition to the consideration of individual cases and making of recommendations, review criterion 4 allows the CDCRC to identify themes and issues from the evidence base to inform research and influence both strategic and operational policy.

In the 2010–11 reporting period, the CDCRC identified that aspects of service delivery during the Intake phase and services provided to unborn children may be strengthened through detailed analysis of all cases considered.

This chapter also examines service delivery to children and young people who died as a result of suicide or fatal assault.

Intake – a critical decision-making process

Overview

Intake is the first step towards Child Safety Services providing support to children and young people experiencing significant harm or risk of harm. It is at this stage that Child Safety Services is required to gather as much information as possible to determine the appropriate response, ensuring children and young people's risk factors are responded to appropriately and in a timely manner.

The CDCRC acknowledges the work that has been progressed by Child Safety Services to strengthen Intake responses. Given the critical role which Intake plays in protecting children and young people, the CDCRC supports initiatives of Child Safety Services to review and further refine service delivery during Intake.

A key strategy to improve the quality of the Intake process has been the rollout of the Regional Intake Service (RIS) which has the following aims:[13]

- improve consistency and quality of Intake decision making
- streamline and simplify the process of reporting for professional and other notifiers
- improve provision of timely feedback and communication with referring agencies, and
- improve management of demand and workload pressures through separation of Intake from investigation and assessment functions.

[13] Department of Communities, Child Safety Services 'Regional Intake Services (RIS) and Child Safety Service Centre (CSSC) Interim Protocol' September 2010, Version 3

Initiatives to improve child safety – Child Safety Services: Training of Regional Intake Services staff

Regional Intake Services (RIS) were operational in the North Queensland and south west regions prior to the 2010–11 financial year, with the remaining regions commencing Intake operations in the south east region from 2 August 2010. A progressive statewide rollout of RIS commenced in July 2010 and was completed by 30 October 2010.

A three-day training package was developed for all RIS Child Safety Officers and RIS Team Leaders and included:

- applying risk assessment and child protection history analysis to meaningfully inform the Intake response
- initiating professional conversations with staff about Intake processes, assessment and decision
- appraising staff practices and decision making
- providing feedback on staff practices and decision making
- understanding the protocol between the RIS and Child Safety Service Centres
- providing information about child protection/family law interface
- integrating personal professional knowledge with technical and procedural guidelines at Intake
- accessing the Child Safety Practice Manual for any technical and procedural guidelines specific to Intake decision making when required
- practice applying risk assessment and child protection history analysis to meaningfully inform the Intake response, and
- articulating (written and verbally) rationales for Intake decisions.

The training package consisted of scenarios and group work where major practice themes identified during the RIS implementation consultation were discussed. Particular emphasis was placed on child protection history analysis (and the identification of cumulative harm), the appropriate use of pre-notification checks, an overview of screening concerns relating to domestic violence and sexual harm, and the use of the Structured Decision Making tools.

As part of the rollout of RIS, periodic reviews of the implementation and its effectiveness will be conducted, the first of which is currently underway. The CDCRC is committed to supporting Child Safety Services in conducting this review and has requested an update of the outcome upon its completion. Given the complexities of the Intake process, the CDCRC considers RIS as one of a number of strategies necessary to improve service delivery at the Intake phase. The CDCRC will continue to monitor this service delivery area through child death reviews and report on its findings in the 2011–12 annual report.

Child Death Case Review Committee cases reviewed, 2010–11

Child Safety Services' actions or inactions were not linked to any child's death reviewed in this period. Of the 65 children and young people whose deaths were considered by the CDCRC in 2010–11, issues during the Intake phase were identified in relation to 36 children and young people (55%). The review of the cases identified opportunities to improve the following aspects of the Intake phase:

- information gathering, and
- assessment and screening decisions.

Information gathering

The Child Safety Practice Manual highlights the critical importance of comprehensive information gathering during the Intake phase. Information gathering includes obtaining as much information as possible from the notifier, conducting child protection history checks (including interstate), pre-notification checks with relevant entities and accessing criminal histories for relevant people as well as consulting with Recognised Entities were applicable. The CDCRC notes that the onus of responsibility for identifying and gathering relevant information is that of Child Safety Services and not the notifier (agency or public).

In the cases reviewed by the CDCRC in 2010–11, the CDCRC observed that strong information gathering at Intake, facilitates:

- comprehensive assessments of children's protective needs
- a better understanding of a parent's ability and willingness to protect a child from harm
- effective information sharing and collaborative working relationships between agencies
- more timely responses to address child protection concerns
- timely and effective engagement with Recognised Entities
- better understanding of the child's cultural identity, and
- more appropriate referrals to other agencies.

In the cases where the CDCRC identified information gathering at Intake as an issue, the CDCRC observed that additional questioning of the notifier to elicit further information and more effective use of information sharing provisions at the pre-notification stage, may have enabled a more holistic and accurate Intake assessment decision to have been made.

In the 2010–11 reporting period, opportunities to improve information gathering at Intake were identified in relation to 27 children and young people whose deaths were reviewed.

CDCRC recommendation – Information gathering and assessment at Intake

In one case, the CDCRC identified issues in relation to information gathering and critical analysis in the recording of three Child Concern Reports. The case highlighted the importance of the following Intake practices:

- information gathering and requesting the Notifier to supply information on all household members
- checking the cultural heritage of any members of the subject child/children's household, and
- ensuring the assessment of the information received addresses each child protection concern which has been raised by the Notifier.

The CDCRC recommended that Child Safety Services take appropriate action to ensure that Intake staff understand the specific issues identified by the CDCRC.

The learnings of the case were shared with relevant officers of Child Safety Services with the aim of improving future service delivery at the Intake stage.

Assessment and screening decisions

Issues regarding assessment and screening decisions at Intake were identified in relation to 25 children.

In relation to six children and young people, it was found that information recorded as a case note or Intake Enquiry, should have been recorded as either a Child Concern Report or Notification due to the information containing allegations of harm or risk of harm.

The CDCRC and original review noted the potential ramifications of recording allegations of harm or risk of harm as a case note or Intake Enquiry including lost opportunities to:

- consult with the Recognised Entity
- provide information and advice to the notifier to help address the protective needs of the child
- make appropriate referrals to other agencies and/or collaborate with other agencies to help meet the needs of the child, and
- assess and investigate the allegations of harm and put in place appropriate intervention services.

The findings of the original review and the CDCRC suggest the following elements may facilitate more appropriate decision making at Intake:

- comprehensive information gathering
- shared understanding as to when information is to be recorded as an Intake Enquiry rather than screened using the Structured Decision Making tools
- shared understanding as to what constitutes allegations of harm or risk of harm to a child, particularly when the information is received in the context of:
  - allegations of domestic violence between parents
  - Family Law Court proceedings, and
  - reports of harm due to the child's own behaviours.
- consideration and assessment of the family's and child's child protection history, and
- strong professional judgement, that considers not only the outcome of Structured Decision Making assessments, but also draws upon the worker's theoretical, research and procedural knowledge and their practice and personal experiences.

Service System Case Study 1

Extensive information gathering facilitates a more informed and holistic assessment of concerns.

The subject child was aged 10–14 years at the time of their death. The subject child was engaged in high risk behaviours. Child Safety Services received concerns about the subject child which were recorded as an Intake Enquiry.

The CDCRC noted that the information obtained by the Intake officer was limited and that further information was required to inform a comprehensive assessment of the subject child's situation, including more details about the subject child's family circumstances, including what may have led to the subject child leaving the home to live with other relatives, the subject child's level of substance misuse, and the reason for the subject child's engagement with a health professional.

The CDCRC concluded that the decision to record an Intake Enquiry was inappropriate as the reported concerns contained allegations of harm or risk of harm to the subject child as defined in the *Child Protection Act 1999*. The CDCRC identified that it would have been more appropriate to screen the concerns using the Structured Decision Making Tools and to either record a Child Concern Report or a Notification.

In considering this issue, the CDCRC referred to the *Child Protection Act 1999* as well the Child Safety Practice Manual. In particular, the CDCRC notes the following:

- while it was the subject child's own behaviours that were potentially placing the young person at risk of harm, the definition of "harm" in section 9 of the *Child Protection Act 1999* states that *"…it is immaterial how the harm is caused."*
- the Child Safety Practice Manual provides guidance on considering a parent's ability to protect the child from harm caused by their own behaviours. In particular, the definitions within the Structured Decision Making tool define "Neglect – failure to protect", as follows:

  "A parent is not able to protect the child from harm. The child's high risk behaviours are causing him/her serious physical, medical, or emotional harm, or pose a risk of such harm, AND the parent is not able to take actions to protect the child. This does not simply refer to parental willingness to take action, but to the effectiveness of the attempted action to sufficiently protect the child."

The CDCRC recommended that a copy of the CDCRC report be provided to the Manager of the RIS, the Regional Director and the Manager of the Child Safety Service Centre for learning and development purposes.

Child Safety Services advised that the learnings in this case were shared with the relevant staff to improve service delivery and Intake practices.

Initiatives to improve child safety – Queensland Health: Child Protection Advisors and Child Protection Liaison Officers

Queensland Health's commitment to effective collaboration in the protection of children and young people is demonstrated through the appointment of key positions across the Department. These positions provide support to frontline staff that may identify concerns regarding an adult's ability to provide care for a child in their care or a child or young person's presentation for health services. They also work in close collaboration with other key government departments and entities to ensure that there is a whole-of-system response to children who are at risk or who have been harmed. The positions are Child Protection Advisors and Child Protection Liaison Officers. These positions are a valuable resource for interagency communication and information sharing.

The Child Protection Advisor plays a key role in the provision of child safety/protection services both at a district and interagency level.

The role of 'Child Protection Liaison Officer' has been implemented within Health Service Districts to provide a single point of contact for child protection issues. There are 40 Child Protection Liaison Officers in health services across the state.

Unborn Child Notifications – opportunities for healthier and safer children

Overview

An Unborn Child Notification (UCN) is recorded when there is reasonable suspicion that an unborn child will be at risk of harm after they are born. UCNs provide unique opportunities for agencies to support pregnant women who have child protection related issues, so they can deliver healthier children into a safe family environment.

While Child Safety Services are the lead agency responsible for protecting children and young people, it may be that some pregnant women are more likely to engage with support services from other government or non-government agencies to address risk factors that may impact on their unborn child.

Child Death Case Review Committee cases reviewed 2010–11

Of the 65 children and young people whose deaths were considered by the CDCRC in the 2010–11 reporting period, 15 (23%) involved service delivery to unborn children. Child Safety Services' actions or inactions were not linked to any child's death reviewed in this period.

Of the 15 cases that examined service delivery to unborn children, UCNs were recorded in 12 cases and Child Safety Services' original review identified that the remaining three cases warranted the recording of an UCN.

The families of these 15 children had complex family issues impacting on the safety and wellbeing of the unborn child as well as the parents' ability to care for the baby after birth, including:

- the mother's own child protection history as a subject child
- parents' criminal history
- domestic violence, and
- substance misuse.

In relation to 10 of these 15 children, the siblings had been removed from the family home or were subject to ongoing intervention prior to the child's birth.

The complex circumstances of these families in many cases resulted in a reluctance to engage with support services, particularly when the involvement of Child Safety Services was perceived as threatening and potentially may result in the removal of the new born baby.

Seven of the 15 children died from prematurity and causes related to prematurity. In relation to four of these seven children, the CDCRC identified that the mother's behaviour during the pregnancy resulted in risk factors relevant to prematurity, for example, substance misuse and not engaging in antenatal care. For a number of reasons, no support services were accessed by these mothers through the UCN process.

In reviewing the cases, the following key service system areas were identified as requiring strengthening:

- timeliness of actioning UCNs, and
- development and implementation of support service plans.

CDCRC action – Unborn Child Notifications

The CDCRC supported the original review's recommendations regarding opportunities to improve service delivery to unborn children and their families. To ensure that these learnings were appropriately integrated into practice, the CDCRC recommended that Child Safety Services provide it with advice regarding how Child Safety Services intends to monitor the Service Centres' responses to UCNs, specifically:

- quality of assessments of UCNs
- timeliness and accuracy of record keeping with respect to the assessment of UCNs, and
- timeliness with respect to the assessment of UCNs.

Child Safety Services provided comprehensive advice to the CDCRC regarding the processes taken within the Child Safety Service Centre to improve the quality of UCNs both at the Notification and Investigation and Assessment stage of service delivery. The strategies include:

- upon a decision being made not to assess a UCN prior to the child's birth, the case will be referred and reviewed by the Suspected Child Abuse and Neglect team
- informing the Senior Practitioner upon the recording of a UCN
- in the event that the mother does not engage with Child Safety Services, alerts will be sent to relevant hospitals to allow Child Safety Services to be notified of the birth of the child. Upon the child's birth, Child Safety Services will record a Notification and conduct an appropriate Investigation and Assessment, and
- a register of UCNs has been developed and is reviewed weekly by the Team Leader within the Child Safety Service Centre.

The original reviews and the CDCRC identified the following learnings which may facilitate more effective service delivery to unborn children:

- engaging mothers at the earliest possible time in pregnancy is crucial to allow for timely and holistic planning, involving engagement with a variety of services including health, mental health, social, educational and other appropriate support services as required. Engaging with mothers during the early stages of pregnancy assists in the development of a respectful/trusting relationship between the mother and Child Safety Services.
- intervention during pregnancy assists to mitigate risk factors to both the mother and unborn/newborn child, such as those caused by substance misuse, domestic violence and other high risk behaviours. Therefore, this may assist in directing newborn children away from the tertiary system who would have otherwise required ongoing or out-of-home interventions.
- guidelines for practice in respect to Indigenous people should reflect Indigenous cultural practices in that a child is usually raised by any number of relatives in the extended family groupings. The Recognised Entity should play a more active role in determining who the appropriate family members are who can support the mother and family.

Child Safety Services has acknowledged the learnings identified by the CDCRC and has provided a commitment to give further consideration to opportunities to strengthen the UCN process and has committed to prioritising review of this service system issue in 2011–12.

Service System Case Study 2

Engaging with mothers during pregnancy to provide planned and holistic intervention to minimise the risk of harm to the child after birth.

The subject child was aged under 1 year at the time of their death. Child Safety Services had a history of involvement with the family, with the subject child's siblings being subject to child protection orders.

Child Safety Services received child protection concerns regarding the unborn subject child six months prior to their birth. However, there was a significant delay in finalising the UCN and subsequently the Investigation and Assessment was not conducted until after the subject child's birth.

While a number of external agencies and family members provided support to the family after the subject child's discharge from hospital, the original review identified that Child Safety Services missed an important opportunity for assessment and intervention during the mother's pregnancy with the subject child.

The original review considered that the delay in investigating and assessing concerns:

- delayed and restricted the opportunity to provide planned intervention, to best address the child protection concerns and minimise the risk of harm to the child, post-birth; and to provide coordinated service delivery, as best as possible, to the family unit, and
- increased the 'crisis' nature of the service delivery. A planned Investigation and Assessment pre-birth would have created better, more considered service delivery to the child and their family, particularly regarding thorough and accurate assessment of the child protection concerns.

The original review identified that this case evidenced a number of learnings in relation to service delivery to unborn children and made several recommendations to address identified practice issues relating to UCNs. The CDCRC agreed with the recommendations identified by the original review.

CDCRC discussion paper – Unborn Child Notifications

Upon the CDCRC reviewing 15 cases involving a UCN, it became evident that this area of service delivery was an opportunity to improve outcomes for mothers at risk and their unborn children. In assessing the policies and resources providing support to Child Safety Officers in actioning UCNs, it was unclear to the CDCRC whether Child Safety Services has a clear practice framework to guide staff. As a result, the CDCRC developed a discussion paper considering UCNs. The discussion paper identified areas of service delivery requiring strengthening and highlighted learnings which may facilitate more effective service delivery to unborn children.

The paper provided an opportunity to prompt discussion regarding: whether a specific practice paper or suite of guidelines is required to support Child Safety Officers to engage with mothers who are the subject of an UCN; approaches which could be used to promote engagement during the pregnancy; and case conferences that involve Child Safety Services, Maternity Services, Child Health Services, the Recognised Entity (where required) and the parents should be conducted when a UCN is recorded. The discussion paper was provided to Queensland Health and Child Safety Services with both agencies supporting ongoing development of network and policies. The CDCRC will provide an update on activities relating to this service delivery area in its 2011–12 annual report.

Service System Case Study 3

Comprehensive assessment of a child's need for protection prior to birth promotes effective service delivery and informed decision-making once the baby is born.

The subject child was aged under 1 year of age at the time of their death. The subject child was born with a complex medical condition.

Child Safety Services recorded a UCN prior to the birth of the subject child. A robust assessment of the risk to the unborn child was conducted and an outcome of "substantiated child in need of protection" was recorded. Child Safety Services appropriately offered a support service case to the family, to provide the parents with an opportunity to address the child protection concerns prior to the baby's birth. However, the parents failed to engage. Subsequently, and in line with UCN procedures, a new Notification was recorded at the time of the subject child's birth.

Child Safety Services conducted a second assessment, incorporating the family's current circumstances and gathering information from a range of external sources. The assessment was holistic and comprehensive. A practice panel was convened with senior and experienced staff to identify the most appropriate intervention for the subject child and their family.

The original review identified that this case was an example of good practice with unborn children and infants and, as part of the review process, explored the strategies used within the Child Safety Service Centre to achieve and sustain this standard of practice.

The CDCRC identified this as a complex case with a number of factors influencing Child Safety Services' ability to effectively engage with the family, including the parents' young age, their significant child protection histories as subject children, and their reluctance to engage with support services. The CDCRC considered that despite these challenges, Child Safety Services demonstrated good practice in relation to a number of areas, particularly information gathering, collaboration with other agencies, and assessment and analysis.

As discussed in Service System Case Study 3, the CDCRC developed a discussion paper regarding service delivery to unborn children. The discussion paper was provided to Queensland Health and Child Safety Services to inform practice improvements. Through this process, the following initiatives have been identified by agencies as supporting vulnerable mothers:

- Maternity and Universal Post Natal Contact Service
- The Indigenous Early Childhood Development National Partnership agreement Element 2, and
- Continuity of Care Model.

Initiatives to improve child safety – Queensland Health: Maternity and Universal Post Natal Contact Service

The $29.67 million Universal Post Natal Contact Service initiative aims to ensure that all mothers have access to appropriate health care after the birth of a baby. The initiative includes:

- antenatal screening for psychosocial risk factors and health-related behaviours to identify families at risk early in pregnancy
- enhancement of community partnerships and service networks to ensure appropriate referral for families identified at risk
- follow-up post-natal contact (telephone or home visit) within a week of discharge from hospital
- greater integration of maternity and child health services, for enhanced continuity of care between hospital and community settings, including the establishment of Newborn and Family Drop-in Services , and
- 24 hour, seven-day-a-week telephone advice and support on infant and child health issues through 13 HEALTH.

Initiatives to improve child safety – Queensland Health: The Indigenous Early Childhood Development National Partnership Agreement Element 2

There are a range of initiatives under the Indigenous Early Childhood Development National Partnership Agreement Element 2 that are targeted to improve young people's health, pre-pregnancy health, sexual and reproductive health, and maternity health outcomes for women and their infants.

Improving sexual and reproductive health of young Indigenous people and the overall health of women generally

- Development of the Aboriginal and Torres Strait Islander Young People's Health and Wellbeing Program through the recruitment of Youth Health Workers in secondary schools to promote healthy lifestyles, to increase access to sexual and reproductive health information and services and increase health literacy. In addition, implementation of the Core of Life Program in some communities introduces teenagers to the realities of pregnancy, birth and parenting and encourages personal responsibility for their own health and wellbeing by allowing them to make informed choices.
- Family Planning Queensland has been contracted to develop an Anatomical Education Resource to assist Indigenous Health Workers to engage with the Aboriginal and Torres Strait Islander population and support Indigenous young people in the area of basic reproductive anatomy, puberty, healthy sexuality and personal hygiene.
- The development of safe sex resources for Indigenous people in urban and rural and remote areas, and for implementation of a safe sex social marketing campaign over five years.
- Implementation of a range of sexual and reproductive health promotion and sexually transmissible disease and blood borne virus screening and testing programs.
- The development and implementation of a sexual health and positive lifestyle program for Indigenous youth, particularly those aged 10–14 years.
- Expansion of the role of the Mobile Women's Health Nurses and Women's Health Workers to include the promotion of women's healthy lifestyles e.g. nutrition, physical activity, reduction of smoking and including good reproductive health, pre-conceptual care, contraception advice and increased community education on women's health issues through the funding of community women's health forums and events.
- The delivery of Women's Health Forums to increase community education about women's reproductive health issues.

Improving health of young pregnant women and their infants

- Midwives and Aboriginal and Torres Strait Island Maternal and Infant Health Care Workers positions have commenced in Cape York, Mt Isa, Townsville (Palm Island), Ipswich, Toowoomba, Logan and Caboolture to improve health outcomes for women in pregnancy and for their infants.
- Young Parent Support Worker positions have commenced in Palm Island, Mt Isa, Cherbourg and Ipswich to provide extra support for young pregnant women, young parents and their infants.
- Development of the 'For Me and Bub' smoking and alcohol prevention program to train and support the maternal and child health workforce to deliver culturally effective brief interventions in pregnancy.
- In May 2011 an Aboriginal and Torres Strait Islander Maternity Conference and Workshop "Partnerships in Caring, Bringing Together Clinical and Cultural Ways" was held with over 240 participants attending, including midwives, obstetricians, Maternity Health Care Workers, child health nurses, allied health and academics.
- Development of a Review of literature, Evaluations and Research on Australian Indigenous young parents' programs to inform Queensland Health staff on evidence-based strategies to improve pregnancy outcomes for young pregnant women and the parenting of infants and toddlers.

Increasing skills and competencies of the Aboriginal and Torres Strait Islander maternal and child health workforce

- Development of the Certificate IV course for Indigenous Health Workers who work across maternal, child and youth health services delivered in partnership between the Southern Queensland Institute of TAFE and the Cunningham Centre. The Child Health and Safety Unit sponsor the participation of the Queensland Health Indigenous Health Workers.
- Two nurse educators have been employed under the statewide Aboriginal and Torres Strait Islander Maternal, Child and Youth Health Workforce Development Program to facilitate the delivery of a wide range of educational training sessions to Indigenous maternity and child health staff across Queensland to increase competencies for Indigenous staff.
- A statewide Aboriginal and Torres Strait Islander Maternity Coordinator position commenced in 2010 to ensure that the best outcomes are achieved for young pregnant women through the new maternity and maternal and infant health care worker positions across the state.
- Recruitment of statewide Aboriginal and Torres Strait Islander Youth Health Coordinator positions to support the Indigenous Youth Health Workers in secondary schools and increase the profile of youth health issues to preventative health services.
- Development of the Which Way – Child and Youth Health Practice Manual DVD Series for Indigenous Child Health Workers. This educational DVD series of five is for educators to support and train Indigenous Child Health Workers, Indigenous Maternal and Infant Health Care Workers and Young Parent Support Workers.

Initiatives to improve child safety – Queensland Health: Continuity of care model

- Queensland Health has made the commitment that by the end of 2013, 10% of all births in Queensland Health public hospitals will occur in a midwifery continuity of care model. Midwifery models of care are about women being cared for by a health professional they get to know and trust.
- Continuity of midwifery care is popular with women. Services offering this model are in high demand. Research shows increased satisfaction by women and reports of feeling a sense of safety and control with a familiar caregiver.
- The benefits of continuity of carer are also measurable in outcomes. Midwifery models demonstrate lower rates of caesarean section and epidurals and higher rates of breastfeeding. There is also evidence that continuity of midwifery care is effective in engaging with Indigenous and young women, who frequently receive limited or no antenatal or postnatal care.

Children and young people under Child Protection Orders

Overview

Effective service delivery to children under Child Protection Orders (CPOs) requires an intensive multi-faceted approach focused on the child's individual needs, combined with effective coordination of relevant government and non-government service providers.

In 2010–11 the CDCRC considered the deaths of six children and young people who were subject to a CPO at the time of their death. While the nature of service delivery requirements for each child differed, some key elements of service delivery were observed to uphold the rights and interests of the children and young people, and facilitate positive outcomes for them during their lifetime.

In relation to these six children and young people, the CDCRC observed that the following factors promoted positive service delivery outcomes:

- strong engagement between case workers and child, family and carers
- child-focused, considered and planned case work
- cross-agency communication, collaboration and planning, and
- stable placements that meet the individual needs of the child.

Strong engagement between case worker, child, family and carers

Child Safety Services' original review and the CDCRC's review observed strong relationships developed and maintained by case workers with the child, their family and/or carers, resulting in a high standard of service delivery. Specifically, the following practices yielded positive relationships:

- consistent and available case workers
- maintaining frequent contact with the child, their family and carers, and
- open, respectful and collaborative communication.

Consistency and availability of case workers

A consistent case worker was identified as a factor that enabled strong working relationships to be developed with the child, family and carers as well as external agencies.

The CDCRC acknowledges that Child Safety Services' ability to ensure continuity of workers is not always within its control. Nevertheless, the value of consistent case workers is evidenced through the positive outcomes for the child and their family in terms of developing open and trusting relationships, and the level of understanding a consistent worker can gather about a child and their family.

Frequent contact

The CDCRC observed that consistent and available case workers helped facilitate frequent contact between case workers, the child, their family and/or carers.

In a case involving a young person engaging in high risk behaviours, the Child Safety Services' original review and the CDCRC observed case workers from Child Safety Services as well as non-government agencies developing unique and innovative strategies to maintain contact with the child, and assisted the child in obtaining employment.

In another case involving a child in foster care who developed a terminal medical condition, it was observed that frequent face-to-face and telephone contact between officers from a number of agencies (including Child Safety Services), the child, family and the carers enabled those involved to get to know the child, including the child's interests. As a result, agencies, including Child Safety Services, were able to more effectively meet the child's emotional needs during the child's lifetime, improving the child's quality of life.

Open, respectful and collaborative communication

The CDCRC observed the importance of open and respectful communication to support strong engagement between case workers, the child, their family and carers.

Of the six children and young people who were under a CPO at the time of their death, two involved young people engaging in high risk behaviours. Service delivery to young people engaging in high risk behaviours was focused on in the CDCRC Annual Report 2009–10, highlighting the need for the child safety service system to establish more intensive, diverse, and specialised service delivery to meet the complex needs of these young people.

The two cases considered by the CDCRC in 2010–11 highlight the importance of respectful communication in developing a relationship between the case worker and the child. These cases also reinforced the ongoing need for innovative and flexible strategies to engage with young people at high risk as well as the complexities in managing their challenging behaviours.

The establishment of strong relationships between case workers, the child, family and carers enabled more child focused considered case planning—an element which will be discussed in further detail on the next page.

Service System Case Study 4

Communication, innovation and commitment foster successful relationships with young people at high risk.

The subject child was aged 15–17 years at the time of their death. The subject child engaged in high-risk behaviours including substance misuse, absconding, truancy, criminal offending, and they were reluctant to engage with support services.

Despite the challenges present in this case, the CDCRC identified aspects of service delivery which were of a very high standard and resulted in positive engagement with the subject child.

The strategies used by Child Safety Officers to develop a successful relationship with the subject child and the family included the following:

- high level communication skills
- quality case work which promoted relationship building
- a strong ongoing commitment to identify and offer suitable placement options, and
- support of the subject child to achieve personal goals.

The CDCRC commended the following aspects of service delivery in this case:

1. Child Safety Services' innovative means of maintaining contact with the subject child by providing them with a weekly allowance which they collected from the Child Safety Service Centre.

2. Child Safety Services' response to the subject child's death and the support provided to the family post death of the subject child.

3. The Child Safety Service Centre completed an audit of all young people at high risk subject to ongoing intervention following the subject child's death. As a result of the audit, the Child Safety Service Centre developed a 'Young person at risk checklist' in the form of a workbook. The workbook acts as a prompt to discuss a range of factors relevant to the safety, wellbeing, and support of young people including accommodation, personal details, financial considerations, physical health/sexual health, mental health and behaviour, substance abuse, transport, education, training, employment, transition to independent living allowance, and transition from care planning.

The CDCRC recommended that Child Safety Services consider adopting the checklist throughout the child safety service system as a training and practice guideline.

After considering the checklist, Child Safety Services advised the CDCRC that it will be progressing development of the checklist as a statewide resource for linking to the Child Safety Practice Manual.

Child-focused, considered and planned case work

The CDCRC observed positive service delivery to children under CPOs where case management was proactive, responsive, flexible, and committed to meeting the individual needs of the child, their family and carers.

In the cases where effective case management was noted, the CDCRC observed the following elements of practice:

- contingency planning and panel discussions
- active planning and management of family contact to ensure it was in the best interests of the child, and
- actively involving the child in decision-making and ensuring their views and wishes were ascertained and respected.

Cross-agency communication, collaboration and planning

Effective cross-agency communication was identified as a key factor in quality service delivery, particularly for those children with complex medical needs who spent extended periods of time in hospital. In two of the four cases where the child was a hospital inpatient at the time of their death, the CDCRC noted that Child Safety Services had implemented a clear and effective communication strategy with Queensland Health. Where a communication strategy was in place, the CDCRC observed that there was a more effective and consistent flow of information between the two agencies.

In a case involving a child with a complex medical condition, the CDCRC observed excellent cross-agency communication, collaboration and planning between Child Safety Services, the relevant hospital, and the child's school as well as relevant non-government agencies. The CDCRC observed all agencies to work well in upholding the rights and interests of the child, as well as providing support to the carers and relevant family members.

Initiatives to improve child safety – Queensland Health: Evolve Therapeutic Services

Evolve Therapeutic Services (ETS) is the Queensland Health component of Evolve Interagency Services (Evolve), funded by the Department of Communities, which provides intensive mental health and disability behaviour support services for children and young people under a Child Protection Order with severe emotional and behavioural problems. All referrals to Evolve are made by Child Safety Services.

ETS teams are situated within Queensland Health Child and Youth Mental Health Services (CYMHS) and are managed within Health Service District structures, policies and procedures. There are 10 teams located throughout Queensland.

As at the end of July 2011, 268 children and young people were receiving ETS. Of these children, the average age was 11 years, 65 per cent were male and 31 per cent identified as being Aboriginal.

The second annual ETS Performance Report (2009) captured the demographic and outcomes data for all consumers open to ETS from 1 December 2008 to 30 November 2009. This evaluation identified improvements in placement stability; attendance and participation in schooling; peer and family relationships; and a reduction in aggressive, deliberate self-harm and emotional related behaviours.

In areas where an ETS has been established, there has been a notable increase in the number of referrals by Child Safety Services that are accepted by Queensland Health CYMHS. Factors influencing this increase appear to include ETS support to facilitate the referral process and an enhanced level of knowledge and understanding of CYMHS by Child Safety Services staff, enabling the targeting of appropriate referrals. ETS provides consultation and engages in co-joint work with CYMHS – building capacity across the two services and a stronger continuum of care for these children and young people.

Stable placements that meet the individual needs of the child

The CDCRC noted positive service delivery outcomes where Child Safety Services had access to appropriate placement options that suited the individual needs of the child. A stable placement was observed to allow case workers the time to focus more strongly on other key case management activities and in turn better meet the holistic needs of the child.

The CDCRC identified that sourcing placement options, particularly for children with high medical needs and young people with complex behaviours or needs, is an ongoing challenge for Child Safety Services. The CDCRC considers that the availability of more appropriate placement options, including respite and semi-permanent placements, will offer improved outcomes for the children and young people.

The CDCRC observed in one case involving a child who was subject to a long-term guardianship order, that a stable placement ensured the child felt happy and settled with his carers, which enhanced their quality of life.

Service System Case Study 5

Stable placements, regular family contact and respectful relationships enhance a child's quality of life.

The subject child was aged 10–14 years at the time of their death. The subject child was in a long-term placement with foster carers where the subject child felt confident and settled.

The CDCRC identified that the service delivery provided by Child Safety Services was of a high standard. The CDCRC agreed with the original review's finding that the quality of case work and the high standard of care provided by foster carers enhanced the subject child's quality of life and encouraged positive relationships with the subject child's family.

The CDCRC considered the following key factors contributed to positive service delivery to the subject child:

- positive interagency collaboration in relation to the subject child's needs
- regular family contact that was well planned, coordinated, and child-focused
- the subject child was actively involved in decision-making and their views and wishes were gathered and respected
- placement stability
- continuity of case workers and manageable caseloads
- open, respectful and collaborative relationships between Child Safety Services, the subject child, family, the carers, and other agencies, and
- an expectation from the Child Safety Service Centre management that all practice and service delivery demonstrate knowledge of the Child Safety Practice Framework and Child Safety Practice Manual.

The CDCRC commended Child Safety Services for their response following the accident which resulted in the subject child's hospitalisation. In particular, the CDCRC acknowledged: the effective communication strategy aided the flow of information between health services and Child Safety Services; the timely, planned and sensitive decision-making following the deterioration of the subject child's health; the forward planning relating to the subject child's funeral; and discussions in relation to grief and loss issues with the family and foster carers.

Children reviewed in 2010–11 who died as a result of suicide

This section examines the service delivery provided to children reviewed by the CDCRC in 2010–11 who died as a result of suicide, including:

- family and child issues
- involvement of child safety services
- key service system issues
- recommendations made by the original review
- recommendations made by the CDCRC, and
- other actions taken by the child death case review jurisdiction.

Family and child issues

Table 4.1 illustrates the presence of individual and family issues impacting on each of the six suicide cases reviewed by the CDCRC in the 2010–11 reporting period.

The most common complex issues identified in relation to these young people and their families were the young person's own behavioural concerns and their involvement in the youth justice system (50%, three young people). Other issues included domestic violence between parents, parental substance misuse, the young person's mental health condition and the young person's disengagement from the education system.

Table 4.1 Individual and family issues for young people who suicided 2010–11

Gender	Domestic violence	Substance misuse (parent)	Parental mental health	Mental health (child)	Parents' child protection history as subject child	Behavioural concerns (child)	Child in youth justice system	Complex medical condition of sibling	Self-harming (child)	Disengagement from the education system	Total *n*
Male	✓		✓	✓	✓	✓		✓	✓		7
Female											0
Male		✓		✓		✓	✓			✓	5
Female				✓					✓		2
Male	✓	✓		✓		✓	✓			✓	6
Male				✓			✓				2
Total	**2**	**2**	**1**	**5**	**1**	**3**	**3**	**1**	**2**	**2**	

The CDCRC identified that three young people who took their own life had five or more issues present. This shows the complexity of the young people's lives. One young person who suicided was only known to Child Safety Services as a result of the suicide incident. Two of the young people were female and four were male.

At the time of death, Child Safety Services did not have any service involvement with any of the young people or their families.

Key service system issues

Table 4.2 illustrates the key service system issues identified by the CDCRC in relation to suicide cases reviewed in 2010–11. This analysis revealed that the service delivery area where there were opportunities for improvement was in relation to the Intake process. In particular, the following areas of Intake were identified as service system issues:

- information gathering/sharing
- screening decisions
- timeliness of recording concerns
- recording cultural heritage of family members, and
- recording concerns as an Intake Enquiry.

Table 4.2 Service system issues identified for young people reviewed by the CDCRC in 2010–11 who suicided

		Intake				
Gender	Age	Information gathering/sharing	Screening decision	Recording concerns as an Intake Enquiry	Timeliness of recording concerns	Recording cultural heritage of family members
Male	13	✓	✓		✓	
Female	13					
Male	14	✓	✓	✓	✓	✓
Female	15					
Male	17	✓			✓	✓
Male	17	✓	✓	✓	✓	
Total		**4**	**3**	**2**	**4**	**2**

The CDCRC identified that for four young people, the information gathering process did not identify all relevant information.

The timeliness of recording concerns was also identified as a service system issue for four of the six young people. The CDCRC noted that timely recording of child protection concerns is essential to enable appropriate service system responses and to ensure accurate records of child protection history are maintained.

Decision-making regarding Child Safety Services' response to the child protection concerns or 'screening decisions' were identified as a service system issue for three of the six young people. For two of these young people, the CDCRC identified that concerns were incorrectly recorded as an Intake Enquiry, when they should have been screened through Child Safety Services' Structured Decision Making tools. A further discussion of one of these cases is outlined in the Service System Case Study 6 below.

In another two cases, the cultural heritage of the subject child, or their family members, was not appropriately recorded. In these cases, the CDCRC highlighted the importance of accurately recording the cultural heritage of children and young people and their families to ensure that the family is receiving service delivery that is culturally appropriate.

Service system issues at the Intake stage are discussed earlier in this chapter.

Service System Case Study 6

High quality information gathering and accurate record keeping at Intake promotes informed Intake responses.

The subject child was aged 15–17 years at the time of their death. Repeated concerns were raised about the subject child's family with Child Safety Services; however Child Safety Services had recorded limited information in relation to the subject child.

The CDCRC identified that this case evidenced a number of missed opportunities to gather information in relation to the subject child given that they were residing in the household during the period when numerous Child Concern Reports and a Notification were recorded.

The original review identified that this case highlighted a number of learnings for consideration by Child Safety Services, including:

- the need to ensure high quality recording and structuring of information within record of concern documents recorded on Child Safety Services' Integrated Client Management System (ICMS).
- the necessity of ensuring a high quality of information gathering during the Intake process, particularly in relation to identifying all persons residing within the relevant household and any concerns in relation to the safety and wellbeing of any child residing in the household.
- the need to update event information on ICMS, such as that relating to event participants, when pertinent information is identified during the investigation process, and
- the need to ensure family relationships are established on ICMS and that these relationship details are updated as additional information is received.

The CDCRC identified the importance of ensuring that staff involved in the Intake processes for this case understand the specific issues which were identified in relation to information gathering/critical analysis of these Intakes. The CDCRC recommended that staff involved with the case engage with the learnings identified by the original review and the CDCRC, in particular:

- information gathering and requesting the Notifier to supply information on all household members
- checking the cultural heritage of any members of the subject child/children's household, and
- ensuring the assessment of the information received addresses each child protection concern which has been raised by the Notifier.

Child Safety Services advised the learnings regarding the recording and screening of concerns were shared with relevant staff with the aim of improving service delivery to children and young people.

Recommendations made in the original reviews

The original reviews recommended that for five cases, the key practice learnings be disseminated to management and relevant staff members to enable further learning, critical discussion and reflection. In each case, the recommendations were implemented, placing the relevant staff in a stronger position to provide services to young people in the future.

Child Death Case Review Committee actions

The CDCRC made four recommendations to Child Safety Services. As illustrated in Table 4.3, two recommendations were aimed at providing training to staff members to improve practice in specific areas. Two recommendations requested that action be taken by the respective specific Child Safety Service Centres including updating of records and disseminating learnings.

Table 4.3 CDCRC recommendations for children reviewed in 2010–11 who suicided

Type of recommendation	Total *n*
Training and professional development	2
Localised action (Child Safety Services)	2
Total	**4**

All recommendations made by the CDCRC have been accepted and implemented by Child Safety Services.

In 2010–11 the CDCRC made four referrals to other agencies to improve service responses to children and young people at risk of suicide.

These included:

- two referrals to the Department of Communities, Youth Justice Services
- one referral to Queensland Health, and
- one referral to Child Youth Mental Health Services.

The CDCRC will report on the response of these agencies in the 2011–12 annual report.

Child reviewed in 2010–11 who was fatally assaulted

In the 2010–11 reporting period, the CDCRC reviewed the case of one child who was fatally assaulted.

Family and child issues

The following family and parental issues impacted on the quality of care and protection provided to the child by their family for the single fatal assault case reviewed by the CDCRC in the 2010–11 reporting period:

- parental mental health
- reluctance to engage with services
- parental criminal history
- parental child protection history as a subject child, and
- lack of extended family support.

The presence of the issues demonstrate the complexities of the family and highlight the challenges faced by the child safety service system in providing services to the family.

Involvement of Child Safety Services

Child Safety Services had no involvement with the child at the time of their death. One concern had been raised with Child Safety Services and the most recent involvement was seven months prior to the child's death.

Key service system issues

The area of Intake was also noted to be an aspect of service delivery where there were opportunities for improvement. In particular, information gathering/sharing and deciding the response to child protection concerns at the Intake stage were noted as service delivery areas that could have been improved for the child who was fatally assaulted.

Recommendations made in the original review

For the child reviewed in 2010–11 who was fatally assaulted, the original review made three recommendations.

Child Death Case Review Committee actions

The CDCRC supported the recommendations made by the original review.

In response to the fatal assault reviewed by the CDCRC during the reporting period, in 2010 the Commission completed a review into the adequacy of the actions of certain government agencies in relation to service provision to a child, some of which are outside of the CDCRC's jurisdiction.

The Commission's final report was delivered to the relevant agencies in October 2010. It found that the quality of decision-making and service delivery by Child Safety Services and Queensland Health was generally appropriate based on the quality of information available to each agency. However, the review identified a number of issues regarding the quality of consultation and information sharing between both Child Safety Services and Queensland Health relating to their service provision to the child and family. The final report made three recommendations to identify possible strategies to improve the quality of information sharing between Child Safety Services and Queensland Health in instances where both agencies are providing services to children in the child safety service system.

Initiatives to improve child safety – Queensland Health Initiatives: Parents with mental health issues

In 2008 Queensland Health released the policy *Meeting the needs of children for whom a person with a mental illness has care responsibilities.*

Senior officers from the former Department of Child Safety were included in this process to ensure the input of child protection expertise to the new policy.

The purpose of this policy is threefold. It clarifies the processes for:

- ensuring the immediate protection needs of children for whom a person with a mental illness has care responsibilities;
- determining the impact of parental/caregiver mental illness on the care and protection needs of children; and
- supporting parents or carers with a mental illness to meet the needs of children for whom they have care responsibilities.

Implementation of the policy and associated documents has been supported by the comprehensive range of child protection guidelines, educational resources and training which Queensland Health has in place, as well as a range of specific initiatives developed and implemented by a statewide Children of Parents with a Mental Illness project.

Appendices

Appendix 1

CDCRC members in 2010–11

In November 2010, the Premier of Queensland approved the appointment of the current members of the third CDCRC. Under section 124 of the *Commission for Children and Young People and Child Guardian Act 2000*, members are appointed for three years.

Current membership of the CDCRC comprises:

Ms Elizabeth Fraser (Chairperson)
Commissioner for Children and Young People and Child Guardian
BA, BSocWk, GradDip in Multicultural Studies, CertTeaching

Elizabeth has worked at all levels of government and has lived and worked in a number of countries, both in direct service delivery roles and in the management of policy development and implementation. She has also been responsible for leading large-scale organisational change and coordinating, overseeing and evaluating major policy and program reforms.

After graduating from the University of Queensland, Elizabeth worked for 19 years as a social worker in child health and welfare in Canberra, interspersed with short breaks to look after children and travel overseas, teaching English as a foreign language in Hong Kong, Sweden and Nigeria. She subsequently worked in the Australian Government's overseas aid program, managing a number of policy and funding reforms.

In 1992 Elizabeth returned to Brisbane, where she started work with the Queensland Government public service, initially to undertake a program review of the Office of Rural Communities. Upon its completion, she held a range of policy and program management positions, including General Manager, Corporate and Executive Services, in the former Department of Innovation and Information Economy, Sport and Recreation Queensland. She also held the position of Executive Director, Social Policy in the Department of the Premier and Cabinet.

Elizabeth has a long-standing commitment to improving government service delivery, particularly for children and young people, and is committed to working closely with key stakeholders to achieve effective policy and program outcomes.

Mr Barry Salmon
Assistant Commissioner
Commission for Children and Young People and Child Guardian
DipTeaching, BA, BEd, MEdSt, FAIM

Barry began his career as a primary school teacher and has over 25 years experience in supporting young people, teachers and administrators in Queensland schools. He has worked in a range of policy and managerial positions with Education Queensland. Before joining the Commission, Barry was Assistant Director of the Queensland School Curriculum Council, managing the Preschool to Year 10 (P–10) curriculum development program for state, Catholic and independent schools in Queensland.

In 2001, Barry was appointed Executive Director of the Commission, with responsibility for the employment screening, Community Visitors and complaints functions. He was appointed to the new role of Assistant Commissioner, with responsibility for the Commission's Child Guardian functions, in February 2005.

Barry is committed to the view that strengthening children and young people's primary relationships will improve their wellbeing.

Ms Moira Bligh
Ms Bligh has worked extensively in policy and community engagement with a particular interest in Indigenous issues. Ms Bligh has held Management, Principal Project Officer and Program Coordinator positions within the Community and Personal Histories section and the Social Development Policy units of the Department of Aboriginal and Torres Strait Islander Policy and Development.

During her time working in government, Ms Bligh has been responsible for providing high level strategic advice to the Director-General on whole-of-government Indigenous Policy and Government Champion work. This has included: evaluating the department's reconciliation strategy, implementation of the Office of Fair Trading's' "Indigenous Fair Go" strategy, and developing and implementing a vision for the Department's Indigenous Service Delivery.

Ms Bligh has received a number of awards for her work, including for outstanding service to the Department of Aboriginal and Torres Strait Islander Policy and Development and outstanding achievement in the field of Indigenous reconciliation.

Ms Bligh is currently the Director, Binambi-Barambah Aboriginal Corporation Ltd and President of the Noonga Reconciliation Group.

Dr Yvonne Darlington

Yvonne is a Senior Lecturer in the School of Social Work and Human Services at the University of Queensland. Her professional background is in social work, with extensive experience in the fields of mental health and family dispute resolution. She has practiced in Queensland and Victoria, in metropolitan and rural locations.

Yvonne researches predominantly in the area of child and family welfare policy and practice. She has completed major projects on interagency collaboration between child protection and mental health services and on the involvement of parents in child protection decision-making.

Her current projects include an evaluation of early intervention services for children with a physical disability and an evaluation of behaviour support services for children in care.

Mr Cameron Harsley

Detective Superintendent, Queensland Police Service

Detective Superintendent Harsley is the Director of Child Safety for the Queensland Police Service. He also manages and leads the Child Safety and Sexual Crime Group in providing statewide, national and international responses to child protection related investigations and is responsible for overviewing all reportable child death investigations conducted by the Queensland Police Service.

Detective Superintendent Harsley has over 20 years' policing experience working predominantly in a variety of operational roles including as a general criminal, and specialist child abuse investigator and as a police Suspected Child Abuse and Neglect (SCAN) Team representative. Since January 2006 he has performed a variety of management roles within the Child Safety and Sexual Crime Group and has been heavily involved in the implementation of child protection reforms from a whole-of-government and Queensland Police Service perspective since 2004.

Detective Superintendent Harsley worked within the former Department of Child Safety during the reform (*Protecting Children*) period and has also worked within the Commission for Children Young People and Child Guardian on projects.

Professor Graham Martin

Professor Martin is the Director of Child and Adolescent Psychiatry at the University of Queensland, and Clinical Director, Royal Children's Hospital Health Service District Child and Youth Mental Health Service.

He is a clinician, researcher, writer and commentator, with 35 years of clinical experience underpinning development of preventive programs in mental illness, and programs for promotion of mental health in families, communities, schools, the defence force cadets and other systems.

Professor Martin has been dedicated to suicide prevention since 1987, and is a member of the International Association for Suicide Prevention and the International Association for Suicide Research. He is currently National Advisor on Suicide Prevention to the Australian Government and Director, Centre for Suicide Prevention Studies in Young People at UQ. In 2004, Professor Martin became a Life Member of Suicide Prevention Australia (SPA) and in 2008 was awarded the SPA 'Lifetime Contribution to Suicide Prevention Research' award. He received a Medal of the Order of Australia in 2006.

A major focus of Professor Martin's work is the area of self-injury in young people. His team has recently completed the largest ever, national survey of self-injury for the Department of Health and Ageing (The Australian National Epidemiological Survey of Self-Injury). Professor Martin is also the Editor in Chief for the online journal AMH (Advances in Mental Health).

Mr Charles Passi

Charles resides on Thursday Island, in the region of the Torres Strait.

Charles has extensive experience in the government and non-government sectors. He has held various management, project, training and research positions in organisations associated with Aboriginal and Torres Strait Islander people.

Charles is actively involved in matters relating to Torres Strait Islander women and children and has affiliations with a number of organizations that represent these interests including:

- Board Member Aboriginal and Torres Strait Islander Healing Foundation Ltd
- Member of Indigenous Reference Group for the Centre for Family and Domestic Violence Research Queensland
- Member of Thursday Island Community Justice Group
- Member of Lena Passi Women's Shelter Inc.
- Member of Mura Kosker Sorority Inc., and
- Member of Kaziw Asesered Le Inc.

Charles has also worked as an Office Manager and Court Support Worker for the Kaziw Asesered Le Association Inc., Thursday Island.

Charles is currently working as an Area Supervisor with the Bureau of Statistics.

Professor Anna Stewart

Professor Stewart is currently the Director of Justice Modelling at Griffith (JMAG) at Griffith University. From 2008–2010 she was the Head of the School of Criminology and Criminal Justice. In 2007–08 she was the Deputy Dean (Learning and Teaching) in the Faculty of Humanities and Social Sciences.

After graduating with her PhD from University of Queensland in 1994, Professor Stewart started work in the School of Criminology and Criminal Justice at Griffith University. The topic of her PhD thesis was *An investigation of decision making by child protection workers.* Her research now includes: examining the links between child protection, youth justice and the adult criminal justice system; system responses to youth offending and domestic violence; management of risk; diversionary responses and system modelling.

A focus of Professor Stewart's work is building the relevant partnerships to strengthen the integration of key research findings into legislative policy and practice development.

Dr Neil Wigg

Dr Wigg is the Senior Director, Community Child Youth and Family Health Services (Central), Children's Health Services, Brisbane and Associate Professor, Discipline of Paediatrics and Child Health, University of Queensland.

Dr Wigg is a graduate of the University of Tasmania Medical School, and undertook his paediatric training in New Zealand and the USA. He specialised in the care of children and young people with developmental disorders and has practised in that field for 30 years. He has also taken a special interest in child public health, with involvement in state and national child health policy development. He was awarded a Masters of Policy and Administration in 1992 (Flinders University).

Dr Wigg has worked in child health service management since the mid 1980's in South Australia and Queensland.

For over a decade he was on the national executive of the College of Paediatrics, and then the Division of Paediatrics and Child Health, The Royal Australasian College of Physicians. Dr Wigg is a past-President of the Paediatrics and Child Health Division, Royal Australasian College of Physicians. Currently he serves on the Executive Committee of the International Paediatric Association, and on the Board of the Asia Pacific Paediatric Association. He is the Congress President for the International Congress of Paediatrics to be held in Melbourne in 2013.

2007–2010 members of the CDCRC

Mr Peter Crawford
Ms Annette Murphy
Ms Jennifer Felton
Mr Geoff Murphy
Ms Gwen Schrieber
Ms Isobel Stephen
Dr Yvonne Darlington

Appendix 2

Review criteria

Commission for Children and Young People and Child Guardian Act 2000

Section 133

Review Criteria for Child Death Case Review Committee

14 November 2008

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

1. Were any actions or inactions of the service system linked to the child's death?
2. What risk factors were relevant to the child's death?
3. Were any service system issues relevant to any adverse outcomes experienced by the child (while he or she was living)?
4. Are there any recurring or unrectified risk factors or service system issues that require further action?
5. 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?

Appendix 3

Abbreviations and dictionary

ARIA	Accessibility/Remoteness Index of Australia Plus (ARIA+). An index of remoteness derived from measures of road distance between populated localities and service centres. These road distance measures are then used to generate a remoteness score for any location in Australia. The 2001 update uses population figures and spatial boundaries from the Australian Bureau of Statistics 2001 Census of Population and Housing.
Autopsy	Also 'post-mortem'. A detailed physical examination of a person's body after death. An autopsy provides detailed information about the person's health and gives an understanding of the various factors that may have contributed to their death.
CDCRC	Child Death Case Review Committee
Case planning	Case planning is a participative process of planning strategies to address a child's protection and care needs and promote a child's wellbeing. It is made up of a cycle of assessment, planning, implementation and review.
Case worker	Child Safety Officer with case responsibility. Case responsibility can relate to the completion of an investigation and assessment or the ongoing intervention case management processes of assessment, planning, implementation and review, until case closure.
Child/young person	A person aged 0–17 years
Child Concern Report	A Child Concern Report is a record of child protection information received by Child Safety Services that has been 'screened out' and does not meet the threshold for a Notification.
Child death case review	The entire process for reviewing Child Safety Services' involvement with a child who has died, as provided for by Chapter 7A of the *Child Protection Act 1999* and Chapter 6, Part 1 of the *Commission for Children and Young People and Child Guardian Act 2000.*
Child in need of protection	A child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering from harm, and does not have a parent able and willing to protect the child from the harm.

Child Protection Order	A child protection order is an order made by the Children's Court under the *Child Protection Act 1999* , when a child is considered in need of protection.
Child Safety Directors' Network	The Child Safety Directors' Network supports the Queensland Government's child safety service system across the continuum from prevention and early intervention to statutory intervention and ensures that child protection is a whole-of-government responsibility. The CSDN operates at the strategic whole-of-system level and leads the coordination, communication and strategic planning in the child safety service system in Queensland to promote the safety and wellbeing of children and to find solutions to complex child protection issues. The CSDN is chaired by the Deputy Director-General, Department of Communities (Child Safety Services) and its members represent 10 government agencies that have been identified as having a key role in the delivery of child protection services.
Child Safety Services	The Department of Communities (Child Safety Services) and also, where applicable, the former Department of Child Safety and the former Department of Families
Child safety service system	The child safety service system consists of whole-of-government and non-government services provided to children and young people and their families with suspected or actual child protection concerns
The Commission	The Commission for Children and Young People and Child Guardian
The Commissioner	The Commissioner for Children and Young People and Child Guardian
Contagion	Contagion is defined as the process by which a prior suicide facilitates or influences the occurrence of subsequent suicides
Child Safety Officer	Child Safety Officers are employed by Child Safety Services and are responsible for delivering statutory child protection services such as investigating and assessing allegations of suspected child abuse and neglect, and intervening to ensure the safety of children in accordance with legislation and practice guidelines
Child Safety Service Centre	Child Safety Service Centres are a contact point for Child Safety Services and provide support and a range of services to children, young people, families and carers to ensure children's safety and wellbeing and to prevent children from being harmed. Child Safety Service Centres are located in communities throughout Queensland.

Cumulative harm	Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.[14]
Death incident	The incident causing the death
Disabilities and Community Care Services	The Department of Communities (Disabilities Services) and also, where applicable, the former Disabilities Services Queensland
External causes	Pertaining to environmental events and circumstances that cause injury, such as motor vehicle accidents, drowning and poisoning
Fatal assault	The death of a child or young person from acts of violence perpetrated by another person, even when the perpetrator may not have intended the outcome. This includes cases where the death is a result of an assault even if the death occurred some time later.
Foster Carer	Any individual, or two or more individuals approved by Child Safety Services to care for a child subject to Child Safety Services' intervention and an out-of-home care placement (irrespective of type of placement).
Hospital inpatient	The child or young person had been admitted to a hospital ward for treatment
Indigenous	Refers to children identified as Aboriginal and/or Torres Strait Islander
Intake	Intake is the first phase of the child protection continuum, and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child, or when a request for departmental assistance is made.
Intake Enquiry	Formerly known as a General Inquiry, an Intake Enquiry may be a request for information or relate to child wellbeing issues or child protection concerns, and is one type of departmental response to information received at the Intake phase.
Integrated Client Management System (ICMS)	ICMS is Child Safety Services information management system.

[14] Victorian Government Department of Human Services, 'Cumulative harm: a conceptual overview', March 2007, page 1

Investigation and Assessment	Investigation and assessment is the second phase of the child protection continuum. It is the Child Safety response to all notifications, to determine the safety and protective needs of a child under the *Child Protection Act 1999*, section 14, where there are allegations of harm or risk of harm to a child.
Jurisdiction	Refers to the Queensland child death case review jurisdiction, which consists of a two-tiered system for reviewing deaths of children known to the child safety service system in the three years prior to their death. The first tier is a review conducted by Child Safety Services about its involvement with the child (the original review). This original review is then assessed by the CDCRC (the second tier) against a set of review criteria.
Neglect	Neglect and negligent treatment are jointly defined as the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres – health, education, emotional development, nutrition, shelter and safe living conditions – in the context of resources reasonably available to the family or caretakers; it is treatment that causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible (World Health Organisation, 1999).
Notification	Information received about a child who may be at harm or at risk of harm which requires an investigation and assessment response. A Notification is also recorded on an unborn child when there is reasonable suspicion that they will be at risk of harm after they are born.
Notifier	A notifier is a person who informs Child Safety Services about alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, irrespective of how the information is recorded or responded to by Child Safety Services.
Ongoing intervention	Ongoing intervention is the third phase of the child protection continuum. It occurs when it is necessary for Child Safety Services to provide support and assistance to the family to reduce risk to a child, or to the extent necessary to ensure that the child's protection and care needs are met. There are three types of ongoing intervention, including: • a support service case • intervention with parental agreement • intervention with a child protection order.

Original review	Original review carried out by Child Safety Services pursuant to section 246A of the *Child Protection Act 1999*
Out-of-home care	Out-of-home care refers to placements of children, subject to statutory child protection intervention, with individuals and services approved or licensed under the *Child Protection Act 1999*. Out-of-home care includes placements with: • a licensed care service, or • an approved carer
Police Report of Death to a Coroner (Form 1)	A form completed by the police in accordance with section 7 of the *Coroners Act 2003* – Duty to Report Deaths
Pool and non-pool drowning	Pool drowning deaths are defined as drowning deaths which occurred in private and public swimming pools. Non-pool drowning deaths are defined as drowning deaths which occurred in non-pool locations including dams, bathtubs and the beach.
Perinatal conditions	Perinatal conditions are diseases and conditions that originated during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. These include maternal conditions that affect the newborn, such as complications of labour and delivery, disorders relating to foetal growth, length and gestation and birth weight, as well as disorders specific to the perinatal period such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders.
Pre-notification check	An enquiry by a Child Safety Officer to another professional, an external agency or an interstate or international child protection jurisdiction, to gather further information about allegations of harm to a child.
Queensland Child Death Register	Register of all deaths of children and young people in Queensland
Recognised Entity	It is a requirement under the *Child Protection Act 1999* that when making a significant decision about an Aboriginal or Torres Strait Islander child, the Recognised Entity for the child must be given the opportunity to participate in the decision-making process.
Reporting period	1 July 2010 to 30 June 2011
Research category	Category used by the Commission for Children and Young People and Child Guardian to classify external causes of death according to their circumstances
Reviewed	Refers to when the CDCRC has provided its final report to Child Safety Services about its review of the original review

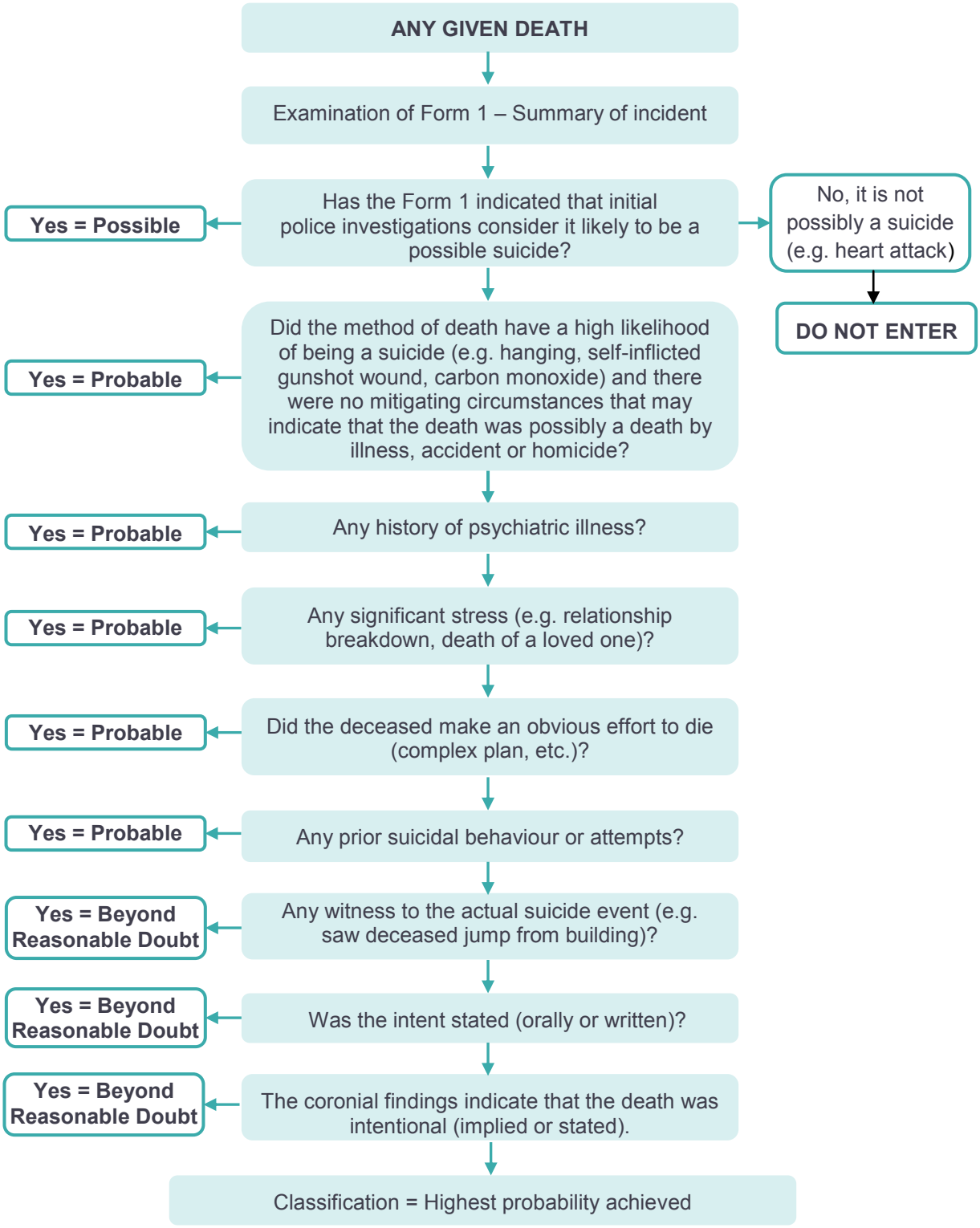
RYSQ Project	The Commission's Reducing Youth Suicide Queensland Project
SCAN Team	Suspected Child Abuse and Neglect Team
Self-placed	'Self-placing' is the decision of a child or young person to leave their Child Safety Services' placement to live somewhere else which has not been approved by Child Safety Services.
SIDS	Sudden infant death syndrome
Structured Decision Making Tools	Structured Decision Making (SDM™) is an assessment and decision making model to assist the Child Safety Officer and team leader in making critical decisions about the safety of children. SDM™ was developed by the Children's Research Centre, and aims to: • reduce subsequent harm to children • reduce the time to permanency arrangements for children in out-of-home care.
Support Service Case	A type of ongoing intervention that can only be used when it is determined that a child is not in need of protection, based on an agreement by the parents, pregnant woman or young person to work with the department.
The subject child	The child whose involvement with Child Safety Services was the subject of the child death case review.
Suicide	A self-inflicted injury that is accompanied by the intention of the individual to die as a result of the action taken.
Suspected suicide	Where no coronial findings are available, but other factors and information raise suicide as a possible cause of death. Relevant evidence and factors include QPS opinions, previous statements of intent by the deceased, the presence of a suicide note, witnesses to the event, prior suicide attempts or any precipitating factors.
Unborn Child Notification	If the information received by Child Safety Services indicates that an unborn child may be at risk of harm after they are born and will not have a parent able and willing to protect them from harm, an unborn child notification will be recorded and an investigation and assessment will be conducted.

Undetermined	Cause of death certified 'undetermined' refers to a death in which available information is insufficient to classify the death into one of the specific causes of natural or unnatural death. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category. Sudden unexpected deaths of infants are certified as undetermined when insufficient findings are present to support a particular diagnosis but when sufficient abnormal features in the history or at the scene, examination, autopsy or laboratory workshop were found that were not typical of sudden infant death syndrome.[15]
Unknown/pending (cause of death)	Includes the following causes of death: 'Autopsy Notice given – cause of death not yet determined', 'Not yet determined pending test results' and 'Not yet established, tests required.'
Young people at high risk	Those young people engaging in behaviours that place them at significant risk of further serious emotional or physical harm
Youth Justice Services	Department of Communities (Youth Justice Services)

[15] E Mitchell, H Krous, T Donald & R Byard, 'Changing trends in the diagnosis of sudden infant death', *American Journal of Forensic Medicine and Pathology,* vol. 21, no. 4, pages 311–14.

Appendix 4

Suicide Classification Model



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Queensland Child Death Case Review Committee

Members

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.

The Commissioner for Children and Young People and Child Guardian chairs the CDCRC and the Assistant Commissioner is one of its permanent members.

Current membership of the CDCRC comprises:

- Elizabeth Fraser
- Barry Salmon
- Anna Stewart
- Yvonne Darlington
- Charles Passi
- Graham Martin
- Neil Wigg
- Cameron Harsley
- Moira Bligh

Ms Elizabeth Fraser (Chairperson)

Commissioner for Children and Young People and Child Guardian
BA, BSocWk, GradDip in Multicultural Studies, CertTeaching

Elizabeth has worked at all levels of government, both in direct service delivery roles and in the management of policy development and implementation. She has also been responsible for leading large-scale organisational change and evaluating major policy and program reforms.

After graduating from the University of Queensland, Elizabeth worked for 19 years as a social worker in child health and welfare in Canberra, interspersed with short breaks to look after children and travel overseas, teaching English as a foreign language in Hong Kong, Sweden and Nigeria. She subsequently worked with the Australian Government's overseas aid program, managing a number of policy and funding reforms.

In 1992 Elizabeth returned to Brisbane and started work with the Queensland Government public service. She has held a range of senior policy and program management positions.

Elizabeth has a long-standing commitment to improving government service delivery, particularly for young people, and is committed to working closely with key stakeholders to achieve effective policy and program outcomes.

Mr Barry Salmon

Assistant Commissioner, Commission for Children and Young People and Child Guardian
DipTeaching, BA, BEd, MEdSt, FAIM

Barry began his career as a primary teacher and has over 25 years experience in supporting young people, teachers and administrators in Queensland schools. He has worked in a range of policy and managerial positions with the Queensland Department of Education. Before joining the Commission, Barry was Assistant Director of the Queensland School Curriculum Council, managing the Preschool to Year 10 (P–10) curriculum development program for state, Catholic and independent schools in Queensland.

In 2001, Barry was appointed Executive Director of the Commission, with responsibility for the employment screening, Community Visitors and complaints functions. He was appointed to the new role of Assistant Commissioner, with responsibility for the Commission's Child Guardian functions, in February 2005.

Barry is committed to the view that strengthening children and young people's primary relationships will improve their wellbeing.

A major focus of Professor Martin's work is the area of self-injury in young people. His team has recently completed the largest ever, national survey of self-injury for the Department of Health and Ageing (The Australian National Epidemiological Survey of Self-Injury). Professor Martin is also the Editor in Chief for the online journal AMH (Advances in Mental Health).

Dr Neil Wigg

Dr Wigg is the Senior Director, Community Child Youth and Family Health Services (Central), Children's Health Services, Brisbane and Associate Professor, Discipline of Paediatrics and Child Health, University of Queensland.

Dr Wigg is a graduate of the University of Tasmania Medical School, and undertook his Paediatric training in New Zealand and the USA. He specialised in the care of children and young people with developmental disorders and has practised in that field for 30 years. He has also taken a special interest in child public health, with involvement in state and national child health policy development. He was awarded a Masters of Policy and Administration in 1992 (Flinders University).

Dr Wigg has worked in child health service management since the mid 1980's in South Australia and Queensland.

For over a decade he was on the national executive of the College of Paediatrics, and then the Division of Paediatrics and Child Health, The Royal Australasian College of Physicians. Dr Wigg is a past-President of the Paediatrics and Child Health Division, Royal Australasian College of Physicians. Currently he serves on the Executive Committee of the International Paediatric Association, and on the Board of the Asia Pacific Paediatric Association. He is the Congress President for the International Congress of Pediatrics to be held in Melbourne in 2013.

Mr Cameron Harsley

Detective Superintendent Cameron Harsley is the Director of Child Safety for the Queensland Police Service. He also manages and leads the Child Safety and Sexual Crime Group in providing statewide, national and international responses to child protection related investigations and is responsible for overviewing all reportable child death investigations conducted by the Queensland Police Service.

Detective Superintendent Cameron Harsley has over 20 years policing experience working predominantly in a variety of operational roles including as a general criminal and specialist child abuse investigator and as a police Suspected Child Abuse and Neglect (SCAN) Team representative. Since January 2006, he has performed a variety of management roles within the Child Safety and Sexual Crime Group and has been heavily involved in the implementation of child protection reforms from a whole-of-government and Queensland Police Service perspective since 2004.

Detective Superintendent Cameron Harsley worked within the Department of Child Safety during the reform (*Protecting Children*) period and has also worked within the Commission for Children Young People and Child Guardian on projects.

Ms Moira Bligh

Ms Bligh has worked extensively in policy and community engagement with a particular interest in Indigenous issues. Ms Bligh has held Management, Principal Project Officer and Program Coordinator positions within the Community and Personal Histories section and the Social Development Policy units of the Department of Aboriginal and Torres Strait Islander Policy and Development.

During her time working in government, Ms Bligh has been responsible for providing high level strategic advice to the Director-General on whole-of-government Indigenous Policy and Government Champion work. This has included: evaluating the department's reconciliation strategy, implementation of the Office of Fair Tradings' "Indigenous Fair Go" strategy, and developing and implementing a vision for the Department's Indigenous Service Delivery.

Ms Bligh has received a number of awards for her work including for outstanding service to the Department of Aboriginal and Torres Strait Islander Policy and Development and outstanding achievement in the field of Indigenous reconciliation.

Ms Bligh is currently the Director, Binambi-Barambah Aboriginal Corporation Ltd and President of the Noonga Reconciliation Group.