Table of Contents

Acknowledgments

I should like to acknowledge that the Terms of Reference determined that the Foster Carer Audit review only those cases where notifications have been recorded against a foster carer. There are many cases of children being well cared for by foster carers in our communities who make a significant and positive contribution to the lives of children for whom they provide care. Similarly, it is acknowledged that in many cases departmental staff strive to provide quality service delivery in a highly stressful environment that is fraught with inadequate resources.

I should like to acknowledge the hard work of the Audit Team who have undertaken with me, a very difficult job in reviewing a very high number of cases of harm to children. The Team has also contributed to this Report. Without their commitment to children and young people and to the Audit process, and their integrity, this comprehensive Audit could not have been undertaken.

I also acknowledge the departmental officers in Review and Evaluation Branch, Services Support Unit, Operations Directorate, Audit Regional Liaison Officers and within the area offices who have assisted myself and the Audit Team in our requests for information and action with respect to particular cases.

Executive Summary

Introduction

As a result of a specific matter (the case of "X") that came to the attention of the Honourable, the Minister for Families, Judy Spence, with respect to the long term abuse of children in a foster home north of Brisbane, the Minister announced on 19 June 2003 that there would be an independent and external audit of current foster carers who have been subject to child protection notifications relating to children placed in their care by the Department of Families (the Department). The Director-General appointed myself, Gwenn Murray as the independent reviewer and to lead the Audit Team. The Audit commenced on 20 June 2003 and Phase One was completed on 28 November 2003.

An Interim Report was requested and was provided on 12 August 2003. The Crime and Misconduct Commission invited me, in my capacity as the independent reviewer, to provide information at the public hearings of their Inquiry into Foster Care on 16 October 2003.

The Terms of Reference determined that the Foster Carer Audit review only those cases where notifications have been recorded against a foster carer. There are many cases of children being well cared for by foster carers in our communities who make a significant and positive contribution to the lives of children for whom they provide care. Similarly, it is acknowledged there are many cases where departmental staff strive to provide quality service delivery in a stressful environment that is fraught with inadequate resources. Further, as the purpose of the Audit was not to examine or critique the Department's current programs or initiatives, it is not possible to make comment on these.

The Audit has found a number of serious issues about under-resourcing, outdated information systems, practice, procedures and policy within the Department. These issues have seriously impacted on the care and safety of many children in foster care, with only 15% of audited cases (or one in seven cases) that required no further action. The Audit has also highlighted a range of systemic matters that require addressing.

Audit methodology and scope

Phases One, Two and Three

The Audit Team (the Team) comprised the independent reviewer and a team of departmental staff who had extensive child protection experience as well as data entry and management staff.

The Team was requested to review notifications and initial assessments involving foster carers who had a current placement at the commencement of the Audit. This was considered as Phase One of the Audit. Phase Two of the Audit will consider notified foster carers who had a placement in the past two years, but did not have a placement at the commencement of the Audit. There is a large number of carers who have not had a placement for some years and Phase Three of the Audit will be a process to consider their carer status.

Methodology

Within the Terms of Reference the Team was asked to determine the accuracy and appropriateness of the assessment outcome for each notification with respect to the foster carers and the subject children. The Team was asked to identify emerging patterns and trends, comment on the adequacy of statutory requirements, policy, practice and procedures

as they relate to notified foster carers and make recommendations concerning necessary changes. Any relevant information identified through the Audit regarding the case of "X", any matters relating to the actions of departmental officers that may require a further response and matters considered to be of a misconduct or criminal nature were requested to be brought the notice of the Director-General.

The Terms of Reference determined that the Audit would be "desk top", that is reviewing notifications, initial assessments and electronic records accessed through the Department's databases. Discussions were held with community groups throughout the Audit process and consideration was given to the findings of previous studies conducted by the Department and relevant reports from other states and overseas.

Audit criteria and requests for action
A set of criteria for assessment was developed with a protocol to ensure consistency in decision making within the Team and a database was constructed to collect and analyse qualitative and quantitative information.

The Audit was not simply a report on the findings, it was action-based. This was decided in the interests of natural justice so that opportunity could be provided to area offices to provide further information or reasons for their decision making. Further, the Director-General requested that the Team report on the safety of children and young people in current placements. Therefore a range of outcomes was determined with requests made to area offices for; further information, clarification of assessment action, referral to Data Management Services where there were recording errors, reassessment of carer's approval status or a Statement of Reasons.

In some cases the Team considered the safety of children to be so serious and urgent that immediate action was required, and a report of the immediate safety of the children was requested to be provided within 24 hours with a follow up written report.

Population (Indices) of the Audit
The Team reviewed 1,060 notifications and corresponding initial assessments. Of these, 637 notifications and initial assessments with respect to 1,258 distinct children, came within the scope of the Audit. Notifications received by the Team but not within the scope of the Audit included those with information incorrectly recorded or with respect to the natural family of the child while they were in placement. In some instances, those notifications not within the scope contained matters that required addressing and were consequently referred to the Operations Directorate for their attention.

Audit findings

Investigation and assessment of notifications
Apart from only a few cases, all of the matters were serious with recorded concerns of physical, sexual, neglect and/or emotional harm. There were matters that should have been referred to the police but were not referred. In 7% of the cases the children were left with foster cares where it was considered there was an unacceptable risk. In addition, the recording of information was insufficient in the majority of cases with only 15% of audited cases requiring no further action.

There were delays in commencing initial assessments with only 36% of notifications commencing within 24 hours (as stipulated in policy at that time). In 39% of cases involving an indigenous child a recognised Aboriginal or Torres Strait Islander agency was not involved in the initial assessment concerning Indigenous children and young people.

Overwhelmingly, there were findings of poor or inadequate investigations and children were often not believed. In 30% of the cases, not all of the subject children were sighted; in 28% of cases not all of the subject children were interviewed; and in 25% of cases the relevant foster carers were not interviewed. Information was not gathered from other relevant people such as the school community or health workers in 55% of cases which would have provided contextual and better information about the child.

Indicators of sexual abuse were often not identified and demonstrated a lack of understanding about harm and future harm. Assessments of harm were not recorded in 42% of the cases and an assessment of future risk of harm was not recorded in 57% of cases. Further, the assessment of the child protection concerns were considered by the Team to be inadequate in 57% of the cases.

In 48% of cases the outcome of initial assessments of allegations of harm were substantiated or substantiated risk (that is departmental officers found the harm had occurred or was likely to occur). In 45% of cases, the outcomes were recorded as unsubstantiated, with the remaining 7% not assessed due to "client reasons" or "workload reasons". This has shown to be a lower substantiation rate for children in alternative care than those children with their natural parents. (During 2002-03, 70% of notifications in the general community were substantiated).

The Team did not agree with the outcomes in 42% of the audited cases.

Immediate actions, sexual abuse and excessive punishment

There were 28 cases from nine regions that required immediate action, that is, advice as to the immediate safety of children within 24 hours. These were the most serious recorded concerns of harm that involved 98 distinct children. The recorded concerns were about sexual abuse and/or excessive physical discipline or corporal punishment, some involving the use of implements such as belts or sticks. In some cases there was evidence of harm occurring over a number of years with little or no departmental action. In some cases, area office staff decided to remove children from their placement as a result of the Team's request for further assessment action.

In other cases there was recorded inappropriate behaviour management such as humiliating or frightening children. This included rubbing children's faces in urine soaked sheets for wetting their beds; in a few cases hitting children for "stealing food" when they had been neglected and underfed previously by their parents; making children stand outside in the dark; or the use of chilli in the mouth as punishment for swearing.

The Team also requested information as to the approval status of a high number of foster carers and requested reassessments of 30 foster carers' approval status based on, for example, the level of harm outlined in the notifications or the carers' extensive child protection history.

High number of children in placements

There is a lack of placement options for children and young people who can not safely remain with their natural parents. This may be the reason for over-crowding some foster carers with too many children. As at 30 June 2003, there were 74 foster carer households with six or more children placed with them (not including foster carers' own children). In some placements there were between eight and twelve foster children plus the carers' own children.

Recruitment, training and support for foster carers
There is a high demand for placements for children with foster carers with some regions reporting they have a shortage of placement options. The on-going recruitment, training and support for foster carers are serious issues for the Department. Policy, procedures and available training are not sufficient to assist and support foster carers with strategies to deal with the difficult and challenging behaviour of some children and young people and in being able to care for and nurture those children who have been seriously abused by their natural parents.

Systemic matters
There is a lack of intensive family support services to assist and support families to safely keep children with their natural parents. There is some evidence that there is a lack of therapeutic services in the areas of health, education and counselling, particularly in the regional areas. There also appears to be a lack of collaboration between the Department and community agencies to work in partnership.

Aboriginal and Torres Strait Islander children and young people
Throughout the Audit, the needs of Aboriginal and Torres Strait Islander children and young people were apparent through their over-representation in the child protection system and with greater risks placed upon them in isolated communities and where alcohol and domestic violence are prevalent. There was a higher and more serious level of physical abuse to Indigenous children recorded in the initial assessment texts, particularly in the cases warranting immediate action.

Information systems
The Department's information systems are outdated and inefficient and coupled with this is the level of inaccuracies recorded within notifications and initial assessments. This has created serious difficulties for the Department in being fully informed of important child protection information. Accessing and obtaining relevant and reliable data was problematic throughout the Audit process. The Team made all attempts to ensure that all relevant data were obtained and correlated with data sets from other information systems (such as Carepay) to ensure that information was complete and accurate. The Department is currently seeking information for the creation of a new system but interim measures will need to be taken to improve the recording and analysis of information.

Caseloads and staffing issues
Clearly there are insufficient Family Service Officers (FSOs) to undertake an increasing level of child protection work. Current caseloads are at an unacceptably high level with little time for planning, training or attending to the emotional resilience of staff working in a very stressful environment. This has contributed to the poor practice and decision making which is evident in the Audit findings, with workers not following policy and procedures and possibly taking 'short cuts' in their assessment of allegations of harm and future risks to children and young people.

Audit recommendations
The Audit findings have highlighted gaps in existing policy and procedures as well as the training needs for departmental staff and foster carers. Specific recommendations have therefore been made with respect to these areas as well as for the urgent need to increase the number of FSOs and other professionals including legal officers in all regions. Legal officers would be able to provide advice and prepare legal documents for Tribunal and Court work, which FSOs are currently (inappropriately) undertaking.

Specific changes and improvements to the Department's information systems have also been recommended.

There is currently little monitoring of children and young people and regulation in foster care, recommendations have been made with respect to the role of the Commission for Children and Young People. Other systemic issues such as the participation of children in child protection proceedings have been responded to within the recommendations.

Concluding remarks and directions for implementation

The Audit findings are serious. They have shown that the current system is failing many vulnerable children in foster care settings. Findings are that in 57% of audited cases, the assessments were inadequate and only 15% of audited cases required no further action, that is one in seven were adequate.

This situation is unacceptable and it did not occur overnight. For years, the child protection system has been stressed by under-resourcing, out-dated case management systems and a lack of quality placement options, to name just a few pressures. The Department is dangerously becoming like one of the children for whom it has a statutory obligation. That is, like a neglected child.

Major reforms need to be planned and implemented to ensure the safety and well being of children and young people, and some of these need to be given high priority. They include better resources for the Department and community agencies; training and professional development and emotional support for its workers; adequate training and support for foster carers; and intensive family support services to assist and strengthen families to keep children safely supported at home where appropriate.

The Audit has provided an opportunity for government and community to rethink current systems and approaches to ensuring children are safe, to contribute to their well being and to collaboratively create a range of integrated services and options. It is also an opportunity to reflect on practice in the past and to move towards a more child-centred approach.

If a child is removed from its natural family because of abuse, the Department has to promise the child that they have been placed somewhere better and safer. We cannot afford to further fail these vulnerable children. As Desmond TuTu said, "it takes a whole village to raise a child", and child protection is not just the business of the Department of Families, it requires a whole of government and community commitment and approach to keeping our children safe.

Chapter One: An overview of foster care within the context of the child protection system

1.1 Receiving concerns about harm to children and young people

When a person suspects a child is being harmed or is at risk of harm and the child's parent is unable, unwilling or deemed unsuitable to care for and protect the child and the matter is reported to the Department, it is recorded as a child protection notification. 'Harm' to a child is defined within the provisions of s9 of the *Child Protection Act 1999* (the Act), as any detrimental effect of a significant nature on the child's psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation.

A departmental officer recording the notification would determine the level of harm or risk of harm, and prioritise the case either as a protective advice response or for investigation and assessment with a rating of 1,2 or 3 (1 being the most serious and urgent).

Department policy between 1 December 2001 and 30 September 2003 states that for a notification with respect to a child who is in alternative care, the priority rating must be 1, requiring commencement within 24 hours. However, only 36% of audited initial assessments were commenced in 24 hours. 43% were not commenced within one month. This is discussed further in Chapter 3 *Child Protection Notifications and Initial Assessments* with Audit findings and recommendations.

1.2 Children and the legal process

Children who enter the formal care and protection system are among the most vulnerable children in Australia and this was evident in the Australian Law Reform Commission's and Human Rights and Equal Opportunity Commission's Inquiry into Children and the Legal Process (1997). In its report "Seen and Heard", there was clear evidence that children who are victims of abuse, neglect and family breakdown, often do not have support from extended family and are often educationally and socio-economically disadvantaged. The Inquiry received considerable evidence indicating that the support offered to children in care is grossly inadequate and too often fails to address their disadvantage. Many of these children are already disadvantaged according to other social indicators. In addition, Indigenous children who are generally disadvantaged on many scales, are particularly over-represented in the care and protection systems in Australia.

The Inquiry heard evidence that as a community we are failing many of our most vulnerable children, and indeed this is one of the findings of the Foster Carer Audit.

It was further reported that the voices of children and young people are not heard. They are often not involved in decision making, they have little contact with their caseworker, often not listened to or believed, or provided an avenue to voice their concerns. This is also a finding of the Foster Carer Audit.

The Inquiry found that all child protection jurisdictions in Australia experience similar problems, including a heavy reliance on other Government services and agencies, poor management, a lack of co-ordination, delays in investigating or deciding placements for children and a lack of reliable information. A number of jurisdictions have recently or are

currently reviewing and considering reform of their child protection systems. These are complex issues to consider.

1.3 Prevention and family support

There is an increasing number of children and young people entering the care and protection system. This highlights the lack of broader based child and family support services to prevent harm to children in the first place. With the lack of intensive support services to assist and strengthen families to keep children safely supported at home, an over-reliance on alternative care and in particular, foster care, has been created (Churches Community Services Forum, 2001). Coupled with this, is a lack of quality out of home placement options. The Audit has also identified the need for better collaborative planning partnerships between Government and the community. For some children, a family-based placement option is not the best option. Any alternative care system needs a range of options and differential responses.

There is an urgent need to respond to the long identified recognition that child protection is under-funded, under-resourced and carrying the burden of out-dated case management systems. This is a theme that has been identified in a number of projects over a period of years, and is discussed throughout this Report.

Current literature and research affirms the need for a balanced continuum of family and youth support services and out of home care services. (Clark, 1997) in a review of intensive out of home care support services, described a continuum as “an appropriate hierarchy of services and the proper balance of prevention and support services, high quality assessment, intensive case management, home based therapeutic services and finally, robust out of home care services. Proper balance implies an appropriate ratio of services with many of the former compared with the latter.”

It seems a "luxury" to be able to properly assess the needs of a child, match these with a suitable placement, and enable the child to participate in the case plan while preserving the links with the natural family. The reality is that it is more often than not about finding a bed, with little expectation of Department of Families workers having the time to assist foster carers with the many challenges that lie ahead in caring for a child that has suffered abuse. In some busy area offices there are not enough placements for children and young people.

1.4 Alternative care

Out of home care is one part of the child protection continuum. Contemporary concepts of child protection and family preservation place alternative care as a phase or stepping stone within the broader child protection process. For those children and young people whose parents are not able to, unwilling or deemed unsuitable to care for and protect them, alternative care is a temporary intervention until they can be returned home when safety and stability can be assured (Sultmann & Testro, 2001). A range of care falls within this context including foster care and residential settings.

For some children and young people who can not be returned to safety within their family home, foster care becomes a long term option.

1.5 Foster care

Foster care is family-based care, provided by approved carers in their own homes to children and young people. The Department of Families approves all foster carers in Queensland. Foster carers can be an individual, couples or a team of adults. They may be approved as

general foster carers or relative carers, and they could also have limited approval status. Fostering is voluntary but an allowance is paid as a reimbursement of costs for caring for a child. Research findings such as those within the McHugh report (McHugh, 2002) show that current allowances are inadequate in properly caring for a child and covering unplanned costs such as birthday and Christmas presents and clothing. The McHugh report recommends a national framework for payments. Some agencies such as PeakCare recommend that foster caring should be professionalised with accredited training and remuneration.

The fact that some children are harmed while in foster care is well documented in research findings, notifications and initial assessments recorded by the Department of Families and in the Commission of Inquiry into Abuse of Children in Queensland Government Institutions, Forde Inquiry (1999). Further, it is not unusual for children and young people to move constantly between a variety of placements and their family home. This has been well expressed by young people through the CREATE Foundation (FACE to FACE, 1999).

In June 1996, a decision was made by the Department to transfer the overall responsibility for the recruitment, training and support of foster carers to the non government sector, and a number of Shared Family Care services were established in this regard.

Shared Family Care services later 'capped' the numbers of foster carers able to be affiliated with each service, based on available levels of funding.

As an indirect result, many departmental area offices continued to recruit, train and support foster carers, resulting in the current dual system which continues today and incorporates:
- departmental foster carers; and
- Shared Family Care foster carers.

1.6 Foster carer recruitment, assessment, approval and support

It is acknowledged that the Foster Carer Audit has reviewed only those cases where notifications have been recorded against a foster carer. There are many cases of children being well cared for by foster carers in our communities who make a significant contribution to the lives of children for whom they provide care.

Clearly there is a lack of quality placement options for children and young people in alternative care, there is an over-reliance on foster care. The Audit findings have highlighted implications with respect to departmental policy and procedures for foster carers with respect to recruitment, assessment, approval, support and the provision of ongoing training for foster carers. Foster Care Queensland (FCQ) and the President of the Children Services Tribunal (CST) provided information at the Crime and Misconduct Commission's (CMC) Inquiry into foster care that many foster carers feel under valued and struggle for support in the difficult role in providing care for vulnerable children and young people who have been abused by their natural families.

Approved foster carers
The assessment and approval of foster carer applicants involves the following the requirements:

- the completion of an application to become an approved foster carer;
- the conduct of suitability checks (including criminal, domestic violence, traffic and child protection history checks) on foster carer applicants and all adult members of applicants' households;

- attendance of foster carer applicants at pre-service training;
- obtaining character references from two referees (excluding applicants' relatives);
- where relevant, an assessment of applicants' physical or mental health;
- the conduct of an assessment specifically addressing the factors which pertain to approval (as directed by legislative requirements); and
- the completion of an assessment report, including:
  - significant issues or concerns potentially impacting the decision regarding approval; and
  - a clear recommendation as to the suitability of applicants for approval as foster carers.

Once completed, the foster carer assessment and all supporting documentation are provided to the area manager who assesses the application. If approved, foster carers are provided with a Certificate of Approval which initially has effect for one year and involves in the development of a Foster Carer Agreement, outlining the roles and responsibilities of relevant parties.

The legislation also requires that approved foster carers apply for renewal of their approval, prior to the Certificate of Approval lapse date. There is a similar process for renewal of approval.

The Audit found that often foster carers approval had lapsed with no indication on the system of a re-approval process.

Relative Carers
The assessment and approval of relative carer applicants involves a similar process to approved foster carers. The area manager also approves the application. Once approved relative carers do not receive a Certificate of Approval as they are only approved to take specified placements (that is children they are related to), are not required to attend pre-service training; and are not required to apply for renewal, as approvals have effect until the child or young person leaves the placement.

There is no current requirement to negotiate a Foster Carer Agreement with relative carers.

Limited Approval Carers
The assessment and approval of limited approval carer applicants again involves a similar process but a less stringent test. Once approved, limited approval carers do not receive a Certificate of Approval, as they are only approved to take specified children for no longer than three months (unless extended by the Regional Director) limited approval foster carers are not required to attend pre-service training; and are not required to apply for renewal, as approvals have effect until the child or young person leaves the placement.

There is no current requirement to negotiate a Foster Carer Agreement with limited approval carers.

Roles and responsibilities
In practice, it is possible that Shared Family Care services and recognised agency staff conduct foster carer assessments, and deliver pre-service training, without the joint participation of departmental officers. It is therefore possible that inadequate attention is given to the statutory requirements of foster carers or possible concerns regarding foster carer applicants, should they be approved.

The conduct of suitability checks and decisions about applications are solely actioned by departmental officers, with area managers being the delegated officers to make such decisions.

The provision of support to foster carers
The Audit had found that in some instances, it was recorded that foster carers had asked the Department for assistance in managing a child or they were requiring some respite but little had been done to assist. In one case, over a two year period the foster carer had asked for a new placement for the child before she was eventually moved.

Current departmental policy requires departmental officers to provide all foster carers with appropriate levels of support, to enable them to care for children and young people in a manner consistent with the Statement of Standards. The provision of support is an ongoing process associated with daily casework practice with support options to be specifically established and reviewed when negotiating a Foster Carer Agreement (approved foster carers only). This would occur if there are significant changes in foster carer's circumstances such as carer notifications result in substantiated or substantiated risk outcomes; or matters of concern arise regarding foster carers' compliance with the Statement of Standards etc.

Support to foster carers include ongoing casework support, advocacy and referral, practical support, learning and development (that is training), peer support and other sources of support. In practice however, relative carers and limited approval carers are less likely to receive consistent or appropriate levels of casework intervention and necessary supports in caring for children and young people.

While the Foster Carer Agreement is a key tool and 'contract' in negotiating and documenting support for foster carers, and associated roles and responsibilities, Foster Carer Agreements presently only relate to approved foster carers, and not to Relative or Limited Approval Carers. This appears to contradict the policy with respect to the provision of support to all foster carers.

Training
Current legislative requirements associated with training are:

- for licensed care services, the chief executive must not grant an application unless satisfied (among other requirements) that methods for the selection, training and management of people engaged in providing the services are suitable (Section 126(d) of Act); and
- with respect to determining suitability, a person is a suitable person for having the daily care of a child if the person (among other requirements) has completed any training reasonably required by the chief executive to ensure the person is able to properly provide the care (Section 9(2)(d) of the *Child Protection Regulation 2000* (the Regulation).

Apart from the policy requiring approved foster carer applicants to attend pre-service training, there are no departmental policies specific to the above-mentioned legislative requirements. In practice, only approved foster carers are required to attend initial training and there are no standards regarding ongoing training, following initial decisions to grant approvals (regardless of the approval category).

1.7 Diversity and quality in alternative care options

There is an increasing number of children and young people entering the care and protection system. This has placed an over-reliance on alternative care and in particular, foster care,

with 97% of children and young people in care, being placed in foster care. Coupled with this, is a lack of quality out of home placement options. One option for increasing the diversity of alternative care options and relieving the pressure on the current foster care system would be the implementation of Family Group Conferencing. Family Group Conferencing is an established process that is now widely used both interstate and overseas and has been successfully used to divert children and young people from the child protection system, explore available supports within the child's or young person's family and community and facilitate earlier reunification.

The Audit has also identified the need for better collaborative planning partnerships between government and the community.

For some children, a family-based placement option is not the best option. Any alternative care system needs a range of options and differential responses. There is an absence of small group home models as an option for some children and young people particularly sibling groups. In addition there is a need to improve training and specialist support for all carers and have effective quality assurance systems to monitor and report on the quality of care.

1.8 Number of children per foster carer family

One of the risk factors widely associated with harm to children and young people in alternative care is the ratio of children to foster carer. The higher the number of children per placement, the higher the risk of harm occurring. Many notifications and initial assessments audited revealed this issue with a high number of children and young people placed with foster carers at one time.

It is of concern that the Department does not have a policy restricting the number of children and young people placed with foster carers. This has lead to a situation where increasing numbers of foster carers have six or more children placed with them and at times up to 12 children. This clearly can not continue.

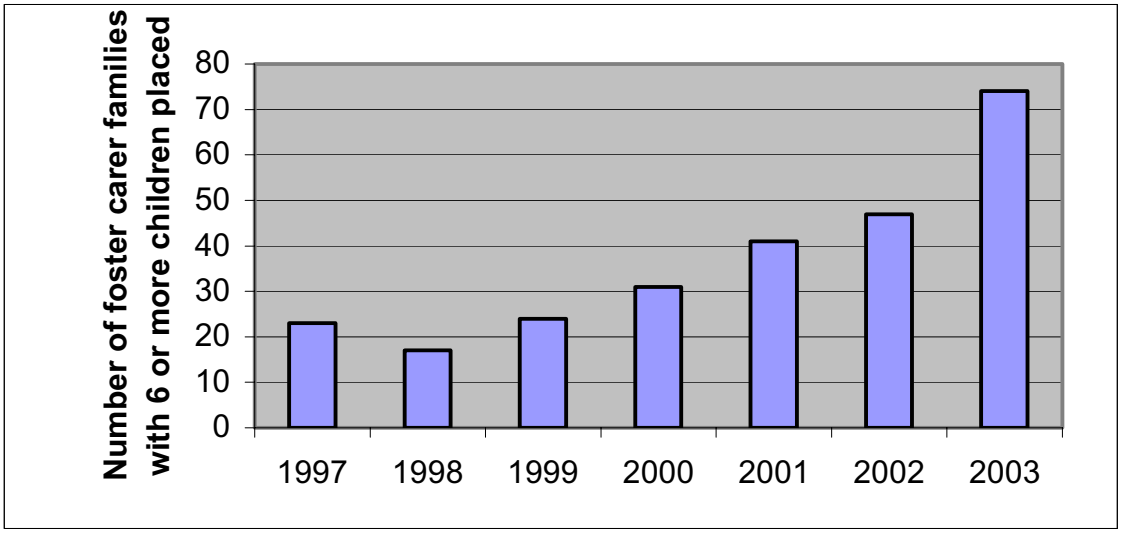
Case examples from the Audit
The Audit has found a high number of children and young people in placements with one or two foster carers. This has included:

- on the 30 June 2003 there were 74 placements with six or more children placed in each carer household,
- up to five different sibling groups in one placement,
- one foster carer was caring for eight children, from five different family groups. There were two babies under 12 months of age, four children were under five years of age and two children were under 12 years of age.
- a high number of young people aged 12 – 15 years in one placement
- and children and young people with intensive support needs in placements with a high number of other children and young people.
- there were five teenage boys in one household between the ages of 13 and 15 years all with high needs and very challenging behaviour.

Note that due to current information management systems, the Audit Team was unable to establish the number of the carers' own children residing in the home. Therefore, the numbers of children and young people in discrete placements recorded in the following tables do not include the carers' own children.

For the period of time subject to the Audit (1997 – 2003), the number of foster carer families with six or more children placed with them has increased by 222% from 23 in 1997 to 74[1] at the 30 June 2003.

Graph 1 Number of foster carer families with six or more foster children placed with the family. Queensland, by financial years ended 30 June



Source: Department of Families

Table 1 Number of foster carer families with six or more foster children placed with the family. Queensland, on 30 June 2003

Number of foster children placed per household	Number of placements or households	Area office
6	36	Various
7	19	Various
8	14	Gladstone, Browns Plains, Logan, Townsville, Bundaberg, Ipswich, Toowoomba, Gympie, Inala
9	2	Logan, Bundaberg
11	2	Logan, Bundaberg
12	1	Bundaberg

Source: Department of Families

Licensing and regulation of child care

The Department of Families is also responsible for the licensing and regulation of child care in Queensland.[2] There would be little dispute about the different characteristics of children placed in home-based child care compared to children and young people placed in alternative care.

[1] Figure provided by Internal Audit, Department of Families, June 2003

[2] Child care is defined as care of a child provided for someone other than a relative or guardian, at a place other than the child's home, for reward and in the course of a service for regularly providing child care.

Children and young people placed in alternative care often come from families characterised by poverty, instability and parents or carers with poor psychological well-being. They have experienced significant harm or have been placed at risk of significant harm. They may have been subject to further trauma through their removal from their parents, siblings and familiar environments. They often have a variety of behavioural and emotional problems including severe attachment disorders (Kortenkamp and Ehrle, 2002). Many children and young people in alternative care have complex needs and require intensive support, a high level of supervision, quality input from their carers and a lot of nurturing to assist them and allow them to reach their potential.

Licensed child care services have legislated restrictions on the maximum number of children that can be cared for in specific age groups. Particularly relevant to the debate around limiting the child to foster carer ration is the child to carer ratio restrictions placed on family day carers in licensed home based services previously know as Family Day Care Schemes. Section 92 of the *Child Care Act 2002* prohibits care providers from caring for more than seven children in their home, four of whom are not yet school children. This figure includes the carer's own children who are not yet school age.

Licensed home based day care carers are also required to:

- Hold a current senior fist aid certificate and a current CPR certificate
- Comply with Qld transport standards for appropriate restraints, road safety, driver authorisation and adult to child ratio when transporting children. For example, when transporting children, if five or more children are less than three years there must be two adults in the vehicle.
- When in the company of another care provider, comply with the adult to child ratio when taking children out for longer than three hours per day. For example, if the children are less than three years of age there must be one adult for every two children who are less than three years of age. For children who are not yet school aged there must be one adult for every four children.
- Ensure appropriate activities and experiences designed to stimulate and develop each child's creative, emotional, intellectual, lingual, physical, recreational and social potential (Department of Families 2003d).

Care providers can be limited to care for a specific number of children (less than that stipulated in legislation) at the discretion of the scheme. For example if caring for a child with a significant disability, restrictions may be placed around the number of other children that can be cared for at the same time. Care providers are able to be fined for breaches to s92.

When compared to the above licensing standards it appears that the well-being of children in alternative care will continue to be compromised when there are no restrictions on the numbers of children and young people placed with foster carers. Foster carers must be able to meet the individual physical, emotional, psychological, educational and safety needs of all children and young people in their care. The Department is responsible for the placement of children and young people and are, at times, placing foster carers in an extremely vulnerable position when they overload them with high numbers of children.

The vulnerability of children and young people in alternative care and their diverse and at times complex needs would suggest that restrictions and standards should be at least equal to if not more stringent than those that apply to home-based day care.

1.9 Why 'Fix up' alternative care?

(Carter, 2002) argues that Governments and their partners should be prepared to 'fix up' foster care for moral reasons, "to ensure that children and young people in the care of the state receive the affirmative policies, programs, practices….and love…that they deserve". Adults have obligations and duties towards all children. Children should be treated as ends, not as means, with human rights and needs sufficient in themselves for action. Carter argues that there are also pragmatic and technocratic reasons to redevelop foster care within the scope of good governance and that carry more power in social policy. It would seem that when foster care 'goes well' it can have enormous benefits for the child and for the state from economic, health, legal and moral perspectives. These reasons can be summarised as:

1. *To improve the economic health of the nation.* Australia needs a productive and competitive highly skilled workforce in the next 30 years. At present too many 'graduates' of foster care become caught up in the juvenile justice, homelessness, mental health, social security and unemployment systems. This is a costly and detrimental outcome for these children and for the future of the country.

2. *To reduce the government's exposure to risk*. Maintaining risky situations, or turning a blind eye to the existence of such, is no longer a moral or legal defence. Allowing risks to continue without taking adequate precautions may invite future legal actions. If foster care constitutes a risk and possible hazard for children it is not prudential to ignore this.

   Indeed it was reported in *the Courier Mail* 2.12.03 that a class action involving notices of claim under the *Personal Injuries Proceedings Act* have been delivered to the Department of Families by a group of 12 former foster children who allege they suffered sexual, physical and emotional abuse and are suing the state government for damages in their lack of care.

3. *The state as parent*. A further governance reason for reform is based on the principle that essentially the government acquires by law the guardianship or custody of most foster care children which means that there is a legal duty to care for these children. These children have been removed from parents deemed to have failed in their parental duties. The government assumes the role of parent, and becomes the 'corporate parent' when it passes the role to foster carers.

4. *The benefit/cost reasons for rethinking foster care*. There is a large cost to the government, in child protection proceedings, child protection workers salaries and any related health and education cost of the child. Carter (2002) argues that the cost of foster care is miniscule compared to the costs of residential care and the long term institutional and public health costs. She asks the question, "is a child in foster care receiving the benefit that he/she should receive from the costs of care"?

5. *International Convention on the Rights of the Child*. Foster care represents an opportunity for governments to work together on the principles of the Convention. Carter argues that if governments took their roles to be the support of children within the framework of the Convention, many of the policy dilemmas around foster care would disappear.

Recommendations concerning foster care and the placement of children

1. Placement options

It is recommended that attention be given to providing intensive family support services to assist and strengthen families to safely keep children with their natural parents.

It is recommended that:

- small residential homes should be available for large sibling groups and young people who do not wish to have, or cannot cope with family based care or who are transitioning to independent living;
- The Department consider the implementation of Family Group Conferencing as a means of diverting children from the child protection system, increasing diversity in alternative care options and relieving pressure on the foster care system;
- the department develop a clear policy framework which proactively seeks support options (eg placement, respite and social contact) within the child's family and community, eg the use of Family Group Conferencing. This policy framework should be developed in consultation with the Departments Alternative Care Committee.

2. Assessment, approval, training and support for foster carers

It is recommended that the Department:

- review and amend relevant policies with respect to determining foster carers' suitability, having regard to foster carers own children, non-household members likely to have ongoing or significant levels of contact with children;
- develop and implement clear standards and policy frameworks regarding the training and support to be provided to, and attended by, all foster carers. This should include the roles and responsibilities of persons or agencies responsible for the training and support of foster carers;
- develop and implement clear standards for the review of relative carer and limited approval carers including their compliance with legislative provisions;
- amend the 'Foster Carer Agreement' policy and procedures to include all foster carer approval types and monitor the 12 monthly review of the Agreements, to ensure that it is undertaken. A standardised Foster Carer Agreement proforma needs to be developed;
- amend the legislation to ensure that standards and monitoring requirements apply to all foster carer types;
- review the draft Sharing the Care training and include content that covers the issues identified by the Audit with clear information about listening to children and taking their disclosures of harm seriously;

- clearly articulate to foster carers the standards of care required for children and young people in foster care;

3. The number of children and young people placed with foster carers

It is recommended that the Department:

- develop and implement policy that places restrictions on the number of children and young people or sibling groups that can be placed with all approved foster carers at any one time;
    - the policy should take into consideration the findings of this Audit and have regard to best practice developed within child care as to restrictions on the number of children in foster care;
- the formula should state standards for the placement of children and young people with foster carers including specific requirements relating to:
    - The number of carers' own children,
    - Children and young people with high support needs,
    - Children and young people that have been sexually abused, or have sexually abused other children and the placement of more than one sibling group with a foster carer.

Chapter Two: Abuse in care

Despite an underlying expectation that once children and young people are removed from their parents they are safe from further harm or risk of harm, children and young people entering the alternative care system are vulnerable to a number of risks. One of these risks relates to the risk of further harm to them by the people entrusted to care for them.

There is little research available in relation to the abuse of children and young people in foster care in Australia (Australian Foster Care Association, 2001). Most research has been conducted overseas. However, harm to children and young people in alternative care in Queensland is well documented within the Forde Inquiry report and in the notifications and initial assessments that were reviewed as part of the current Audit process.

This is not the first time that the Department of Families has sought to understand the level of harm to children and young people in alternative care and develop strategies to address it. It is of concern however, that little has been implemented or progressed as a result of this work.

1. A project undertaken by the then Queensland Department of Families, Youth and Community Care in 1996-97 titled "Abuse of Children in Care", examined the level of abuse of children in care, identified factors that contributed to the abuse and outlined strategies to prevent the incidence of abuse.

2. In preparation for the implementation of the Regulation under the *Child Protection Act 1999* and in response to recommendations of the Forde Inquiry, a working group was established in 2000. It involved representatives from the Department of Families, Queensland Association of Fostering services, the then Foster Parents Association of Queensland, PeakCare, and the then Aboriginal and Islander Child Care Agency (AICCA).

   The working group undertook an analysis of notifications involving foster carers in the period October 1998 to the end of September 1999. They established principles and minimum requirements underpinning an effective system for dealing with notifications. The group considered alternative systems and processes for dealing with reports of abuse in care, developed options and recommendations in order to meet the Department's commitment made to the Forde Inquiry and identified resource implications of the options recommended.

   A summary of their analysis of the deficiencies in the system at that time include:

   - An inability to respond, assess and record assessment outcomes in a timely manner;
   - A failure to review and plan remedial action in many situations where significant harm or significant duty of care issues were identified;
   - Some evidence and anecdotal reports relating to the inconsistencies in the distinction between a notification and a Standard of Care Issue across area offices;

- A failure to deal with a small number of foster care situations where there were documented histories of repeated notifications and substantiations of harm or risk of harm and where children were exposed to ongoing abuse; and
- Indications of poorly conducted assessments and inadequately recorded reports.

The final report titled *Departmental Response to Notifications and other Standard of Care Issues involving Children and Young People in Foster Care* was distributed in December 2000 and made 13 recommendations. Of particular note are four recommendations:

- Consideration be given to the establishment of a central unit in Brisbane plus a "satellite" office in Townsville or Cairns to respond to notifications relating to foster carers and other standard of care issues;

- The central unit to undertake a quality assurance role, collate data, coordinate and monitor responses and assessments, provide case advice, develop specific skills, undertake complex investigations, and oversee compliance with support, review and action requirements;

- That a comprehensive database be built and an annual report be produced on outputs and outcomes in responding to notifications involving foster carers and other Standard of Care Issues; and

- That strict time lines be set for all initial assessments involving children in alternative care.

The report identifies that it is essential to locate responsibility outside the area office for the investigation and assessment of all child protection notifications involving foster carers in order to:

- Improve the timeliness and effectiveness of the assessment and review;
- Separate the support function from the investigation/assessment function;
- Avoid potential conflict of interests; and
- Enable skills development in this specialised area of work where different types of response and assessment are required.

It appears that many of the recommendations of this report were not progressed and the proposed structure was not adopted.

Subsequent attempts have been made to address some of these issues by the development of policy and other departmental initiatives such as *Future Directions*. However, the findings of the Audit have clearly indicated that these strategies have not been sufficient.

3. More recently the Department has developed information papers discussing the data relating to substantiated notifications involving children and young people in alternative care, *Substantiated notifications involving children and young people in alternative care 2000-01,* and *2001-02.* While these reports did not contain recommendations, they identified strategies for reducing the risk of harm to children and young people in alternative care. These reports were provided to the Department's Executive Management Committee (EMC) and have been made available on the Department's web site.

2.1 General research findings about abuse in care

Most other available literature on abuse of children in foster care focuses on the United States of America, the United Kingdom and Canada. Current literature suggests that the abuse of children in foster care is a result of complex and varying factors caused by the interaction between the characteristics of the foster carer family, the child protection agency practices and characteristics of the child or young person (Department of Families, 2003a).

The Department of Families (2003a) summarises the risk factors relating to the characteristics of the foster carer family, the practices of the agency and the characteristics of the child or young person. The characteristics of the foster carer family include: economic or relationship difficulties being experienced by the foster carer; emotional or psychological problems, stress or 'burn out'. Many foster carers begin with an unrealistic view of caring for foster children or unrealistic expectations of the foster child. Additionally, it is not uncommon for the foster carer to experience difficulties with their own children, with the important role that carers' own children play in the fostering situation, often overlooked. These children can help to settle in foster children, they are asked to share their belongings, their parents, their siblings, and their life.

In relation to the practice of recruiting, assessing, training and supporting foster carers, risk factors include:

- Lack of initial and ongoing training to foster carers.
- Lack of support to foster carers, particularly relative carers and foster carers with a large number of placements or with placements of children and young people with difficult behaviour.
- Inadequate monitoring of foster carers and placements.
- Lack of information or poor quality information provided to foster carers on child and young person's behaviour and background.
- Limited or poor assessment of foster carers.
- High ratio of children and young people to foster carer.
- Poor matching between child or young person and foster carer and
- Lack of training to agency staff on alternative care and the assessment of carers; and re-approval or continued use of inadequate foster carers.

While children and young people are not responsible for the harm or risk of harm that occurs to them, there are a number of characteristics of the child or young person that are identified as increasing the level of risk to them. The child or young person has previously been harmed and/or neglected and has a range of complex needs. The child may have a history of unstable or unsuitable placements or numerous placements. They may be 'acting out' or have challenging or at risk behaviours. Substance abuse, psychological or emotional problems, a high level of vulnerability or disability or special needs may be issues for the child or young person.

2.2 The experiences of some Australian jurisdictions

There is little acknowledgment that the dynamics of harm to children and young people in alternative care are different to that in familial settings. Some of the key differences include:

- Parents have greater discretion in child rearing than foster carers therefore what is permissible in familial settings may be unacceptable in alternative out-of-home care;
- Harm to children and young people in alternative care includes forms of abusive restraint or "treatment"; and

- Any report against a foster carer represents a potentially serious breach in contract between the Department and an agency or foster carers (Nunno and Motz, 1988; Barter, cited DFYCC, 2000).

Previously, most jurisdictions have relied on procedures developed for familial abuse and neglect when dealing with notifications on children and young people in alternative care. More recently, there has been increasing awareness of the need to develop more specialised processes to address allegations relating to foster carers. Two examples follow:

- Family and Youth Services, Department of Human Services (DHS), South Australia, is currently updating and reviewing the Special Investigation program that responds to allegations of abuse or neglect of children or young person in foster care and other DHS funded alternative care; and

- The Department of Education, Youth and Family Service (Australian Capital Territories) undertake Special Appraisals in response to allegations of abuse in care. The Allegations of Abuse in Care procedures are outlined in the Family Services Policy and Procedures Manual. Of note is that at the conclusion of a Special Appraisal, a report is forwarded to the Office of the Community Advocate. This report outlines the allegations, the Outcome Report, the final advice or actions in relation to the person whom allegations were made against, the final advice to the care facility or agency, and any internal review decision.

It is difficult to compare data across the Australian jurisdictions due to differences in legislation, policies, procedures, recording practices and definitions, and a lack of available data (Department of Families, 2003a). The Australian Foster Care Association (2001) recommended that States and Territories initiate national data collection relevant to foster care, including data related to allegations of abuse.

The Australian Institute of Health and Welfare (AIHW) and the Productivity Commission collect and publish information on child protection including data about children and young people in alternative care. For the period 2001-02, three jurisdictions, New South Wales, South Australia and Northern Territory, were unable to provide data on children and young people harmed in alternative care. In Victoria, notifications on children and young people who are already placed in alternative care are not recorded. However, given these restrictions, it is still interesting to note the data.

Table 2 Children and young people in alternative care who were the subject of a child protection substantiation and the person believed responsible was in the household 2001-02 Australia

	VIC	QLD	WA	TAS	ACT
Number of children harmed in alternative care	2	151*	6	2	2
All children in alternative care for the 12 month period	7,551	4,297	2,170	729	493
Proportion of all children in alternative care who were harmed	0.0	3.5**	0.3	0.3	0.4

Source: Department of Families. *Previously reported in the Report on Government Services as 162
** Previously reported in the Report on Government Services as 3.8%

Given the above data, it cannot be assumed that Queensland foster carers are more likely to harm children and young people in alternative care than in other jurisdictions. The discrepancies in the data are more likely to do with policies, procedures, recording practices and reporting decisions (Department of Families, 2003a).

2.3 General statistical information

Within the Terms of Reference, the Audit focused on notifications and initial assessments on foster carers recorded on FamYJ. This included notifications and initial assessments recorded from the commencement of the (CPIS) in March 1997 to 30 June 2003[3].

General statistical data is provided for the period 30 June 1997 until 30 June 2003 to provide contextual information for the Audit findings.

Note that due to data reports being provided at different times, with different specifications, there may be slight variations in data to that previously reported or recorded elsewhere. Every attempt has been made to provide up-to-date and accurate data which has also included correlating this data with other data available through the Carepay system and Internal Audit Division.

The Foster Carer Audit has found that there needs to be an urgent response to the outdated Department's current data management systems and is discussed further in Chapter 7 *Information Systems*.

Table 3 Summary of child protection data, 1996-97 to 2002-03, Queensland

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03
Estimated resident population 0 – 17 yrs	-	889,787	898,959	908,018	917,918	929,521	938,464
Cases notified*	14,599	17,233	18,721	19,057	22,069	27,592	31,068
Initial assessments	13,733	15,245	15,889	16,177	18,925	24,103	27,218
Substantiated outcomes**	4,839	6,323	6,373	6,919	8,395	10,036	12,203
Children admitted to alternative care***	1,558	1,647	1,506	1,375	1,478	1,868	2,152

Source: Department of Families

* Cases notified refers to the number of children who are the subject of the notifications. A child notified more than once during the period is counted once for each notification

** Substantiated outcomes refers to substantiated and substantiated risk outcomes

*** Children admitted to alternative care refers only to children with protective casework

Children in alternative care

The increasing number of children and young people entering alternative care is a result of a number of factors. For example, the availability and effectiveness of prevention and early intervention programs that assist families to safely care for their children and young people.

[3] With the exception of 16 notifications and initial assessments that were included in the original data that were recorded prior to March 1997. At times, other notifications and initial assessments prior to 1997 and after 30/06/03 were reviewed to provide further contextual information on foster carers as required.

There is also an increasing number of notifications of harm due to increased public awareness of child abuse and the social pressures on at-risk families.

The number of cases notified against parents within the general community increased by 113% during the period of time subject to the audit (1997 – 2003).

The number of children entering alternative care increased by 38% during the period of time subject to the Audit (1997-2003) and it is of most concern that the number of cases notified relating to children and young people in alternative care increased by 422% during this period of time.

Note that data provided in this section relates to all children and young people (subject to protective casework) in alternative care including those placed with foster carers, relatives in unpaid placements, in residential settings, placed at home or "other placements".

Table 4 Children in alternative care by cases notified and substantiated outcome, Queensland, 1996-97 to 2002-03

	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03
Children in alternative care	3,180	3,149	3,146	3,230	3,516	3,823	4,380
Cases notified*	116	127	154	365	459	499	605
% of cases notified to children in alt care	3.6%	4.0%	4.9%	11.3%	13.0%	13.0%	13.8%
Substantiated outcomes**	66	65	85	144	229	257	321
% of cases substantiated to children in alt care	2.0%	2.1%	2.7%	4.5%	6.5%	6.7%	7.3%

Source: Department of Families

* Cases notified refers to the number of children who are the subject of the notifications. A child notified more than once during the period is counted once for each notification

** 'Substantiated outcomes' refers to substantiated and substantiated risk outcomes

Notification and substantiation rates

In general, there is a higher proportion of notifications reported in relation to foster carers than notifications reported with respect to parents in the general community. This could be due to a number of factors; the increased scrutiny of foster carers due to the nature of their role, a higher standard of care expected from foster carers compared to parents in the general community and increased reporting by children, young people and their families who are aware of departmental processes or who are known to the Department are more 'visible'.

High reporting may also be reflective of the Department's policies and legislative provisions, including the prohibition of physical discipline. Conversely, substantiation rates are lower for notifications in relation to foster carers than parents in the general community.

Cavara and Ogren (1982) identify that lower substantiation rates may be due to staff being reluctant to make a finding of substantiated harm with a heavy reliance on facts that can be proven and a hesitation to rely on their professional judgement in drawing conclusions from these facts.

Foster carer families
Despite difficulties associated with recruiting and retaining foster carers, the Department has maintained a fairly stable pool of foster carers over the last seven years. However, a number of foster carers who are recorded as current and approved have not had children or young people placed with them for a considerable length of time. Refer to Table 6 (Current approved foster carer families without a placement as at 20 October 2003).

Table 5 Distinct foster carer families by type of carer, Queensland, by financial year ended 30 June

	1997	1998	1999	2000	2001	2002	2003
Approved foster carer families	1,278	1,330	1,365	1,385	1,427	1,429	1,485
Approved foster carer families with placement	613	664	678	710	776	798	869
Limited approval carer	150	122	124	140	145	159	183
Relative carer	309	341	389	466	489	570	615

Source: Department of Families

There has also been a 35% increase in the number of children in alternative care placed with limited approval carers from 234 in 1997 to 317 in 2003. A limited approval carer is a person who has not been fully assessed or trained but is approved for a particular child or young person, for a specific purpose, for a defined period of time.

Aboriginal and Torres Strait Islander children and young people
Aboriginal and Torres Strait Islander children and young people are over-represented in the Queensland child protection system and are subject to more intrusive interventions than non-Indigenous children and young people. The further into the 'system', the greater the level of over-representation (Department of Families, 2003b).

In Queensland in 2003, Aboriginal and Torres Strait Islander children and young people comprised 5.7% of the population of children and young people aged 0-17 years, yet they comprised 8.3% of cases notified, 10.3% of substantiated cases and 23% of all children and young people on finalised orders (Department of Families, 2003c).

Previous data reported (Department of Families, 2003a) showed that 47.7% of the distinct children and young people harmed in alternative care during 2001-02 were recorded as being of Aboriginal or Torres Strait Islander descent.

Note that the figures in relation to Aboriginal and Torres Strait Islander children and young people may be more over-represented than the above data indicates due to recording practices within area offices and limitations of the departmental recording systems.

Chapter Three: Description of the foster carer audit

Introduction

On 19 June 2003 the Honourable, the Minister for Family Services, Judy Spence announced that there would be an independent and external audit of current foster carers who have been subject to child protection notifications relating to children placed in their care by the Department of Families. The Director-General appointed myself, Gwenn Murray to lead the Audit Team. The Audit of Phase One was commenced on 20 June 2003 and was completed on 28 November 2003.

3.1 Terms of Reference of the Audit

1. Determine the accuracy or otherwise of the assessment outcome for each notification.
2. Consider whether the action taken following substantiated notifications was appropriate for the circumstances in respect of both the foster carers and the subject children.
3. Identify any emerging pattern in relation to foster carers who have been subject to a number of notifications (whether substantiated or not).
4. Comment on the adequacy of statutory requirements, departmental policy, practice and procedures as they relate to notified foster carers.
5. Make recommendations for any change to policy, practice and procedures that may be required.
6. Refer any relevant information identified through the audit regarding the case of "X", to the review of that case.
7. Bring to the notice of the Director-General any matters relating to the actions or inactions of departmental officers that may require a further response.

3.2 Scope and methodology of the Audit

The Terms of Reference of the Audit determined that the scope would be 'desk top'. That is, it would be limited to reviewing practice undertaken and recorded within notifications and initial assessments. The Audit Team also searched the child protection information system (CPIS) database for further information contained in case notes, intake notes, placement history and other relevant information. In response to the views expressed by Foster Care Queensland (FCQ) that foster carers and children were not interviewed concerning individual cases, the Audit Terms of Reference were clear that it was not a review of each case or a re-assessment as such, but auditing departmental practice. FCQ, as were other community based organisations, consulted on a number of occasions about their general views about foster care and their experiences with the Department.

Audit Team was requested to:

1. Review all of the notifications and initial assessments involving foster carers who were currently approved carers for the Department and had a current placement as at 20 June 2003. This was considered as Phase One of the Audit.

   Phase Two of the Audit was then defined as notified foster carers who had a placement in the past two years, but did not have a placement at the commencement of the Audit.

Phase Three of the Audit was defined as notified foster carers who have not had a placement since 1 January 2001. It was recommended that as a large number of these carers have not had a placement for some years, a process be instigated to consider their carer status and reassess them or take appropriate action as to their approval status.

2. Review relevant legislation, policy and procedural information.

In addition to this,

3. Discussions were held with community groups throughout the audit process, and

4. Consideration was given to the findings of previous studies conducted by the Department of Families and relevant reports from other states and overseas.

3.3 Audit team

Gwenn Murray – Independent and External Reviewer lead the Audit Team, with 20 years experience in working in the area of child protection, youth justice and crime and violence prevention.

There was a turnover in staff within the Team due to the lack of available departmental staff with the requisite skills and experience to conduct the Audit. There have been on average 7 core equivalent full time (EFT) senior departmental officers with extensive child protection experience conducting the audit. In addition, 2.5 EFT staff assisted with database research, data management and entry.

The Commissioner for Children and Young People has provided a representative to be actively involved in the audit process, including the development and monitoring of recommendations coming from the Audit.

Senior Policy Officers, Social Policy Division, Department of the Premier and Cabinet were appointed to provide strategic advice on the Audit.

3.4 Audit assessment criteria and definition

A set of criteria for assessment was developed to record quantitative information as well as qualitative information such as practices, procedures and decision making and tested to ensure that it was rigorous. A protocol was developed to guide the Team in deciding on the assessment of cases and to ensure consistency in decision making within the Team.

A range of information was developed by the Audit Team to undertake and manage the Audit. This included the construction of a database with the assistance of an information technology consultant so as to record Audit information. It is anticipated that the database can be used by the Department in on-going audits. In addition, spreadsheets for tracking matters, referrals and requests for further information or action were developed.

The Audit Team considered recorded information within the notifications and initial assessments. The Team also searched the CPIS database for further information.

The criteria and audit assessment of the Audit Team had due regard to the *Child Protection Act 1999* and definitions and purpose set out in the Act. In particular Principles for

administration of the Act (s5), Provisions about Aboriginal and Torres Strait Islander children (s6), Chief Executive's functions (s7) and Part 3 Division 1 – Basic Concepts, such as the definition of harm, physical, psychological or emotional abuse or neglect or sexual abuse or exploitation (s9). The focus of the Audit Team was within this context of harm and considered departmental practice in response to concerns about any unsafe, improper or unlawful care or treatment of children and young people. Practice, policies and procedures that are insufficient were also identified within the Audit findings so that recommendations would be made to the Department in accordance with Term of Reference 4.

3.5 Limitations on the audit

Under-reporting of harm or risk of harm
It is possible that the actual extent of harm to children and young people in alternative care may be higher than that indicated by the data produced for and by the Foster Carer Audit. This is supported by:

- A lower incidence of substantiated notifications in alternative care than that in the general community;
- Children and young people removed from their foster carer placements following allegations of harm without a notification or an initial assessment with a substantiated outcome being recorded and
- Anecdotal reports of some area offices previously recording allegations of harm or risk of harm as either a Standard of Care Issue or more recently as a matter of concern and addressing it through regular case work, rather than recording a child protection notification.

Standard of care issues
Prior to the implementation of the policy *Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care* in October 2003, there was no centralised recording for breaches of standards of care (previously known as a Standard of Care Issues). Due to this, no information can be provided in relation to the number of Standard of Care Issues for foster carer families or how they were resolved during the period of time subject to the audit. When reviewing child protection histories for foster carer families, the information about Standard of Care Issues was generally not available or unable to be identified in electronic case records.

The audit revealed that very few notifications (five in total) were recorded that could have been more appropriately recorded and addressed as a Standard of Care Issue.

Limitations of data systems
Accessing relevant data for the audit was most difficult throughout the whole Audit process due to the poor departmental data systems that have a limited capability of generating required data. At the commencement of the Audit it took three to four weeks to gain access to relevant data and have some understanding of the extent of the Audit. That is, the Department quite simply did not know how many notifications and initial assessments had been recorded and would be within the scope of the Audit.

Information required for the audit is stored on the CPIS and FamYJ databases. There is limited interface between these systems consequently information on "a case" may be stored across both systems and on paper files stored in the Area Office. Consequently auditing cases was time consuming and complicated process that required searching two databases.

During the Audit, the Team identified additional notifications recorded on foster carers that were not included in the first search of the databases due to information time lags and incorrect or inadequate recording. Further notifications were identified late in the Audit by the Team that related to notifications recorded with respect to approved foster carers who had either emergency or unpaid relative placements. These notifications were not provided to the Audit Team in the initial data reports.

The Team also consulted with the Department's Internal Audit Division as further data are held by the Division through the Carepay System. The Division undertook a data analysis and a correlation of the Carepay foster carer data and the notification and initial assessment data to ensure that the Audit Team had all relevant data and to assist in further prioritisation of cases for audit.

3.6 Population of the audit

Phase one

In order to manage the immensity of the task faced by the Audit Team, a decision was made to initially audit notifications and initial assessments relating to current and active foster carer families with children placed with them as at the commencement of the Audit (20 June 2003). During the course of the Audit, this became known as Phase one. Due to the timeframe and constraints faced by the Audit Team, the Audit has only been completed at this time in relation to those foster carer families identified in Phase one (this has included reviewing 1,060 notifications and the corresponding initial assessments, 637 of these notifications and initial assessments came within the scope of the Audit) .

Phase two

The Director-General approved the Audit Team to undertake the audit of notifications recorded on those foster carers who did not have a placement at the commencement of the Audit, but have had a placement since 1 January 2002. This will involve auditing 112 notifications and has been identified as Phase two.

Phase three

Phase three relates to foster carer families that have not had a child placed with them since the end of December 2001 (some foster carer families have not had a placement for a number of years but still appear on the system as "current"). The Services Support Unit, Operations Directorate, has commenced a process to clarify the current status and review the 123 foster carer families identified as part of Phase three.

Table 6 Currently approved foster carer families without a placement as at 20 October 2003. Phases two and three of the Audit

Audit Phase	Year of last placement	Number of carers without a placement
Phase Two	**2003**	**295**
	2002	**98**
Phase Three	**2001**	**50**
	2000	**24**
	1999	**22**
	1998	**9**
	1997	**10**
	1996	**4**
	1995	**3**
	1994	**0**
	1993	**0**
	1992	**0**
	1991	**1**
	Total	**516**

Source: Foster Carer Audit

Number of foster carer families

The Audit Team considered and audited 637 notifications and 570 corresponding initial assessments relating to foster carer families[4]. Of the 637 notifications, 420 related to approved foster carers, 181 to approved relative carers (paid and unpaid) and 31 to limited approval carers with five notifications where the foster carer approval type was recorded as unknown.

The 570 initial assessments related to 362 carer families, or 211 distinct carer families. An accurate breakdown of these carer families by approval type has not been possible due to problems with the information provided to the Audit Team.

Distinct number of children and young people

Notifications

The 637 notifications audited related to 1258 subject children (cases) or 888 distinct subject children. Of the 888 distinct subject children, 447 (50.3%) were recorded as female and 441 (49.7%) were recorded as male. In terms of Indigenous status, 230 (26%) were recorded as Aboriginal, 10 (1%) as Torres Strait Islander and 648 (73%) as non-Indigenous.

Initial Assessments

The 570 initial assessments audited related to 1201 subject children (cases) or 855 distinct subject children. Of the 855 distinct subject children assessed, 181 (21%) were recorded as Aboriginal, 10 (1%) were recorded as Torres Strait Islander and 664 (78%) were recorded as non-Indigenous.

Of the 855 distinct subject children 429 (50.2%) were recorded as female and 426 (49.8%) were recorded as male.

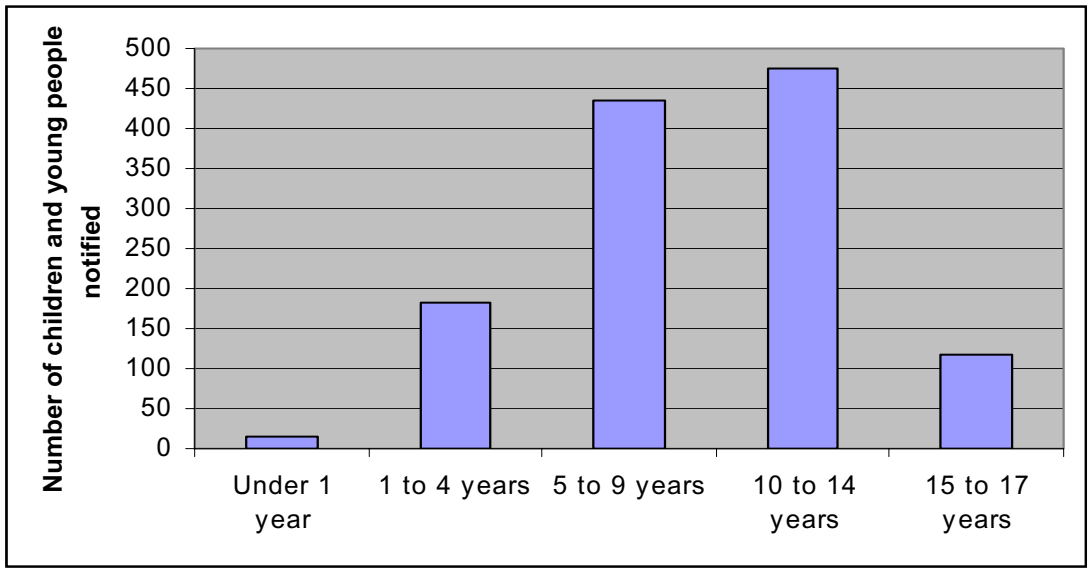
Of the 1201 cases assessed, 367 (30.5%) cases had a recorded outcome of substantiated and 225 (18.7%) cases had a recorded outcome of substantiated risk, making a total of 592

[4] This refers to the number of foster carer families who are recorded in the notifications. A foster carer notified more than once during the period is counted once for each notification.

(49.2%) cases with a substantiated outcome recorded. The 592 cases related to 457 distinct children.

The ages of the children and young people at the time the notification was recorded were as follows:

Graph 2 Ages of children and young people at the time the notification was recorded, Queensland, 1997 - 2003



Source: Foster Carer Audit

3.7 Notifications and initial assessments within the scope of the Audit

Data for the audit was not sought by standard data requests to Information Services Branch but by a specific request to Corporate Services Centre to provide a more exhaustive list. This required the Audit Team to eliminate notifications and initial assessments not within the scope of the Audit. However, it meant that every attempt was made to ensure all notifications and initial assessments which should be included in the Audit were not missed due to incorrect data entry or the limitations of the current departmental data reporting systems.

Some of the notifications and initial assessments that were eliminated from the Audit related to natural family members. The alleged harm to the child or young person may have occurred during a family contact visit with a natural family member while the child was living with a foster carer or the child may have disclosed historical abuse by a natural family member. Other notifications that were eliminated related to the carers' own children. However, if the information contained within the notification or assessment indicated a safety concern that could impact on the safety of children and young people in alternative care, these were reviewed by the Audit Team and considered as part of the child protection history relating to the foster carer family.

Initially the Audit Team was informed by data reports that there was a total of 1,129 notifications with corresponding initial assessments with respect to the 37 area offices for the period 1 January 1997 to 30 April 2003[5] and covering Phase One and Two of the Audit. During the course of the Audit, additional notifications and initial assessments that were not

[5] With the exception of 16 notifications and initial assessments that were recorded prior to March 1997.

included in the initial data were identified as falling within the scope of the Audit. This was due to a number of factors:

- Foster carers recorded in the initial assessment document but not in the notification document;
- The manual collection of additional notifications and initial assessments for the period 1 May 2003 to 30 June 2003 with delays in recording notifications on the system affecting the Audit Team's ability to access the data electronically;
- Notifications recorded after 30/06/03 were included in the audit process where appropriate; and
- Additional notifications and initial assessments were provided by Information Services Branch following clarification of the original data requests.

Note that this has caused discrepancies with data previously reported.

Table 7 Total number of notifications audited by year, Queensland (current and active carers with a placement as at 20 June 2003)

Year	Number of notifications
01/07/03 – 30/11/03	23
01/07/02 – 30/06/03	311
01/07/01 – 30/06/02	246
01/07/00 – 30/06/01	202
01/07/99 – 30/06/00	117
01/07/98 – 30/06/99	77
01/07/97 – 30/06/98	52
01/07/96 – 30/06/97	20
Prior to 01/07/97	12
Total	**1,060**

Data: Foster Carer Audit

Due to a number of factors, including the consideration of the immediate safety of children and young people in placements, the Audit Team commenced the Audit with the most recent notifications and initial assessments for 2002-03 where there were 311 notifications. However, if a foster carer family was identified as having more than one notification recorded, all notifications and initial assessments were reviewed at the same time to enable the auditor to gain a thorough child protection history and identify patterns and trends.

As previously mentioned, the Audit Team focused on notifications and initial assessments from the commencement of CPIS in March 1997 to 30 June 2003. However, a number of additional notifications and initial assessments prior to 1997 and after 30 June 2003 were reviewed to provide further contextual information on foster carers as required.

Outstanding initial assessments

There were 14 initial assessments that fell within the scope of the Audit but were not able to be audited due to their non-completion as at 28 November 2003. Several requests were sent to area office staff to complete and approve the recording of the initial assessments to enable them to be audited however this did not occur in some cases. Data relating to these are therefore not able to be included in this report.

Chapter Four: Audit findings - requests for information and action

4.1 Audit processes and outcomes

It was decided that the Audit would not simply be a report on the findings but it would be action-based, particularly in light of the Director-General's request that the Team report on the safety of children and young people in current placements. Therefore, at the commencement of the Audit, through the Audit criteria and protocols, a range of possible outcomes were identified and endorsed. The Audit of a notification and initial assessment may have resulted in no further action being required. However, specific requests were made to area offices when the Audit Team considered that:

- initial assessments were not adequate, comprehensive, holistic or child-focused;
- the recorded outcomes were not an accurate reflection of harm or risk of harm recorded in the initial assessment text as experienced by the child or young person;
- planned intervention or monitoring did not occur to ensure the ongoing safety of the child; or
- an immediate assessment of the safety of a child or young person needed to be undertaken by the area office with a report to the Audit Team within 24 hours as to children's immediate safety.

In these instances, area office staff were asked to provide further information, explain the reasons for their decision-making, take some action and/or rectify errors or omissions.

The following is a list of audit processes or outcomes:

No further action
If a case was reviewed by the Audit Team and considered to be 'sound' or 'holistic', that is, it had an appropriate assessment and outcome and the foster carer approval was current, no further action was required. No further action was also used when child protection notifications and initial assessment text were considered old, children and young people had left care or left the placement, appeared to be 'one-off'.

Further information required
Initially, if there was insufficient information recorded in the notification or initial assessment document, matters were referred within the Team for further information to be gathered from either the CPIS or FamYJ databases. As the Audit progressed, it became usual for each Audit Team member to consult the databases in relation to all notifications and initial assessments. This ensured that the foster carer family's full child protection history was taken into account and the approval status of each carer was reviewed.

Refer to Data Management Services
Where there were recording errors identified with no practice issues requiring clarification or follow up by the area office, cases were referred to the Resource Officer, Data Management Services (DMS), for amendments to be made to the documents.

Clarification of assessment action (AOAA)

When sufficient information was not able to be elicited from the audited documents or the electronic records available to the Audit Team, a referral was sent to the area office requesting clarification of the assessment action.

Reassessment of carer's approval status (CACA)

When information available to the Audit Team indicated a high level of concern about the ongoing suitability of a foster carer or where a foster carer's partner has not been approved, a referral was sent to the area office requesting that the approval status of a foster carer be reassessed.

Statement of Reasons (SOR)

When the Audit Team considered, on the basis of the information available to them, that a decision did not appear to be appropriate, a referral was sent to the area office requesting a Statement of Reasons as to why decisions were made or actions were taken.

Immediate action (DGIA)

If the Audit Team considered that there was an immediate safety risk to a child or young person, a request was sent to the area office for immediate action to be taken. If this occurred, the area office was asked to advise the Audit Team within 24 hours of the safety of the child or young person with a follow up full assessment report to be provided within 14 days. These matters were brought to the attention of the Director-General.

Immediate action requests were also sent in relation to a number of cases where it appeared that insufficient departmental intervention had occurred over a long period of time.

At times, due to the complexity of requests or the involvement of area office or regional staff, specific requests were made for senior staff or staff independent to the area office to undertake action or respond to the requests.

Refer to the Director- General

Matters reflecting some type of criminal behaviour that needed referral to the police were referred directly to the Director-General. In the case of official misconduct, the Director-General would refer the matter to the Crime and Misconduct Commission. Within the Terms of Reference other serious matters could be brought to the attention of the Director-General such as relevant information regarding the case of "X" referred to the CMC in June this year and subject to a separate independent investigation. Emerging patterns or matters relating to the actions or inactions of departmental officers that may require a further response were also brought to the Director-General's attention.

Refer to Operations Directorate

During the course of the Audit, matters came to the attention of the Audit Team that raised concern for the safety of children or young people but fell outside the scope of the Audit Terms of Reference. In these instances the matters were referred to the Service Support Unit, Operations Directorate for their follow up.

4.2 Other outcomes of the Audit

During the course of the Audit, a number of other outcomes became evident:

- Following requests to area offices and the subsequent assessments of the child or young person's current situation, area office staff decided to remove a number of children and young people from their placements to ensure their ongoing safety;

- Since the commencement of the Audit, which has had a high profile within the Department, significant improvements in recording and practice have been noted by the Audit Team in more recent notifications and initial assessments recorded by some area offices;
- In some cases it has been noted that there has been improved monitoring of children and young people in their placements as a result of an inquiry or request from the Audit Team;

- The Audit Team has received feedback from certain Audit Review Liaison Officers from the various regions. They reported that in some areas the Audit process has been a positive experience as it has provided an opportunity for staff that they may not have otherwise had, to reflect on their practice and identify areas that need further attention; and

Case example from Audit
One foster carer family had no 'current approval status' since July 1996 (according to FamYJ) however had eight children placed with them at the time of the request for immediate action. Four of the children placed with this family had been in this placement for over one year and two of the children had been placed for approximately three years.

- During the Audit process, the current approval of each foster carer was reviewed. It soon became apparent that a significant number of foster carers did not have current recorded approvals. When requests were sent to area offices, clarification was also sought regarding the approval status of the relevant foster carer. Area offices were requested to either complete the relevant administrative requirements to ensure FamYJ reflects the foster carers' correct and current status or if the foster carer approval had not been actioned, to undertake and decide an application for approval or renewal of approval, in accordance with departmental policy requirements.

Table 8 Audit processes and outcomes relating to notifications and initial assessments (N = 821)*

Audit outcome	Number	%
Unable to complete audit (initial assessments outstanding)	14	2
No further action required	123	15
Further information required (CPIS or FamYJ databases)	74	9
Refer to Data Management Services (recording errors only)	178	22
Requests to Area Offices (including immediate action)	432	52
Referred to DG to Crime and Misconduct Commission	0	0
Total	**821**	**100**

Source: Foster Carer Audit

*The auditing of the 637 notifications and 570 corresponding initial assessments could have resulted in more than one of the above outcomes.

Requests to area offices
At the conclusion of the audit, a total of 268 specific requests were sent to area offices in relation to 432 matters. Of particular note is that 28 requests (in relation to 35 notifications and initial assessments) were made requesting immediate action.

Table 9 Requests to area offices* June - December 2003

Region	AOAA	SOR	CACA	DGIA	Total
Brisbane City	15	4	4	5	28
Central Queensland	6	5	1	2	14
Caboolture/Redcliffe Peninsular	13	5	2	-	20
Far North Queensland	14	4	1	3	22
Gold Coast	18	4	4	1	27
Ipswich Logan	34	9	6	4	53
Mackay/Whitsunday	9	2	2	-	13
North Queensland	24	11	2	4	41
Sunshine Coast	8	3	-	2	13
Toowoomba & South West	3	9	-	2	14
Wide Bay Burnett	9	8	1	5	23
Total	**153**	**64**	**23**	**28**	**268**

Source: Foster Carer Audit
*Requests to area offices usually related to more than one notification

Responses to the Audit Team requests

The Audit Team requests sent out to area offices have generated a large body of work that is continuing to be undertaken by departmental officers. Area offices continue to struggle to undertake this work with staff already overwhelmed with current workloads and in some areas it was difficult to allocate senior staff to conduct assessments for other regions.

It was beyond the scope of the Audit Terms of Reference for the responses to the requests to be returned directly to the Audit Team. The responses have been sent to the Review and Evaluation Branch and the Service Support Unit, Operations Directorate, therefore further data about these requests is not able to be provided as part of this report.

The exception to this has been responses to the requests for immediate action and carer reassessment. An analysis of the requests for these follows later in this Report.

Referrals to Operations Directorate

A total of 29 referrals were made to the Operations Directorate for their follow up.

Table 10 Referrals to Operations Directorate

Region	Number of requests
Brisbane City	5
Central Queensland	2
Caboolture and Redcliffe Peninsula	1
Far North Queensland	2
Gold Coast	4
Ipswich and Logan	3
Mackay and Whitsunday	1
North Queensland	7
Sunshine Coast	1
Toowoomba South West	1
Wide Bay Burnett	2
Total	**29**

Source: Foster Carer Audit

4.3 Analysis of requests to area offices for Immediate Action (DGIA)

The DGIA outcome of audited cases refers to circumstances where the Audit Team determined that a case required immediate attention, due to current or future safety concerns regarding children and young people in placement with foster carers. These cases warranted referral to the Director-General.

There were 28 cases, involving 98 distinct children from nine regions, requiring immediate action. An assurance to the Audit Team (as to the immediate safety of children) was required within 24 hours, with a written report of this assessment within 48 hours. Following this a full assessment of the cases addressing the concerns outlined by the Audit Team was provided within 14 days.

Graph 3 Number of immediate action requests and number of distinct children by region

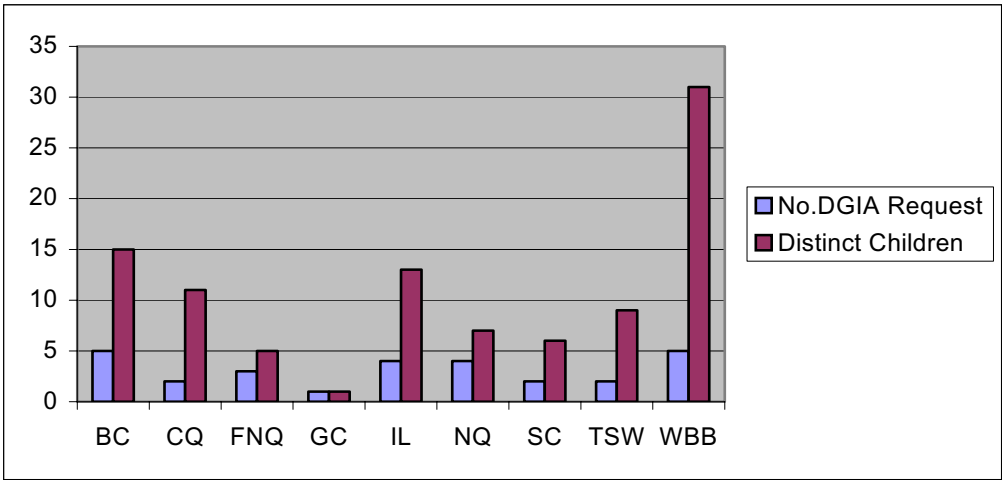


Table 11 Number of Immediate Action requests and number of distinct children by region June - December 2003

Region	Number of Immediate Action request (DGIA)	Distinct number of children
Brisbane City	5	15
Central Queensland	2	11
Far North Queensland	3	5
Gold Coast	1	1
Ipswich Logan	4	13
North Queensland	4	7
Sunshine Coast	2	6
Toowoomba South West	2	9
Wide Bay Burnett	5	31
Total	**28**	**98**

Source: Foster Carer Audit

An analysis of these matters was undertaken by the Audit Team with specific data collated. This included the foster carer type, the most serious harm type and foster carers' Aboriginal or Torres Strait Islander status. Other information provided in this analysis included foster carers' child protection history, persons responsible for the harm and frequently identified practice issues and trends.

The Audit Team identified some trends in relation to the 28 foster carer families subject to immediate action and these are outlined in the sections below.

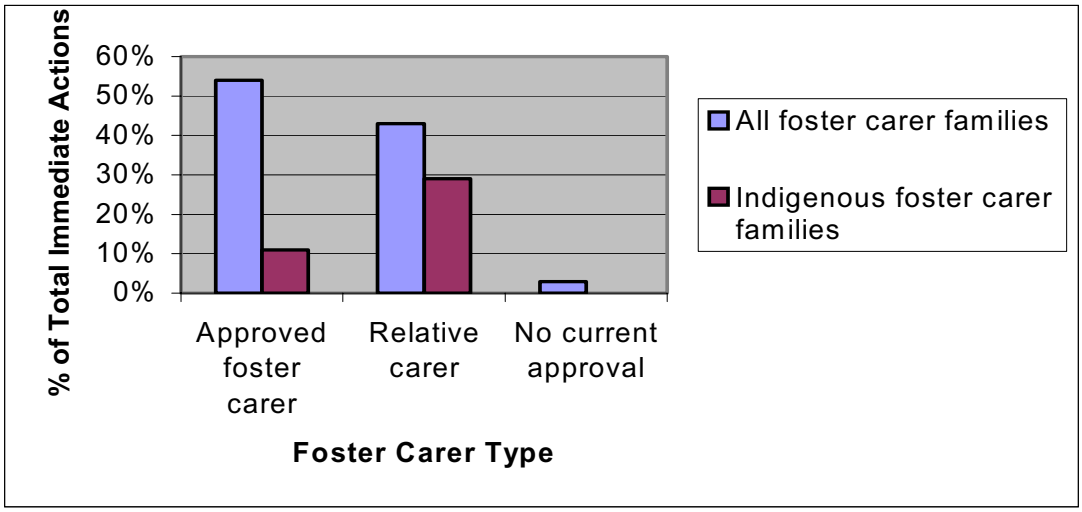
In general, DGIA requests related to the safety of children and young people placed with foster carers where there were:

- previous and/or current indicators of sexual abuse; or
- incidents or patterns of excessive or inappropriate physical discipline, often resulting in extensive bruising to foster children.

Foster carer type

Graph 4 illustrates the foster carer type for all DGIA matters by Indigenous status. In summary, non-Indigenous foster carers accounted for 61% of all immediate actions and Indigenous foster carers accounted for 39% of immediate actions. Audit findings show some serious child protection concerns relating to relative carers. Findings indicated a lack of monitoring and casework intervention for children and young people placed with relative carers, even following the completion of substantiated or substantiated risk initial assessments.

Graph 4 Foster carer type by Indigenous status

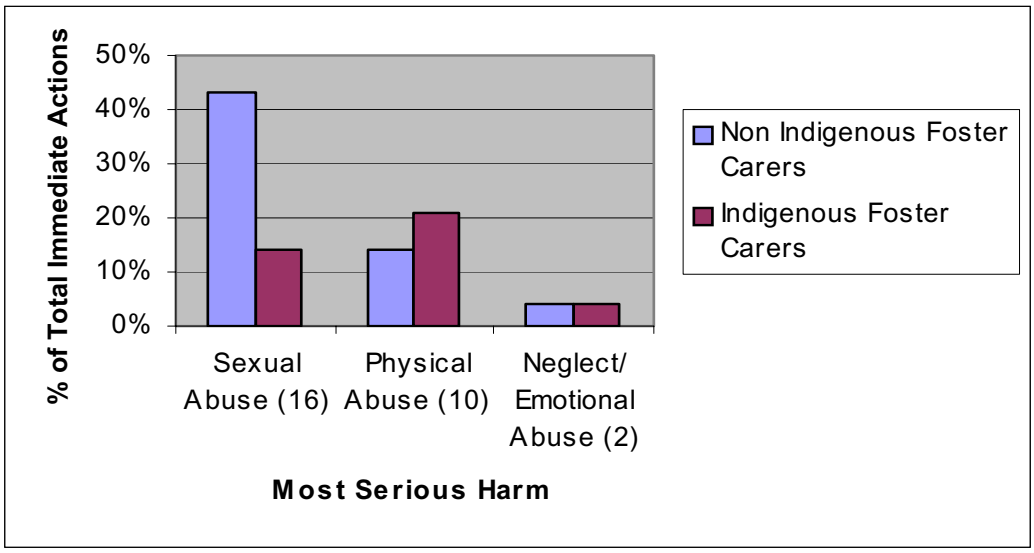


Source: Foster Carer Audit

Most serious harms

Graph 5 reflects the most serious harm constituting requests to area offices for immediate action. The graph does not incorporate secondary abuse types despite that in most cases, sexual and physical abuse involved elements of emotional abuse and/or neglect.

Graph 5 Immediate actions requested by most serious harm type by Indigenous status



Source: Foster Carer Audit

The Indigenous and non-Indigenous comparison within the 28 DGIA matters indicates that the child protection concerns of excessive or inappropriate physical discipline strategies in these matters more often related to Indigenous foster carers.

Foster carers' child protection history
The Audit findings showed that often times, the carers' child protection history demonstrated clear patterns of escalating concerns regarding the quality of care provided by foster carers, even where assessments have resulted in unsubstantiated outcomes. Further, in the majority of all cases audited, foster carers' history was not thoroughly considered and discussed with foster carers or assessed within the context of current child protection notifications.

Indigenous foster carers with child protection histories represented 32% of all immediate actions. Non-Indigenous foster carers with child protection history represented 18% of all Immediate Actions.

With respect to the following graph, the data confirm that child protection concerns consisting of previous and/or current indicators of sexual abuse were more likely to relate to non-Indigenous foster carers rather than Indigenous foster carers.

Persons responsible
The immediate actions relating to sexual abuse varied in nature with respect to the persons alleged responsible for the abuse. Foster carers were identified as persons responsible for the harm in 57% of DGIA matters, while 'other persons' were recorded as persons responsible for harm in the remaining 43% of cases of these the relationship to the foster carer was recorded as:

- 18% of DGIA matters involved foster carers' relatives
- 11% of DGIA matters involved foster carers' children
- 7% of DGIA matters involved other foster children.
- The remaining 7% of DGIA matters involved non relatives.

Practice issues and trends – DGIA matters relating to sexual abuse
The Audit Team identified a range of concerning practice issues and trends in relation to 16 of the DGIA actions involving allegations of sexual abuse.

Most of the requests for immediate action reflect inadequate and unacceptable levels of placement matching (with respect to children who have been sexually abused and children who have sexually abused other children), in that children and young people who have experienced sexual abuse are frequently placed in the same foster placement. Findings also showed that the subject children generally presented with extensive sexual abuse histories prior to their placement. In many cases, excessive numbers of children with sexual abuse backgrounds also resided in the one foster placement.

Audit findings specific to DGIA actions involving concerns of sexual abuse are further heightened by the more general audit findings, such as:

- in most cases there were significant delays in the commencement and completion of initial assessments associated with alternative care notifications;
- basic investigation and assessment processes were not attended to;
- departmental officers tended not to complete investigations and assessments based on police decisions not to charge persons alleged responsible; and
- overwhelmingly, assessments were not holistic (ie. significant contextual factors were not taken into account).

Audit findings reveal that in some cases, poor placement matching has resulted in:

- additional foster children being sexually abused by other foster children in placement;
- children initially removed from parents due to physical, emotional abuse or neglect, and sexually abused while living in foster care placements; and
- children being removed from current placements due to foster carers not receiving information (at the point of placement) about children's sexual abuse histories.

The following case example illustrates the above-mentioned findings.

Case example from the Audit

Jack and his sister, Jenny were taken into care when they were aged 12 months and 3 years old. They were assessed to be at continued risk of physical and emotional harm, due to their mother's alcohol dependency and a pattern of being left in the care of inappropriate adults. Jack and Jenny were placed (by the Department) with friends of the family. Approximately two years after his placement commenced, Jack was sexually assaulted by a 13 year old boy living in the same household. Approximately a year later, information was received alleging physical abuse of Jack and Jenny by their carer and sexual abuse of both children by an eighteen year old person living in the household. This matter was not investigated due to the person leaving the household. When Jenny was 13 years old, she was found to be pregnant as a result of sexual abuse by her carer. Subsequent to the children's removal from their placement, Jack also disclosed sexual abuse by his carer's relative. Jack is now 15 years old and is alleged to have abused a three year old girl, he has since been moved to another short term placement.

The Audit found that in some cases, little consideration was given to the possible causes of children's sexualised behaviours particularly where children's child protection history does not indicate sexual abuse. Further, where children were directly interviewed but made no disclosures about foster carers, they were generally not questioned as to whether anyone else had ever sexually abused them (eg. other people living in or visiting foster carers' households and the foster children).

In other cases a number of children and young people from different sibling groups have at different times, alleged sexual abuse relating to the same foster carers, however departmental officers have continued to place other children (including children with extensive sexual abuse histories) in these placements.

Case example from the Audit

In one immediate action there were recorded allegations of sexual abuse by a foster carer and the carer's own child. Multiple child protection notifications had been recorded and children from other sibling groups had made clear disclosures of sexual abuse. A subsequent decision was made and recorded that no further placements (for children of specified ages or gender) should occur, however since this decision was taken, additional male and female young people had been placed with the foster carers.

There was an apparent reluctance to believe that children and young people may have been sexually abused within foster care placements. (even in circumstances where clear disclosures were made by children), that necessitated immediate action.

Illustrations of this finding include the following comments:

- "unreliable disclosures";
- "lack of clarity about events and dates" (even where disclosures appeared consistent with children's developmental abilities, or when there have been substantial delays in the Department's commencement of initial assessments which could impact on the children's ability to recall the information);
- references to the 'promiscuous' behaviour of young people

Case example from the Audit

In one Immediate Action the subject child made consistent disclosures over time and appeared distressed when discussing the sexual abuse in the foster placement. However the outcome of the initial assessment was recorded as unsubstantiated. The initial assessment text states that the subject child disclosed to a departmental officer that they had "tried to tell people [about the abuse] but no one would listen until they told "Sam" about it".

With respect to relative carers the Audit often found an inability or unwillingness of foster carers to protect children from sexual abuse by other persons. In many of these cases there are indications that numerous adults are in contact with the foster children however limited information is known by the Department about these persons and their suitability to have contact or potential contact with children and young people placed in foster care.

General matters, findings and recommendations about sexual abuse are further discussed in 5.3 Identifying indicators of sexual abuse.

Practice issues and trends – Immediate Actions relating to physical abuse
The Audit Team identified a range of concerning practice issues and trends in relation to the 10 DGIA matters involving allegations of excessive and/or inappropriate physical discipline. Six of these DGIAs involved Indigenous foster carers, with the remaining four relating to non-Indigenous foster carers.

The following trends in practice were identified in relation to these requests for immediate action associated with physical abuse:

- limited assessments of harm and likely future harm;
- inadequate actions taken with respect to foster carers physically disciplining children and young people;
- limited monitoring and casework following substantiated initial assessment outcomes, particularly where children have received serious bruising as a result of foster carers' actions;
- the apparent inability or unwillingness of some foster carers to stop the use of excessive physical discipline for children and young people placed with them;
- a lack of police referral or action with respect to adults responsible for causing significant injuries to children; and
- a practice of departmental officers not completing investigations and assessments based on police decisions that no charges will be made.

Indigenous children and carers

The immediate actions involving children placed with Indigenous foster carers highlighted extensive concerns for the physical and emotional safety of children and young people already in need of protection. For example, of the six immediate actions regarding Indigenous carers and excessive physical abuse:

- there were three cases where children received extensive bruising as a direct result of physical abuse by foster carers, however, there was no record of referral to police;
- the foster carers consistently presented with significant child protection histories, with five of the immediate actions involving foster carers who had five or six previous notifications;
- concerns were frequently noted with respect to the foster carers' own children, other children in placement on an informal, family arrangement and children regularly left with persons considered unsuitable;
- in three cases domestic violence in foster carers' relationships or other family violence were identified as risk factors, and in some cases foster children were physically assaulted by extended family members;
- in three cases the foster carers would not work with the department and were aggressive in their dealings with departmental officers;
- two foster carer families consistently failed to keep the department informed of the foster children's whereabouts;
- concerns regarding excessive alcohol consumption were identified with respect to three of the immediate actions; and
- foster carers' new partners had not been assessed or approved by departmental officers (according to FamYJ) in two cases warranting immediate action.

The Audit frequently revealed limited recognised agency involvement in:

- the investigation and assessment of alternative care notifications;
- case work service delivery to children and foster carers; and
- the ongoing monitoring of care provided to Indigenous foster children.

The audit team was particularly alarmed by the extent and nature of concerns associated with immediate actions involving Indigenous children and young people. Based on audit findings these children and young people experienced significant, ongoing abuse and neglect while placed in foster care.

In these cases there appeared to be an over-reliance on other government or non-government agencies to provide casework services and monitor children in foster placements.

While it is recognised that in some circumstances (particularly for rural and remote communities) departmental officers are unable to provide appropriate levels of casework intervention and direct monitoring, there are strong indications that this reliance on other services tended to occur in the absence of coordinated case management by the Department.

Further, with respect to some Immediate Actions involving Indigenous children and young people, departmental case records refer to the 'political nature' of cases and conflict within Indigenous communities regarding placement decisions. It is considered possible that in such circumstances, departmental officers may be less likely to intervene to ensure the safety of children and young people placed with Indigenous foster carers.

4.4 Analysis of requests to Area Offices for reassessment of foster carers' approval status (CACA)

The 'carer reassessment' outcome of audited cases refers to circumstances where the Audit Team determined that the nature of concerns regarding a foster carer family called for the reassessment of the foster carers' approval status. Of the 30 requests for carer reassessments 27% of the requests also incorporated DGIAs.

An analysis of all requests for carer reassessments was undertaken by the Audit Team with specific data collated. This included the foster carer type, most serious harms, foster carers' child protection history and foster carers' Indigenous status.

The collated data identified some trends in relation to the 30 foster carer families subject to requests for carer reassessments and these are outlined in the sections below.

Foster Carer Type
Table 12 illustrates the foster carer type for all carer reassessments, and compares the total number of non Indigenous foster carers with Indigenous foster carers.

Table 12 Foster carer reassessment by foster carer type and Indigenous Status

Foster carer type	% of total carer reassessments	% of Total carer reassessments – non Indigenous foster carers	% of total carer reassessments – Indigenous foster carers
Approved foster carers	77%	64%	13%
Relative carers	17%	7%	10%
Limited approval carers	3%	3%	0%
No current approval	3%	3%	0%

Source: Foster Carer Audit

Case example from the Audit

The one foster carer family who had limited approval status for a period of four years (according to FamYJ) had provided placements to approximately 35 children and young people. The one foster carer family who had no current approval (according to FamYJ) had eight children in placement at the time of the request for a carer reassessment.

Most serious harms
Table 13 reflects the most serious harm constituting requests to area offices for carer reassessments by Indigenous status.

Table 13 Foster carer reassessments by most serious harm type by Indigenous status

Most serious harm	% of total carer reassessments	% of total carer reassessments – non Indigenous foster carers	% of total carer reassessments – Indigenous foster carers
Sexual abuse	43%	37%	7%
Physical abuse	50%	33%	17%
Neglect/emotional abuse	7%	7%	0%

Source: Foster Carer Audit

The above data shows similar trends to the findings within the requests for DGIAs. That is, carer reassessments for non-Indigenous foster carers are more likely to relate to concerns regarding sexual abuse issues, than for Indigenous foster carers. Similarly, carer reassessments for Indigenous foster carers are more likely to relate to concerns associated with physical abuse, than for non-Indigenous foster carers.

Foster carers' child protection history

Similar to DGIA findings, foster carers' child protection history are particularly relevant to the requests for carer reassessments.

Findings of the Audit reveal that of the 30 foster carer families subject to carer reassessments:

- 73% had child protection history as foster carers
- 7% had child protection history as carers and parents
- 20% had no recorded child protection history.

Non-Indigenous foster carers with a child protection history (as foster carers) accounted for 50% of all carer reassessments, whereas Indigenous foster carers with child protection history (as foster carers) accounted for 23% of all carer reassessments.

Table 14 outlines the number of previous child protection notifications relating to foster carers subject to carer reassessments.

Table 14 Foster carer reassessment by previous child protection notifications by Indigenous status

Number of previous notifications	% of total carer reassessments	% of total carer reassessments – non Indigenous foster carers	% of total carer reassessments – Indigenous foster carers
0	20%	20%	0%
1	23%	23%	0%
2	20%	10%	10%
3	10%	7%	3%
4	10%	7%	3%
5	7%	3.5%	3.5%
6	7%	3.5%	3.5%
7	0%	0%	0%
8	3%	3%	0%

The extent of previous child protection notifications relating to foster carers and the nature of matters requiring carer reassessment, indicate that inadequate attention is given to addressing and resolving ongoing child protection concerns relating to foster carers.

In conclusion, the combined findings of requests for immediate action and carer reassessment paint a disturbing picture with respect to the quality of care presently provided to children and young people in foster care, in particular to the 98 distinct subject children within the 28 DGIA matters. This presents implications for effectively implementing the Regulation of Care provisions of the *Child Protection Act 1999*, as they relate to ensuring the safety of children and young people requiring protection.

Chapter Five: Audit findings and reports - child protection notifications and Initial Assessments

5.1 Child protection notifications

Section 14 (1) of the *Child Protection Act 1999* states that "If the chief executive becomes aware (whether because of notification given to the chief executive or otherwise) of alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, the chief executive must immediately have an authorised officer investigate and assess the child's need of protection or take other action the chief executive considers appropriate". This section equally applies if the notification relates to a child or young person in alternative care.

If the concern is sufficiently serious, a child protection notification is recorded. Prior to 1 October 2003, it was departmental policy that an allegation of harm or risk of harm to a child or young person in alternative care was recorded as a child protection notification with an initial assessment response and a Priority Rating of 1 requiring commencement within 24 hours.

If the level of concern raised by the notifier in relation to a child or young person in alternative care is not considered to be serious, a "Matter of Concern" (previously known as a Standard of Care Issue) is recorded and addressed with the foster carer.

A total of 1,160 child protection notifications were reviewed as part of the audit process and 637 notifications came within the scope of the Terms of Reference of the Audit. The types of harm to children and young people recorded within the notifications fell within the categories of harm defined within the Act, that is sexual, physical, emotional and neglect. The Audit findings showed a range of harms to children, with very few notifications (five in total) where the Audit Team considered the allegations could have been more appropriately dealt with as a Standard of Care Issue or Matter of Concern. Apart from these, all notifications reviewed by the Audit Team were considered to be of a serious nature.

The following is a descriptive overview of the Audit findings concerning the information gathering and recording of child protection notifications.

Recording of child protection concerns

Total number of notifications reviewed by the Audit Team	1,060
Total number of notifications audited within the scope of the Audit	637

Table 15 Population of subject children by notified harm

Type of harm notified	Cases		No of distinct subject children	
	No	%	No	%
Sexual	226	18.0	201	23.0
Physical	465	37.0	366	41.0
Neglect	250	20.0	133	15.0
Emotional	276	22.0	167	19.0
Unknown	41	3.0	21	2.0

Total	**1258**	**100.0**	**888**	**100.0**

Source: Foster Carer Audit

For the purposes of the reporting on the notified harms recorded for the 888 distinct subject children, a hierarchy of the most serious harm type was used for those subject children that were included in more than one notification. The hierarchy is: sexual; physical; neglect; and emotional. Using this hierarchy, 201 (23%) of children had sexual harm notified, 366 (41%) of children had physical notified, 133 (15%) of children had neglect notified and 167 (19%) and 21 (2%) had an unknown harm type. It was not possible to identify the correct harm types for the 21 unknown types due to a range of system issues and inconsistencies found in the data provided. See Table 15.

Table 16 Child protection notifications recorded

Child protection concerns	Number	%
Number of child protection notifications audited	**637**	**100**
Notifications where other persons were alleged responsible for the harm (in addition to the foster carer)	**190**	**30**
Notifications where a clear statement of harm or risk of harm was provided	**506**	**79**
Notifications where the context for the harm or risk of harm was provided	**465**	**73**
The recorded harm category was consistent with the child protection concerns expressed	**555**	**87**

Source: Foster Carer Audit.

In 30% of notifications, 'other persons' were alleged responsible for the harm/risk of harm to the subject children. Of these, the relationship to the foster carers was recorded as:

- The foster carers' own child (47 or 25%);
- The foster carers' relative (53 or 28%);
- Other foster children in the home (41 or 21%).

Data indicate that the recording of child protection notifications generally provides a clear statement of harm or risk of harm to all subject children, and the context in which the harm or risk of harm occurred with respect to the subject children.

The selected 'notified harm' category was found to be consistent with the 'concerns expressed' in 87% of the notifications audited.

Contrary to departmental policy, 12 or 2% of audited notifications were responded to through the provision of Protective Advice to the notifier, that is, an investigation or assessment was not undertaken. Protective Advice is not an appropriate response to notifications on a child or young person in alternative care due to the Department's duty of care. Most of these matters were referred back to the area offices for either further action or amendment.

Subject children and young people

- The majority of notifications audited were made at the time that the subject children or young people were placed with the foster carers (88%). The remaining 12% were recorded subsequent to the time the subject children were placed with foster carers alleged responsible for the harm or risk of harm.

- There was an absence of recorded information as to whether consideration was given to recording other foster children and/or the foster carers' own children despite the notified concerns clearly indicating a level of harm or risk of harm to other children. As a result, often limited consideration was given to the protective needs of these children and young people during the assessment phase.

Table 17 Notification history on foster carers

Child protection (CP) history recorded on foster carers	No.	%
Notifications where foster carers have CP history as a foster carer	**251**	**39**
Notifications where foster carers have CP history as a parent	**34**	**5**
Notifications where foster carers have CP history as a foster carer and a parent	**31**	**5**
Notifications where foster carers had 1 - 2 previous notifications as foster carers	**215**	**34**
Notifications where foster carers had 3 or more previous notifications as foster carers	**61**	**10**

Source: Foster Carer Audit

85 (44%) of foster carers had previous child protection history (notifications and initial assessments) recorded on FamYJ or CPIS either as foster carers and/or parents. The number of previous notifications recorded per foster carer is significant:

- 215 (34%) foster carers presented with 1-2 previous notifications; and
- 61 (10%) foster carers presented with 3 or more previous notifications.

Generally, notifications did not record whether the foster carers were departmental carers or carers affiliated with licensed care services and regarding the latter, the specific services responsible for the carers.

The Relevant Persons Table (RPT) of the notification often recorded the details of one carer only, when further inquiries by the Audit Team revealed the foster carers were part of an approved couple and had dual approval. Further, there was a tendency to only consider or involve one foster carer in the investigation and assessment process.

The RPT frequently excluded the details of all other people residing in the foster carers' household at the time of the notification, particularly other foster children in placement and the carers' own children. While this information may not be known by the notifier, details of other children and young people placed with the foster carers is available to departmental officers on FamYJ.

Often, other people alleged responsible were not recorded in the RPT. This means that the child protection history of that person would not be entered into the notification by staff at CPIS who undertake the previous history checks. This could mean that a person's child protection history may not be known or considered as part of the assessment.

Recording

In many notifications, the notification category was incorrectly recorded as 'standard notification' rather than 'notified careprovider' or 'alternative care'. There appears to be a lack of understanding about the difference between 'standard' and 'alternative care'

notifications and limitations in knowledge of the recording requirements specific to alternative care notifications.
There was an absence of recorded information about the rationale for decisions taken.There was a lack of consistency in the recording of information about the foster carers' ability and willingness to protect notified children and young people from harm/likely future harm. There also appeared to be confusion about the recording of information related to 'sibling' sexual abuse.

In addition, 58 (9%) audited notifications had no Priority Rating assigned or recorded during the period of time that it was departmental policy to record a Priority Rating.

Table 18 Recording outcome of notifications

Recording of the notification was considered by the Audit Team to be:	No.	%
Comprehensive	**57**	**9**
Sufficient	**474**	**74**
Insufficient	**106**	**17**

Source: Foster Carer Audit

Overall, the Audit Team found that the recording of information within notifications while sufficient in 74% of notifications, was only considered to be comprehensive in 9% of notifications.

To be considered comprehensive, the recording of a notification included:

- all relevant information about the subject children;
- consideration of the risk to other children or young people living in the household;
- clear statements of alleged harm or risk of harm to all subject children;
- the context in which the harm or risk of harm occurred;
- information about other relevant people;
- information about the person alleged responsible;
- an initial assessment response;
- an appropriate Priority Rating;
- the rationale for any decisions made at the time the notification was received and recorded and
- inclusion of all relevant people in the relevant persons table including foster carers children and other children placed in the home.

Comprehensive information gathering at the point of intake and a sound assessment of all the information available to the officers is critical in determining the level of departmental response and the timeliness of that response. A failure to do this can have serious consequences for children and young people. The findings indicate that regularly, the intake officer did not ask sufficient information of the notifier or gather other relevant information.

While the Audit Team did not hold significant concerns in relation to the practice and recording of notifications, the audit revealed areas where improvement is required.

5.2 Initial assessments

In undertaking an initial assessment in response to a notification, officers need to find a balance in their approach. There are essential elements of an assessment that make it holistic and thorough to ensure the current and on-going safety of a child. Initial

assessments should be of an inquiry and forensic nature but also have a child protection assessment focus that works towards a therapeutic outcome for the child. Indeed, quite a lot is asked of an FSO in this regard.

The findings to date have highlighted a range of issues around practice, procedures and the recording of initial assessment information. Feedback of the Audit findings with regard to practice is considered important in assisting the professional development for area office staff.

The Audit has found that in a large number of initial assessments, many of the essential elements were missing. For example, subject children were not always sighted or interviewed, relevant people were not always contacted and often, limited contextual information was considered. Practice has tended not to include a risk assessment or consideration of protective factors. The Audit Team further found that sexual abuse risk factors were not well identified within investigations of concerns.

Below is a discussion of the Audit findings of the 570 initial assessments audited as part of Phase One of the Audit. It has been separated into various aspects of the initial assessment process for ease of discussion.

Table 19 Initial assessment commencement, completion and approval

Initial assessment commenced within	**No.**	**%**
24 hours	**204**	**36**
2 days	**32**	**5**
1 week	**89**	**16**
1 month	**132**	**23**
2 - 6 months	**101**	**18**
Over 6 months	**12**	**2**
Initial assessment completed within		
I month	**277**	**49**
1 - 3 month	**219**	**38**
4 - 6 months	**39**	**7**
6 - 12 months	**22**	**4**
over 12 months	**12**	**2**
Unknown	**1**	**-**
Initial assessments approved within		
I month	**36**	**6**
1 - 3 month	**263**	**46**
4 - 6 months	**134**	**23**
6 - 12 months	**78**	**14**
over 12 months	**38**	**7**
Unknown	**21**	**4**
Reason for delay documented (when not commenced within specified timeframes)		
Yes	**30**	**5**
No	**317**	**56**
Not applicable	**223**	**39**

Source: Foster Carer Audit

Delays in commencement, completion and approval

The Audit found that only 36% of the initial assessments were commenced within 24 hours. departmental policy between December 2001 and 30 September 2003 required notifications with respect to children in alternative care to be given a priority rating of 1 which requires commencement of the initial assessment within 24 hours. Given the Department's duty of care, it is considered that notifications on children in alternative care should always be assigned a high priority, regardless of existing policy. The Audit found that this was not always the case.

Departmental policy stated that between December 2001 and 30 September 2003 that an initial assessment must be completed and approved within 45 calendar days, however, only 299 (52%) of the initial assessments had been completed and approved within 3 months. The Audit found significant discrepancies between recorded and actual start dates as reflected in the assessment text and significant delays in the completion and approval of initial assessments.

The Audit found that in 317 (56%) initial assessments, where there were delays in the commencement of the initial assessment, the reasons for the delays were not recorded. This indicates that departmental officers were either unaware of relevant policy requirements, did not have the capacity to fulfil policy requirements or were not complying with procedures. There appears to be no consistent understanding of what actions constitute the 'commencement' of an initial assessment.

Of concern was the number of initial assessments approved by Team Leaders or Managers, despite the presence of significant recording inaccuracies and assessment deficiencies.

Table 20 Recognised agency involvement with initial assessments

Recognised agency involvement with identified Aboriginal or Torres Strait Islander children	No.	%
Yes	**92**	**61.0**
No	**59**	**39.0**
Aboriginal or Torres Strait Islander status not known (of 570 initial assessments)	**220**	**39.0**
Not applicable	**193**	**34.0**

Source: Foster Carer Audit

Recognised agency involvement with initial assessments involving Aboriginal and Torres Strait Islander children

The Aboriginal or Torres Strait Islander status of children often was not recorded or noted. Where children and notified foster carers were Aboriginal and Torres Strait Islander, there was often no record of whether recognised agencies were informed of the notification and it appeared that recognised agencies (where they are operational) are regularly not involved in the conduct of initial assessments. A critical lack of consultation with recognised agency staff regarding acceptable standards of care for children was apparent, along with a reluctance to take action because "at least" the children were in a culturally appropriate placement.

Recognised agency staff are regularly not involved in the actions taken subsequent to substantiated or substantiated risk outcomes. In many cases, Aboriginal and Torres Strait Islander children appeared to receive 'lower' standards of care within their placements, and both children and foster carers were frequently found to receive less support, monitoring and casework intervention.

Table 21 Initial assessment actions taken

All recorded subject children sighted	No.	%
Yes	**400**	**70.0**
No	**123**	**22.0**
Unknown	**47**	**8.0**
All recorded subject children interviewed		
Yes	**380**	**67.0**
No	**139**	**24.0**
Not applicable	**28**	**5.0**
Unknown	**23**	**4.0**
All relevant foster carers interviewed		
Yes	**410**	**72.0**
No	**141**	**25.0**
Unknown	**19**	**3.0**
Other relevant persons interviewed		
Yes	**72**	**13.0**
No	**108**	**19.0**
Not applicable	**372**	**65.0**
Unknown	**18**	**3.0**
Were Police involved where relevant		
Yes	**125**	**22.0**
No	**54**	**9.0**
Not applicable	**369**	**65.0**
Unknown	**22**	**4.0**
Was information gathered from other relevant people (to inform a holistic assessment)		
Yes	**181**	**32.0**
No	**316**	**55.0**
Not applicable	**45**	**8.0**
Unknown	**28**	**5.0**
Was the matter referred to the Police following the assessment if serious physical or sexual abuse		
Yes	**77**	**13.0**
No	**42**	**7.0**
Not applicable	**425**	**75.0**
Unknown	**26**	**5.0**

Source: Foster Carer Audit

Sighting and interviewing subject children and foster carers

The Audit data indicates that departmental officers are not undertaking basic investigation and assessment processes. In 170 (30%) initial assessments all subject children were either not sighted, or information recorded did not identify that they were sighted. Similarly in 162 (28%) initial assessments not all subject children were interviewed that should have been. There is no reason why a child in the Department's care, placed with foster carers, should not be able to be sighted and interviewed where appropriate. Failure to do so indicates that there are issues impacting on the performance of basic tasks in ensuring the safety of children.

In 160 (28%) initial assessments, there was a failure to interview all relevant carers, or record if this had occurred. The Audit found that often only one carer was interviewed and no attempt was made (or recorded) in relation to interviewing or speaking to the second

foster carer. In many cases it seemed that one foster carer was the 'prime' carer and all inquiries were directed to them, with little sighting or referral to the other partner. Most often this was the female of the family. This limits the ability of departmental officers to undertake a thorough assessment of the foster carers' ability and willingness to protect children from harm or likely future harm.

Case examples from the Audit

In many of the cases where there was an allegation of abuse by the male foster carer, the female partner was interviewed but the male was not interviewed. Often no reasons were given for not doing this or that the male was at work or not home at the time. In one case (this was a common response) the FSO took the word of the female that "he wouldn't do that". In another case, the worker was informed that "B" did not own a belt and therefore could not have belted the children.

Qualitative findings of the Audit have indicated departmental officers are likely to accept foster carers' assertions, often in the absence of contextual information or a holistic assessment, despite clear disclosures made by children. The foster carers views are also more often reflected in the text of the assessment document and in the outcomes recorded. In these cases departmental officers failed to proactively conduct further investigations and assessments, particularly by interviewing other relevant persons or agencies who could potentially provide significant information about notified concerns.

The Audit also found an apparent lack of consideration given to foster carers' child protection history in the investigation and assessment process. This includes notifications, initial assessments, previous Standards of Care Issues and current 'matters of concern'. This was particularly apparent where foster carers had one or more previous child protection notifications and there was a demonstrated pattern of (and often escalating) concerns, even though concerns had resulted in unsubstantiated outcomes.

The findings overwhelmingly indicated that where subject children deny or retract allegations of sexual abuse by foster carers (even where children initially provide direct disclosures to notifiers), departmental officers are quick to accept such denials or retractions as evidence the abuse has not occurred or that the child has lied. There appeared to be little consideration, exploration or understanding of the factors potentially leading children to retract or deny allegations.

In comparing available departmental data concerning investigating and assessing allegations of harm by natural parents and foster carers, the Audit has found that children are more likely to be believed when they disclose harm from their natural parents than when they make disclosures about foster carers.

Likewise, in 126 (22%) initial assessments 'other persons' alleged responsible for the harm or likely harm were not sighted or interviewed, or the information recorded does not identify that they were interviewed. There appears to be an incorrect assumption that if the person alleged responsible does not live in the carer's home, the Department is not responsible for interviewing them. It is also noted that at times, other persons were recorded as persons responsible for harm when they had not been spoken to (and were unaware of the allegations against them).

Holistic assessment
In 344 (60%) of initial assessments, information was not gathered from other relevant people prior to the finalising of initial assessments. The initial assessments audited frequently consisted of interviews only, and did not include (or record) critical information obtained from case files, children's caseworkers, other foster children in the placement, specialist alternative care workers, licensed care service staff, recognised agency staff and other relevant people. The absence of information gathering to inform holistic assessments was particularly evident in cases where the foster carers denied the notified concerns and subject children retracted allegations or made no disclosures upon interview. This could be a significant factor in the high rate of unsubstantiated outcomes recorded for initial assessments with respect to foster carers.

Police referral and involvement in initial assessments
The Audit found that in up to 76 (13%) of the initial assessments, no referral was made to the Police when appropriate. It would also appear that when a referral did occur and Police subsequently decided not to take further action due to lack of clear disclosures, medical evidence or children retracting allegations, there was a tendency for departmental officers not to conduct, complete or follow up on the assessment of notified concerns.

This highlights a lack of clarity around the specific roles of the Police versus the Department. There appears to be a false assumption by departmental officers that an absence of evidence or a decision that charges won't be laid, means there is no basis to notified concerns.

Table 22 Initial assessment – assessment and decision making process and outcomes

Significant contextual factors taken into account	No	%
Yes	**172**	**30**
No	**175**	**31**
Limited significant contextual factors taken into account	**223**	**39**
A subject children was left with foster carers, but considered at unacceptable risk		
Yes	**39**	**7**
No	**531**	**93**
Did each subject child have a assessment of harm identified and recorded		
Yes	**330**	**58**
No	**240**	**42**
Did each subject child have a assessment of future risk identified and recorded		
Yes	**247**	**43**
No	**323**	**57**
Initial assessment outcomes		
Substantiated	**191**	**34**
Substantiated risk	**83**	**14**
Unsubstantiated	**258**	**45**
Part assessment - no outcome possible (client reasons)	**17**	**3**
No assessment possible - client reasons	**6**	**1**
Unable to commence/complete (workload reasons)	**15**	**3**
Recorded outcome and assessment text consistent		
Yes	**394**	**69**
No	**176**	**31**
Recorded outcomes considered appropriate		
Yes	**331**	**58**
No	**239**	**42**
Other foster children's protective needs should have been, and were not, assessed.		
Yes	**195**	**34**
No	**138**	**24**
Not applicable	**237**	**42**

Source: Foster Carer Audit

Initial assessment and decision making process

With respect to assessment, judgement and decision making, the data indicate that assessments were not conducted in a holistic manner and significant contextual factors were not taken into account in 172 (30%) initial assessments, with a further 222 (39%) having only limited contextual information considered. It was found that initial assessments did not adequately take into account the current and ongoing suitability of foster carers with respect to their own situation, members of their household and the relatives or acquaintances who occasionally or regularly frequent the home.

There were 39 (7%) initial assessments where it was considered that children should have been removed before, during or following the assessment but were not.

The Audit found that departmental officers had a limited understanding of the concepts of harm and risk of harm. In 240 (42%) initial assessments, an assessment of harm was not

identified or recorded for all subject children. In 323 (57%) initial assessments an assessment of likely future harm was not identified or recorded for all subject children. This potentially results in initial assessment outcomes being incorrectly recorded as unsubstantiated.

This indicates a widespread lack of knowledge or understanding of what constitutes harm to children, the relationship between abuse and harm, risk and protective factors, the essential elements of a holistic and comprehensive investigation and assessment and initial assessment outcome categories.

Outcomes of the initial assessments

The Audit found that 274 (48%) initial assessments with respect to foster carers were substantiated. This is in contrast to the substantiated rate for all initial assessments in the year 2002-2003, which was 70%.

The substantiated risk outcome was consistently under-utilised. Departmental officers did not seem to understand they could substantiate risk due to the presence of risk factors (even though no identifiable harm had been experienced by a child). This was also apparent in cases where notified concerns and other information contained in case notes clearly demonstrated the presence of sexual abuse indicators or risk factors.

Thirty-eight (7%) initial assessments had an outcome of either "Part assessment – no outcome possible (client reasons)", "No assessment possible – client reasons" or "Unable to commence or complete (workload reasons). When assessments are not undertaken or completed children are potentially left at risk of harm or significant harm. This is not acceptable, particularly for children in care of the state.

In many cases the selected outcome of the initial assessment did not reflect the content of the recorded assessment text. As a consequence, the outcomes recorded were not considered appropriate for each subject child in 239 (42%) initial assessments. The recording of an unsubstantiated outcome that should have been substantiated or substantiated risk is particularly concerning. As previously stated, unsubstantiated outcomes were frequently recorded in the absence of gathering and considering information from other relevant sources.

Based on the notified concerns, the protective needs of other foster children were not assessed in 195 (34%) of initial assessments. In these cases, the other children should have also been included as subject children.

Type of harm substantiated

Table 23 Population of distinct subject children with a recorded outcome of substantiated or substantiated harm

Type of harm for initial assessments with a substantiated or substantiated risk outcome	No of distinct subject children	
	No	%
Sexual	64	14.0
Physical	223	49.0
Neglect	87	19.0
Emotional	83	18.0
Total	**457**	**100.0**

Source: Foster Carer Audit

For the purposes of the reporting on the substantiated harms recorded for the 457 distinct children, a hierarchy of the most serious harm type was used for those subject children that were included in more than one initial assessment. The hierarchy is: sexual; physical; neglect; and emotional. Using this hierarchy, 64 (14%) children had an outcome of sexual, 223 (49%) children had physical harms notified, 87 (19%) children had neglect notified and 83 (18%) had emotional harm recorded.

The type of harm substantiated following allegations of sexual abuse ranged from inappropriate comments and touching to rape. There were several young women who became pregnant as a result of rape by the male foster carer.

Table 24 Initial assessment actions taken and audit outcome

Following a substantiated or substantiated risk outcome, was the action taken with respect to the subject child/ren considered appropriate?	**No.**	**%**
Yes	**179**	**65**
No	**41**	**15**
Unknown	**54**	**20**
Following a substantiated or substantiated risk outcome, was the action taken with respect to the foster carer/s considered appropriate?		
Yes	**118**	**43**
No	**59**	**22**
Unknown	**97**	**35**
The assessment of the child protection concerns were considered by the Audit Team to be		
Comprehensive	**36**	**6**
Adequate	**212**	**37**
Inadequate	**322**	**57**

Source: Foster Carer Audit

For initial assessments with a substantiated or substantiated risk outcome, the actions taken with respect to the children were considered by the Audit Team to be appropriate in only 179 (65%) cases. The actions taken with respect to the foster carers were considered to be appropriate in only 118 (43%) cases.

The Audit found the assessment of child protection concerns to be inadequate in 322 (57%) initial assessments, adequate in 212 (37%) initial assessments and comprehensive in only 36 (6%) initial assessments. This data are alarming and reflect poorly on existing levels of departmental action with regard to the children for which the Department has custody and guardianship.

5.3 Identifying sexual abuse indicators

As the Audit progressed, it became apparent that there was a low level of understanding of the dynamics of sexual abuse by workers undertaking initial assessments involving foster carers. This was evidenced by a lack of action taken when there were clear indicators of sexual abuse recorded and/or clear disclosures made by a child. Often, information recorded about incidences of sexual abuse and inappropriate boundaries between the carer or person alleged responsible and the subject child was not followed up by a professional assessment of the harm or risk of future harm to the child, or actions to ensure the child's safety.

Of the 457 distinct subject children included in the Audit, 64 (14%) had an outcome of substantiated or substantiated risk of sexual abuse recorded. In many of these cases, follow up action or monitoring did not occur, even when planned.

At present FSO training contains only a brief discussion around sexual abuse indicators and FSOs may not attend this training for some months after employment, or for up to two or more years. While attempts have been made to reduce the waiting time for attendance at FSO training, the level of training regarding sexual abuse is clearly not sufficient to ensure workers have the knowledge and frameworks to protect children from this abuse or the resulting harm.

It is imperative that staff responsible for placing children with foster carers and for assessing their needs are well skilled in risk assessment and sexual abuse dynamics, or else the Department risks exacerbating the abuse of the children in its care.

Because the effects of sexual abuse are potentially so devastating for children, child protection workers should attend training that provides them with a comprehensive overview of the dynamics of sexual abuse and be able to demonstrate their understanding of it, prior to undertaking assessments.

The current ICARE training should remain as one part of a professional development strategy for workers and additional training should be available for staff who wish to specialise further in this area.

Additionally, foster carers must be provided with sufficient training to allow them to adequately meet the needs of the children in their care. The level of training now provided to carers is not considered sufficient. Initial training should be followed up by ongoing training opportunities. It is also recognised that foster carers may require additional support from departmental workers to ensure foster carers are able to identify risk and protective factors. They may also require assistance with practical strategies to manage highly sexualised behaviours so that other children in the placement are not harmed.

Additionally, the Department needs to improve the assessments for carers to ensure their suitability to care for children who have experienced sexual abuse. The initial approval and renewal of process provide a prime opportunity to gather sufficient information in terms of vetting potential foster carers who may pose a threat to children. It is considered, in light of the material audited, that “erring on the side of caution” when approving potential foster carers is necessary. Consideration should be given to making sexual abuse placements’ a specialist skill and providing additional training to particular foster carers who are approved to provide this care.

Limiting the number of children with sexual abuse issues placed together would also reduce the incidence of sexual abuse between children in care.

At present there is a lack of therapeutic intervention programs available, particularly for young offenders. The funding of therapeutic intervention programs and sexual abuse prevention programs would assist in working with victims and potential victims. There is a lack of inter-agency protocols with respect to child abuse assessment and intervention. The establishment of protocols could particularly assist workers in rural and remote areas to deal with sexual abuse matters more effectively.

Consultation with the Sexual Abuse Counselling Service (SACS) occurred as part of the Audit. At present, SACS is not placed to meet the needs of all departmental clients in addressing sexual abuse matters, given it has one location in Brisbane. Feedback from the consultation process identified a number of levels required to address and strengthen services for sexually abused children. Most importantly the need for workers to be trained, supervised and mentored in sexual abuse dynamics so they can undertake holistic, needs led assessments for children was highlighted.

Future provision of funding for, and any expansion of the role of SACS, should focus on increasing the number of locations and accessibility to the services it provides, particularly in remote and rural areas.

5.4 Specialist unit for assessment of notifications concerning foster carers

The Audit findings have highlighted a range of practice issues with respect to investigating and assessing allegations of harm to children and young people in foster care placements. Further that in 239 (42%) cases, the Audit Team did not agree with the outcome of the initial assessment, with children left in placements where there were documented unacceptable levels of risk.

In particular, the Audit Team identified that there clearly is a lack of quality placements for children and young people who are not able to safely stay at home with their natural parents. This has presented a dilemma for FSOs if they consider a child may not be safe in their current foster carer placement, simply where else could they go? Some initial assessments have recorded reasons for staying in a placement when the level of harm or risk of harm has been recorded as unacceptable.

Within the text of some other assessments, it is documented that the child's allegations of harm are not believed or disregarded as the foster carers are well known to the FSO, have taken many placements in the past, in particular children with very challenging behaviour who are hard to place. The dual relationship of the FSO as advocate for the child and supporter to the foster carer, relies heavily on ensuring foster carers continue to provide placements for children and young people. This may present a conflict of interest for the FSO when they are investigating the allegations of abuse.

Foster carers may feel betrayed by the alternative care worker who is involved in the investigation and assessment process, due to their lack of understanding of the different requirement of this role. Similarly, children may feel betrayed by their case worker if they are involved in the investigation and assessment process and the child is not believed.

The Audit concurs with the findings of the Standards of Care Working group report (2000), which asserts that there are critical shortcomings in the investigation procedures and practices that have had an adverse affect on children in alternative care and on foster families.

Review of relevant literature, including the Department’s report of the Standards of Care Working group (2000), indicates support for the separation of the investigation and assessment role from the foster carer support or caseworker role. This is due to the differences between familial and state care, the dynamics of abuse and harm in alternative care and a potential conflict of interest for an area office who may have recruited and trained the foster carers. The area office is also likely to have selected the foster placement and may not wish to disrupt the child’s placement.

In light of the findings of the Audit, it is considered that there is a need for a specialist unit to assist departmental staff in the assessment of notifications with respect to foster carers. Further information regarding the possible role and responsibility of such a unit is provided in this report.

5.5 Policy gaps with respect to investigations and assessment of notifications involving foster carers

Planning and assessing
The Department has no policy or procedures specific to planning investigations and assessments associated with notified children and young people in foster care.

Policy should specify planning requirements for investigations with respect to notified foster carers, which would include a requirement to review foster carers' files for previous concerns not constituting child protection notifications and gathering relevant information from licensed care service and recognised agency staff.

The Department does not have policy or procedures to support and achieve consistent practice with regard to the following legislative requirements:

- the referral of allegations involving the possible commission of a criminal offence to Police; and
- making decisions about Aboriginal and Torres Strait Islander children only after consultation with the recognised agency for the child or alternatively, consulting as soon as practicable after making the decision (where child safety/urgency prevents consultation prior to actions being taken).

The Department has two policies and procedures outlining investigation and assessment processes with respect to notified foster carers:

- Child Protection Notification Response – Initial Assessment, and
- Responding to Matters of Concern Raised in Relation to the Standards of Care Provided to Children and Young People in Alternative Care (effective from 1 October 2003).

Prior to October 2003, the 'Standards of Care Issues and Notifications of harm for Children and Young People in Alternative Care' policy applied to departmental practice (instead of the current 'matters of concern' policy). This policy was effective between (01/12/01 and 30/09/03).

The 'Child protection notification response – initial assessment' policy currently requires departmental officers to make a judgement about the child's current level of safety, including making sufficient inquiries (within 24 hours) to determine the child's safety and determine the appropriate priority rating. In addition departmental workers must gather information about the children, the parents, the family environment and the alleged harms, following interviews and other assessment actions.

In responding to matters of concern current policy requires departmental officers to always have contact with, and interview, children or young people when conducting initial assessments involving notified foster carers. Departmental officers are also required to assess the protective needs of other children or young people residing in the same alternative care placement as notified subject children and advise parents of the receipt of a notification requiring investigation and inform them of the assessment outcome.

Previous policy required departmental officers to automatically categorise notifications involving foster carers as a Priority Rating 1, requiring commencement within 24 hours. This policy was rescinded as of 1 October 2003.

5.6 Rural and remote issues

The data and qualitative findings of the Audit has revealed various patterns or trends associated within area offices located in rural and remote areas (particularly those responsible for Indigenous communities), including:

- delays in commencing initial assessments (eg. some rural and remote staff only visit isolated and/or Indigenous communities once every six to eight weeks);
- a significant reliance on other persons or services to complete certain aspects of initial assessments;
- a significant reliance on other persons or services to deliver casework services, to monitor children and the quality of care received while in placement, and to support foster carers; and
- an apparent lack of active or consistent case management and review of children and foster carers generally serviced and supported by other persons and services.

5.7 Following a substantiated or substantiated risk outcome

The Audit has identified gaps in practice and policy with respect to intervention after there has been a substantiated or substantiated risk outcome for children and young people in foster care.

The current policy 'Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care', requires departmental officers to review the appropriateness of the placement to meet the children's needs, with issues specific to children and young people included in their case plans. It is also a requirement to conduct updated Placement Meetings with foster carers to clarify case planning goals and to review and decide carers' support and training needs specific to children and young people. The Foster Carer Agreement can be updated, and certificates of Approval amended, suspend or cancelled in accordance with the requirements of the act. However, these responses were rarely document in initial assessments or follow up case notes.

Foster carer agreements
A related policy, 'Foster Carer Agreement's, requires the Department to develop and regularly review Foster Carer Agreements with each Approved Foster Carer. Foster Carer Agreements incorporate (among other matters) general training and supports required by, or to be provided to the foster carer, to ensure the quality of care provided to children and young people is consistent with legislated standards.

The policy currently requires that Foster Carer Agreements be 'undertaken at least every twelve months and may also be reviewed' in specified circumstances, including for example, when there are significant changes in the foster carer's circumstances (eg. death, divorce, new adult partner/relationship) or following a substantiated initial assessment outcome.

There is a need for a standardised Foster Carer Agreement proforma to ensure consistency and effectiveness with respect to the nature and use of agreements negotiated with approved foster carers, and a demonstrated need to negotiate and regularly review Foster Carer Agreements with Relative Carers and Limited Approval Carers.

5.8 Use of corporal punishment and behaviour management strategies

The Audit Team identified various trends and concerns commonly associated with foster carers' use of corporal punishment and other behaviour management strategies that are prohibited by the *Child Protection Act 1999.* The Audit found that in some instances the excessive physical punishment of children should have been referred to the police but was not referred.

Section 122, Statement of Standards, currently requires the chief executive to take reasonable steps to ensure that children who are placed in the care of an Approved Foster Carer, licensed care service or departmental care services are cared for in a way that meets the legislated standards (Statement of Standards), including:

- 'the child will receive positive guidance when necessary to help him or her to change inappropriate behaviour'; and
- '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'.

Legislative provisions associated with the Statement of Standards do not specifically apply to Relative Carers or Limited Approval Carers, however the Department has made a policy decision that the same standards will apply to children placed with these carers.

Foster carers are not presently required to sign a formal 'contract' with the department (with respect to their compliance with behaviour management provisions, or for that matter the Statement of Standards). However, for Approved Foster Carers, the 'contract' is implicit in the granting of their Certificate of Approval. Relative Carers and Limited Approval Carers are advised (by departmental officers) of the Department's requirements associated with the Statement of Standards.

The Department does not currently have policy or procedures specific to prohibited behaviour management techniques and there are no consistent requirements regarding the Department's response to foster carers who directly contravene legislative and policy requirements.

The 'Sharing the Care' foster carer training (generally attended by Approved Foster Carer applicants only) and the recently drafted update of this training, both inform foster carer applicants of legislative requirements associated with behaviour management techniques. This training however only provides limited advice or skills-based education in relation to alternative, acceptable discipline strategies. Relative Carers and Limited Approval Carers are not required to attend any training prior to, or following, their approval as foster carers.

The following issues and trends were frequently identified in the Audit in relation to foster carers' use of inappropriate or excessive behaviour management: These issues and trends are not exceptions but were commonly identified as:

- consistent use of corporal punishment, in many cases involving the use of belts, sticks, wooden spoons or shoes.
- children are punished or humiliated for wetting their beds
- children are not fed as punishment, or are punished for stealing food
- children and young people being hit on their bodies, faces and heads.
- the inappropriate or excessive implementation of 'time out' strategies, including:

  - requiring children to remain in 'time out' for excessive time frames (for example periods for more than an hour).
  - choosing 'time out' places that are likely to frighten children (for example, dark rooms with doors closed, outside or under the house.
  - being made to hold hands on heads or walls of rooms for the lengthy periods of 'time out'.
- the use of tobasco or chilli sauce on children's tongues, in response to swearing.
- disciplining foster children with respect to matters or behaviours for which the foster carers' own children are not disciplined.

Examples of Information taken from initial assessment texts

- *the children were like animals when they arrived and the only effective way to keep the them safe while in the car was to carry the strap in the car and threaten to smack them*

- *the foster carer did punch him in the face because he threw a tantrum although she did not punch him often*

- *she would be hit on the head with the hairbrush for refusing to have her hair brushed*

- *the children had their faces pushed into their urine soaked sheets for wetting their bed*

- *he was made to stand in a corner until he told the foster carer everything his father said*

- *he was made to stand with his face to the wall and did not move until the foster carer said so*

- *his hands were sore when they were on the bedroom wall but he didn't let go because he was scared*

- *chilli was used but only after lots of warnings and when other strategies didn't work*

- *if chores aren't finished by a certain time he gets time out and has to stand in the corner with his hands on his head for an hour*

- *if they did not do what was expected of them they were made to sit on the front stairs of the house until it was dark*

- *the child was hit as a last resort, as nothing else had worked*

- *the child was given a choice of punishment options and she chose being smacked*

Information was also recorded in initial assessments about the differential treatment or emotionally hurtful treatment of the foster children, to which carer's own children would not be subjected, or using food as a punishment.

Examples of Information taken from initial assessment texts

- *The boys had bruises on their legs and they said that the foster carer had hit them for "stealing" food from the fridge and hiding it in their beds. (The boys were neglected and starved by their parents before they moved to this placement).*

- *He said that when they went out, the carer's own children would get pizza but he was given something else to eat when they went home.*

- *The carers' own children were given hamburgers and chips and the carer took vegemite sandwiches for her to have at the restaurant.*

- *The carer stood on the boy's present that he had made for his mother for mother's day as punishment for breaking something that belonged to the carer's own child.*

- *When the children were picked up by the FSO to move to a new placement they had a grocery plastic bag each with all of their belongings. After a number of years with the carers that was all they had.*

Recommendations concerning investigating and assessing child protection notifications relating to foster carers and responses to outcomes

4. The recording of child protection notifications

It is recommended that the Department:

- amend FSO training to include information on specific procedures and recording requirements associated with notifications involving foster carers;

- amend policy to require that all children and young people placed with foster carers are recorded as subject children, irrespective of the nature of the notified concerns;

- the current *Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care* policy is amended to reinstate the 24 hour commencement time frame for all notifications relating to children and young people in alternative care.

5. Initial assessments

It is recommended that the Department:

- develop a comprehensive training package that includes quality assurance tools such as check lists for Team Leaders and other staff responsible for the approval of Initial Assessments, as a matter of priority, to improve the assessment of notifications and the recording of initial assessments. This training is to be available on a regular basis to departmental officers.

- develop and implement training for all FSOs in relation to investigating and assessing of notifications involving foster carers with particular emphasis on risk assessments and the concepts of future harm.

6. Central specialist unit for assessment of notifications with respect to foster care

It is recommended that a central specialist unit be established (possibly within the Operations Directorate) with staff to:

- provide advice, training and support to specialist departmental officers in each region who will be responsible for the recruitment, assessment, approval and re approval of foster carers and the management of matters of concern.

- develop systems to oversight all aspects of the management of matters of concern, including the investigation and assessment of notifications with respect to foster carer. This will require the development of a database for the collation of data and the formulating of protocols;

- provide assistance (in the form of advice) in relation to the development of action plans after there has been a substantiated or substantiated risk outcome;

- analyse data, monitor and report on trends relating to matters of concern. This is to involve the ongoing use of the Foster Carer Audit database.

The role of the Unit would be to improve current practice to ensure its objectivity and focus on best practice. It is important that Unit staff are not involved in day to day casework matters.

7. Policy regarding investigating and assessing notifications on foster carers

It is recommended that:

- the Child Protection Procedures Manual is updated and re-implemented as a critical tool for FSOs undertaking the broad range and complex requirements of child protection work. It should include chapters specific to the regulation of care and monitoring. The Manual should also set out the role of the FSO, who has casework responsibility for the case and foster carers, in the investigation and assessment, to ensure that there is no conflict of interest in the investigation process.

- the investigation and assessment of child protection notifications involving foster carers be conducted in liaison with the recommended special investigation unit;

- the Department amend its *Child protection notification response – initial assessment* policy to include factors specific to formulating assessments in circumstances involving notified foster carers;

- all foster carers in the household are included in the investigation and assessment process, with all reasonable attempts made to interview and include other persons alleged responsible for harm/risk of harm;
- investigation and assessment requirements are clearly specified in relation to decisions about:
    - children or notified foster carers who are Indigenous,
    - the involvement of Police and the outcomes of their investigations,
- the development of a training module specific to the investigation and assessment of alternative care notifications that must be attended by departmental officers responsible for such investigations and assessments;
- the Department implement formal monitoring and evaluation processes to ensure compliance with investigation and assessment processes.

8. Identifying sexual abuse indicators

It is recommended that:

- all departmental officers attend training prior to undertaking assessments that provides a comprehensive overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it;
- all foster carers are required to attend training that provides a sufficient overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it, prior to their initial approval;
- all foster carers are provided with appropriate information at the time of placement outlining any sexual abuse history or issues for the child;
- there are limits placed on the number of children with a sexual abuse history that can be placed together. Consideration should be given to restricting the placement of children with a sexual abuse history together with children who do not have a history of sexual abuse;
- foster carers are supported and provided with strategies for their family to be able to respond appropriately to children who have been sexually abused.

9. Responding to substantiated or substantiated risk outcomes of notifications concerning foster carers

It is recommended that the Department develop policy and procedures specific to:

- the purpose and requirements of intervention with children and young people following substantiated and substantiated risk outcomes, including support, access to therapy and the updating of case plans and case decisions. Policy and procedures are to include

provision of support for children and young people when they are moved to a new placement.

- the purpose and requirements of intervention with notified foster carers following substantiated and substantiated risk outcomes, including consideration of the removal of children and young people and the suitability of individuals approved to care for children and young people;

- review of Foster Carer Agreements following every substantiated or substantiated risk initial assessment outcome in relation to foster carers; and/or other persons responsible for harm where these persons are related to, or in regular contact with foster carers;

- training modules specific to the purpose and nature of intervention following substantiated or substantiated risk outcomes, including relevant policies and procedures, that must be attended by departmental officers; and shared family care service staff;

- The Department must implement formal monitoring and evaluation processes to ensure compliance and related policies and procedures.

10. Appropriate management of the behaviour of children and young people in foster care

It is recommended that the Department:

- give urgent attention to developing 'best practice' standards and indicators associated with the legislated Statement of Standards;

- develop an advanced training module that incorporates appropriate discipline and behaviour management strategies, that must be attended by foster carers, departmental officers and shared family care staff;

- prioritise the implementation of a clear policy framework for responding to foster carers who contravene legislated standards;

- automatically include (as conditions of all Certificates of Approval) the requirement that foster carers provide care in a manner consistent with the Statement of Standards; and do not use corporal punishment or techniques that humiliate, frighten or threaten children in ways that are likely to cause emotional harm;

- amend the legislation with respect to relative carers and limited approval carers so that they are subject to the same regulation and monitoring as approved foster carers, that would similarly enable the provision of conditional Certificates of Approval.

Chapter Six: Towards child-focussed practice

6.1 Listening to children and young people and their participation in decision making

One of the most clear and apparent findings of the audit, was that practice is not child-focussed. That is, ensuring their safety in foster care, listening to children, focussing on their needs and best interests and enabling them to participate in decision making that affects them. This is not to say that attention should not be focussed on the family particularly when initiatives and practice is aimed towards prevention. However, when a child or young person is harmed, the focus must be on the child. That is, what are their immediate and future safety needs?

It is of concern that in 30% of cases audited, not all subject children were sighted or it was not recorded whether they were sighted during the assessment of allegations of harm. Further, about 28% of subject children were not interviewed. The Audit Team found that children when interviewed were often not believed.

In the majority of initial assessments, the Audit Team found that the views of the foster carer were recorded but very little information was recorded about sighting the child, interviewing the child and listening to their views. In the many of cases the expressed views of children and young people were not recorded. Information was recorded about the process of conducting the assessment of the notifications and attention was paid to the adults involved, however support for the child and their needs were not the focus.

The CREATE Foundation provided information to the CMC public hearings that the most significant barrier when reporting abuse experienced by children and young people in care, is finding someone who will firstly believe them and then second, take the matter seriously enough to act.

PeakCare Queensland and Foster Care Queensland also echoed these sentiments in their submissions to the CMC. PeakCare considered that the extent to which children and young people are given a voice and are heard is a measure of the quality of the care system and its capacity to effectively protect and support them.

Children in care settings are so vulnerable after having experienced significant harm from their families. It is common for children not to disclose abuse in fear of retribution or that they will not be believed. Some children retract their disclosures in fear that they may be moved from their placement as a result of disclosures or that they will be punished by their foster carers for disclosing. Some children compare the abuse and consider it “not as bad as they received at home”, or “they deserved the physical punishment as they were behaving badly at the time” or “it didn’t really hurt that much and I know that they love me”. (Documented statements from children recorded in initial assessments).

The Child Protection Act 1999 sets out a Charter of Rights for a Child in Care (Schedule 1) and it clearly articulates that a child has a right to be provided with a safe and stable living environment, to be placed in care that best meets the child's needs, and that the child is to be consulted about, and to take part in making decisions affecting the child's life. The CREATE Foundation reports that the Department does not have the resources and time to enable children and young people to participate in decision making and for there to be regular contact with workers throughout the case work.

In July 2003 the CREATE Foundation undertook a consultation with young people and provided this information to the Department for its report, "Stopping the Drift". In the report, young people expressed their knowledge and experiences of being in care and key issues that are important to them about decision making and long term care. They talked about what stability meant to them and their attachments to family, carers, friends and their communities. The young people were clearly concerned about how decisions were made about their lives without their involvement in this process.

Young people stated the following with respect to what stability means to them and why it is important:

…Belonging to something, somewhere where you are loved, feel safe and accepted.

…Knowing where you are going to be living and knowing that you will be safe there.

…So you can feel normal, have a happy life.

…Stability helps you stay out of trouble, have better grades and feel less anxiety so you are less likely to want to commit suicide.

What needs to happen for you to have stability?

…Regular contact with your FSO.

…Better training for foster carers so they can learn to deal with difficult situations and don't just get rid of you when things get tough.

…Foster kids need to be treated as part of the family and treated the same as foster parents' kids.

…Kids need to be consulted with and believed.

The Queensland Government's Submission to the CMC (2003) stated that it is evident that children in foster care need to participate in decisions about their lives and acknowledged that the CREATE Foundation is currently funded to provide systems advocacy for children and young people in care.

6.2 Working effectively with Aboriginal and Torres Strait Islander children, young people, families and communities

High levels of poverty and community dysfunction in isolated communities have been found within information recorded in initial assessments, and this has contributed to the abuse and neglect of children in foster care. The level of violence and alcohol abuse was higher for Indigenous children and young people in the Audited notifications. These matters have limited the availability of alternative care options for children in or near their communities. Uncertainty about the most appropriate and effective models of service delivery to support Indigenous families and alternative care providers is evident in the Audit findings.

The matters concerning practice and recording with respect to Indigenous children and young people are dealt with further in the Report in other sections.

6.3 Lack of contact with children and young people in alternative care

Overwhelmingly the Audit process revealed, through a review of individual children's electronic case files, that either home visits are not occurring regularly or the recording on the child's electronic case file does not accurately reflect the case activity. Anecdotal evidence would support the former. Many cases audited showed a significant lack of direct contact between the FSO and the child. In extreme cases only one or two home visits were recorded over the period of time subject to the Audit (seven years).

Home visits are a critical factor in the prevention of harm to children and young people placed in alternative care. Home visits should occur regularly even when the FSO sees the child or young person in other circumstances such as supervising contact visits.

Routine visits to the child or young person at the foster carers' home ensures that the child is sighted, their presence in the home is noted, their safety is assured and their progress and ongoing needs are identified. Also,

- The FSO has the opportunity to talk confidentially with the child independent to the foster carer to allow the child to talk freely with the FSO.
- The FSO is able to observe the interaction between the child and their foster carer.
- The child's environment is observed including their sleeping arrangements, clothes, toys and other personal belongings.
- The FSO is able to monitor the standards of care as outlined in s122 Statement of Standards.
- The FSO becomes fully aware of the child's situation and their physical, emotional, cultural, educational and safety needs so they can advocate on behalf of the child.
- The foster carer has the opportunity to raise concerns with the FSO regarding the child their support needs or difficulties they may be experiencing and
- The FSO has the opportunity to observe the foster carer in their own environment home, assess their level of stress and support needs.

The other critical function of regular home visits is to monitor the presence of risk indicators or 'red flags' that may be a precursor to harm or risk of harm to children in alternative care. McFadden (1984) identifies a range of risk indicators including:

- A foster carer's reluctance to allow the FSO to visit or to have contact with the child independent to the foster carer.
- Medical appointments for the child are postponed or not kept.
- A foster carer's own children 'acting out'.
- Significant changes within the home situation.
- One family member over-involved with the foster child.
- A child unfavourably compared to other children in the home.
- The relationship with the child is the primary focus of adults in the home rather than with the other adult foster carer.
- A change in appearance of the home.
- Sudden or unusual over-concern with reimbursement.
- The child clings to the FSO on a home visit.

The Department's draft policy *Monitoring the care provided to children under the custody or guardianship of the chief executive,* outlines the minimum requirements for direct contact between departmental staff and the child. The FSO with case responsibility must meet with a child or young person:

- Subject to short-term child protection orders on a three monthly minimum basis: and
- Subject to long term child protection orders, on a six monthly minimum basis.

This policy is clearly inadequate in light of the findings of the Audit. Harm or risk of harm to children and young people in alternative care can be reduced and prevented if FSOs are having regular and meaningful contact with children and young people and their foster carers.

6.4 Case planning and case management

The Audit process has highlighted a lack of case planning and case management for children and young people. A review of individual children's electronic case files reveals limited recording of case discussion meetings, family meeting and placement meetings. The lack of documentation of these meetings suggests that these meetings are not occurring or case planning activity that is occurring is not being recorded by FSOs.

To address the protective and care needs of children and young people subject to statutory intervention, ongoing processes of assessment, planning, implementation and review is required. In Queensland, this occurs via a Case Management Framework that was formally introduced in 1992 which aims to direct case practice with a family from initial intervention to case closure. This framework is seen as a pivotal tool in resolving the protective needs of children and young people and to facilitate responsive, ongoing casework with children, young people and their families. Within this framework three separate forums are used to facilitate formal decision making:

- Case discussion meetings between Family Services Officer with case responsibility, Team Leader or other senior departmental officers and other key professionals;
- Family meetings between the Department and the child's family (where appropriate the child/young person is included); and
- Placement meetings between departmental officers and foster carers and (where appropriate) Shared Family Care Staff.

Each of these meetings results in formal documentation that contains an overview of current assessments and decisions, and the three planning documents together constitute the overall case plan for the child or young person and their family. These documents are inter-related and consist of Assessment of Protective Needs Report, Planning Statement and Placement Agreement, which are recorded on the Child Protection Information System database.

Key decision points of each case determine the timing of these meetings. For children and young people subject to a child protection order granting custody or guardianship to the Chief Executive, the legislation requires that arrangements for the child or young person's carer and protection be reviewed at least every six months.

Despite this requirement, review of individual children's electronic files indicates that these meetings are not occurring regularly or the recording on the child's electronic case file does not reflect the case management activity.

6.5 Professional decision making

Sound and holistic decision making is critical to ensure effective and accountable child protection practice. The Audit findings have shown that in 80% of cases audited, decision making practice has been poor or inadequate. The Department has a legal and moral obligation to ensure that statutory intervention is necessary to protect a child and does not exceed that which is necessary. Interventions must be appropriately targeted and based on the child's and family's circumstances. Child protection workers must also be able to defend their process and conclusions in a Tribunal or Court.

A common difficulty in child protection work is having to make decisions that could cause distress for the child or young person and their families. Solutions that workers are able to offer may not be ideal for all parties. Decision making in child protection work, is therefore not only intellectually challenging, it is also emotionally challenging. Many workers are not well prepared and equipped to deal with the emotional challenges of child protection work and can be apprehensive about making decisions, so they may procrastinate or avoid decisions altogether (Munro, 2002).

The context in which workers have to make their assessment and decisions can present barriers to effective decision making in child protection work. This is a highly charged context in which to work, with structural constraints such as scarce resources, staff shortages and a high staff turnover due to burnout, little or insufficient supervision and heavy caseloads (Dalgleish, 2000). Intense media interest, political and public accountability and daily exposure to emotionally disturbing material create extraordinary circumstances in which to make important decisions about people's lives.

The demands of child protection work and daily exposure to traumatic events and experiences can have a significant impact on workers' emotional health and lead to vicarious trauma. An explicit recognition of vicarious trauma and the emotional health needs of staff is therefore critical to effective and accountable child protection practice. Nelson-Gardell and Harris (cited Department of Families 2003g) state that the most important resources in the effort to care for vulnerable children are the people who do the work.

Findings from the Audit concur with the research findings of Munro (1999) on errors of reasoning in child protection work, which include the following:

- basing decisions on too little information, that is failing to gather information from external sources such as other government departments and community agencies who are involved or have been involved with the child and his/her family;
- reliance on single session interviews, with limited observation and assessment of parent/child relationships,
- tendency for child protection workers to focus on present day issues and failing to take into account past evidence such as child protection history;
- reliance on personal testimony rather than written records such as case notes and reports;
- failure to sight and interview the child and tendency not to believe the child or to accept the child's testimony only when it corroborates with the worker's risk assessment and lack of understanding of why children retract their statements.

6.6 Staff training, retention and professional development

The Audit findings raise concerns about the qualifications and experience of staff and their subsequent training in child protection theory and practice. For example, there was overwhelming evidence in the Audit findings that departmental workers are not identifying the sexual abuse of children or indications that children are being groomed for abuse. Further, there is a lack of risk assessment undertaken about children's future risk in a placement. Little information is contained in the initial assessments about safety plans, risk and protective factors or case plans.

For new graduates commencing their career with the Department, to date their induction training has been insufficient to properly prepare them for the difficult task of 'front line' child protection work. Further, training has not always been available immediately and for some workers, it may be offered some months after they commence and are already undertaking assessments of notifications. Team leaders have also not had access to training in management of staff, supervision and mentoring workers.

High case loads, high turn over of staff, a lack of resources and poor information systems are important issues for staff that have been emphasised over a number of years, and called for in Area Offices. These calls were reiterated over and over again during the CMC's public hearings. The Audit Team has found that this large gap in resources has greatly impacted on officers capacity to undertake the important tasks of child protection work.

6.7 Case loads of Family Services Officers

For the financial year ended 30 June 2003 there were 31, 068 child protection cases notified to the Department of Families. There were 4,380 children in alternative care. The increasing workloads and corresponding pressures on front line workers cannot be underestimated. It is inevitable that this will impact on the quality of service provided to all departmental clients.

It has been difficult to ascertain the number of FSOs employed by the Department of Families who undertake child protection work. One source (Queensland Government, 2003) reports that as at 29 June 2003, there were 574 FSOs (both child protection and youth justice).

A second source (Department of Families, 2003e) sent surveys to all area offices to identify all recurrently funded positions for the 2003-04 financial year. It reports 384 FSOs undertaking child protection work and 96 FSOs undertaking youth justice work, a total of 480 FSOs.

While the issue of workloads and lack of resources at the frontline is beyond the scope of the Audit Terms of Reference, the audit process revealed concerning information about the service that is provided to children and young people in alternative care. Much of this information has been previously mentioned in this report. Other examples include children and young people not having an allocated FSO for up to 12 months, children and young people not being regularly visited, children and young people not being involved in decisions that affect their lives, and children and young people being isolated from their families and drifting from placement to placement.

It is critical that FSOs working with children and young people in alternative care have adequate time, training, resources and support to enable them to undertake their job to a

high standard. Children and young people in alternative care are some of the most vulnerable people in our society and the Department must make them a priority.

It is vital that FSOs working with children and young people in alternative care are able to:

- Fully assess the needs of children and young people when they enter care.
- Regularly support and monitor placements including separate time with the child or young person independent to the foster carer.
- Support children, young people and their families to participate in decision-making.
- Arrange and monitor regular contact between the child and young person and their parents, siblings, and extended family.
- Plan towards reunification where possible or towards a long term, stable and secure placement.
- Maintain contact with other relevant people in the child or young person's life, for example the child's doctor, counsellor, teacher; and
- Record all contact, case plans, meetings and decisions fully on the Department's computer system.

The findings of the Audit support recommendations contained in other submissions to the Crime and Misconduct Commission that there must be caseload limits set. In addition, cases relating to children and young people should at no time be unallocated.

Based on the findings of the Audit[6], it would appear that in many area offices, alternative care FSOs' caseloads are unacceptably high and this is having a direct impact on service delivery. While a specific formulae has not been researched and set by the Audit Team, the Audit findings indicate that any ratio above one FSO per 20 children is unmanageable and that one FSO per 15 children is more realistic.

There are a number of factors that would need to be considered in deciding the appropriate formula. Therefore, it is recommended that the Department develop a caseload formula to set limits for each FSO in alternative care and determine the requirements for the number of alternative care FSOs for each area office taking into account the following factors:

- Geographical location of the area office, children, their families and their placement
- The experience and skills of the FSO;
- The complexity of the case and the needs of each child; and
- The availability of the Team Leader for supervision and support to the FSO (including the ratio of Team Leader to FSO).

It is therefore recommended that additional FSO staff be employed immediately with a planned approach to employ further staff at a ratio of one FSO per 15 children within the next two years.

It is recommended that policy articulates, and practice dictates that every child or young person in alternative care must have an identified and allocated FSO.

6.8 Review of alternative care in other jurisdictions

[6] The term 'audit findings' refers to the contextual information gathered by the Audit Team through data reports on the number of children in alternative care, the number of FSOs currently employed, and the Team had regard to research finings from other jurisdictions and the CMC submissions on caseloads.

It is significant to note that some other States and Territories are conducting major policy and practice reviews in relation to how alternative care services are delivered to children in care.

Across all child protection jurisdictions there is a general acknowledgment about the correlation between children and young people having regular contact with their case workers and the provision of safe effective alternative care.

To this end, policy review in other states is similarly examining issues such as minimum home visiting requirements and defined case loads for child protection workers, regulations in relation to the numbers of children placed with foster carers and assessment of the child's specific needs, the expertise and ongoing training for front line child protection workers and the assessment and approval of foster carers and their ongoing training requirements.

Recommendations concerning child-focussed practice

11. Child-focussed practice frameworks

It is recommended that:

- there is a systematic approach to ensuring children and young people in care can participate in decisions about their lives and that the philosophy of the Department's child protection framework is child-focussed;
- departmental officers become more skilled in communicating with children and young people;
- children and young people must be consulted and involved in the development of case plans, placements and in their transition from care. A copy of their case plan should be provided to them with an updated copy as the plan progresses or changes;
- children and young people in the guardianship of the chief executive be provided with information about the *Charter of Rights,* advocacy services and complaints procedures upon entering care and regularly throughout their time in care;
- that policy clearly articulates, and practice dictates that children and young people in alternative care have access to a support person during the assessment of notifications;

The Audit Team endorses the recommendation of the Queensland State Government contained in its submission to the CMC that the role of the CREATE Foundation be expanded to provide independent views and representation to the Department of Families based on the views of children and young people. The Government submission recommended that funding be increased to CREATE Foundation to expand its systems advocacy role.

12. Aboriginal and Torres Strait Islander children and young people

It is recommended that:

- alternative care services for Aboriginal and Torres Strait Islander children and young people should be developed and funded at a greater level to ensure safety and equity in the provision of alternative care services;

- a range of initiatives be implemented to address alcohol, violence and child protection issues in isolated communities;

- the Coalition Of Attorneys General collaboration should be expedited in relation to child protection, and identify what gains could be made in the Cape York trial sites project;

- Recognised Agencies under the Act must be funded adequately, and their staff trained and supported to enable them to respond to requests made for advice and involvement in case planning;

- the Department in consultation with Recognised Agencies develop indicators and measures regarding standards of care required of Indigenous foster carers.

13. Contact with children and young people

Given that an overwhelming finding of the Audit was that there was a significant lack of direct contact between the FSO and the children and that home visits are a critical factor in the prevention of harm, it is recommended that the Department:

- adequately resource and prioritise alternative care to ensure that the Department is able to fulfil all of its responsibilities as outlined in the *Child Protection Act 1999*;

- amend departmental policy to articulate that children and young people are visited frequently in their home environment, with a minimum requirement of once a month when subject to short-term child protection orders and once every two months when subject to long-term child protection orders;

- provide training to departmental officers with regard to the purpose and function of home visits for children and young people in alternative care.

14. Case planning

It is recommended that the Department:

- incorporate into the new Integrated Client Management System a bring-up system to ensure effective monitoring and compliance with the six monthly review requirements of *the Child Protection Act 1999*.

- provide ongoing training to Family Services Officers and Team Leaders about the Case Management Framework covering areas such as:

    - purpose of the Case Management System,
    - facilitation of these meetings to maximise the participation of children and young people in outcomes,
    - development of recorded case plans which clearly articulate the basis for the professional judgement of appropriate departmental intervention.

15. Professional decision making

It is recommended that the Department develop:

- ongoing training in the area of professional decision making in child protection targeted at Team Leaders and Family Services Officers. The training among other things, should address the emotional and intellectual challenges of decision making in child protection. It should also include information on building and maintaining child protection worker's emotional resilience with tools for decision making strategies.

- Training for Team Leaders in relation to supervision to enable critical review of assessments and decisions with attention to the emotional challenges of child protection work, practice frameworks and the values placed on the consequences of their decisions.

- information systems to enhance efficient recording and retrieval of client information to facilitate better decision making (see also recommendations under Information Systems).

16. Caseloads of Family Services Officers

It is recommended that the Department:

- develop a caseload formula to set maximum caseload limits per FSO. This formula should take into account the factors outlined in the body of the report;

- employ additional FSOs within the next 12 months to reach a ratio of one FSO per 15 children in alternative care and accordingly ensure an appropriate increase in Team Leader positions.

- amend policy to require that every child in alternative care has an allocated FSO.

17. Recommendation concerning staff training and professional development

It is recommended that:

- consideration be given to developing partnerships with relevant Universities in order to inform the structure and course content regarding statutory child protection. Curricula must provide appropriate skills base, including components of human and child development and the importance of record keeping as part of professional practice. There should also be post graduate studies in child protection.

- a consortium could be developed between relevant Government departments including the Commission for Children and Young People, Youth Legal Aid and the Children's Issues Committee of the Queensland Law Society. It is also recommended that consideration be given to funding through the partnership consortium of a Chair in Children and Young People at a particular University to raise the profile and give greater importance to the needs of child protection and youth justice in Queensland.

- the Department provide a range of appropriate training to new child protection workers, Team Leaders and Area Office Managers with on-going training. Course content needs

to be relevant and current. There needs to be recognition that staff with a range of disciplines are employed by the Department.

- that greater support and supervision be available to staff to assist them professionally and emotionally in the high level of stress and the management of vicarious trauma.

Chapter Seven: Information systems

Currently departmental information related to its clients is stored in a range of different places. Child protection information is recorded in area office databases on the Child Protection Information System (CPIS), on FamYJ, on the CarePay system, on paper files and in a range of area office and regional office spreadsheets. Youth Justice Court and Order information is recorded on FamYJ, however, there is no departmental system for recording youth justice casework information. Adoption information is recorded on CPIS and in two existing data systems that are unique to the Adoptions Branch and Foster Carer information is recorded on paper and stored in paper files, with other information on FamYJ and in CPIS.

Departmental reporting and monitoring processes are problematic due to a range of issues and interfaces with the existing information systems. Data reporting is time delayed and relies on programming by data technicians. Some reports cannot be backdated.

7.1 General findings

Issues with the existing systems and the recording of information within current systems
In the process of completing the Foster Carer Audit, the Audit Team has encountered a range of difficulties relating to the existing departmental information systems. These difficulties have impacted on the Audit at every stage. A discussion of the various aspects of the information systems follows.

Information storage
In undertaking the Audit, the Audit Team found that there are too many systems containing separate information, that is often inaccurate or not up to date. Information about a matter could be stored across two or three databases.

Data reports
The initial requests to Information Services Branch for information on foster carers subject to a child protection notification were problematic and this has been discussed previously. An anomaly in the way information is recorded exacerbates the problem with provision of accurate data for the project. For example, there are three types of approval for foster carers, however when an emergency placement is made with an approved carer, it registers on FamYJ under the carer's approval details as an Emergency Placement. This leads to confusion and inaccuracies in the reporting of data.

Foster carers
Information on the initial approval process for foster carers is recorded on paper forms and stored in paper files at the affiliated area office. This means that there is not statewide access to information regarding the approval process or any concerns or limitations regarding the carers. Following approval, client details, placements, approval and re-approval details are recorded on FamYJ. The accuracy of this information is reliant on area office staff completing paper forms that are forwarded to Data Management Systems for data entry. Other information is collated via the CarePay system, which manages the payment of foster allowances. Often, due to the need to ensure carers are paid for placements, the information on the CarePay is more reliable than information recorded on FamYJ.

At present a foster carer may be recorded as a client in two different places – as a client number on FamYJ, or as a client profile in CPIS. This can result in the creation of duplicate client numbers and can result in a "split" in the foster carer's history on FamYJ. This could be addressed by restricting the method of creating a client to one. All foster carers should be established as clients when they first apply to undertake the initial approval process if they are not already known to the Department.

The Audit found a large number of foster carers did not have a current approval recorded on FamYJ and their reapproval dates were outstanding by up to two years. While the physical tasks involved in the reapproval may have occurred, the paperwork has not been completed.

The current information systems do not have the provision to record information specifically related to a foster carer. Information currently recorded would be directly related to the foster carer's involvement with a child placed with them. Even when searching by subject child, the Audit Team found there was often very little information recorded on CPIS in relation to any follow up action with foster carers following a substantiated notification.

There is an urgent need to revise the process for recording carer information in order to integrate information related to approval, re-approval, training, family and placement meetings, general case note information, matters of concern, notifications and initial assessments into the departmental information systems. The revised process needs to ensure that accurate data related to the number of foster carers and foster carer families (including affiliation) is available.

It may also be appropriate to be able to record specifically a foster carer's involvement in matters that are taken to the Children Services Tribunal. This information could be incorporated into the foster carer's child protection history (along with matters of concern, Intakes, Notifications and Initial Assessments) which should be readily accessible whenever the foster carer record is accessed.

Due to the large amount of inaccurate information on FamYJ, the Department should consider the automatic lapsing of approval for relative and limited approval carers either at the end of the placement for relative carers or at the end of three months for limited approval carers. Information Services Branch estimates that there are currently 900 relative carers still approved following the removal of the relative child from their care. A report could be generated to trigger any required follow up action prior to the cancellation of approval to allow the area office to take appropriate action.

Alerts

At present there is a range of alerts that can be entered on a client profile in CPIS to indicate particular events, such as "mobile family", "member of a family where a child has died" and "risk to staff". At present there are no options covering foster carer issues or specific issues related to children placed with foster carers. The current alert options should be reviewed and a wider range of alerts incorporated to cover restrictions or concerns regarding foster carers, foster carer suspension or withdrawal information, the presence of or review of previous matters of concern, notifications and initial assessments. The option for alerts on children placed with foster carers, such as children with sexually inappropriate behaviour, or who have already abused other children should be included.

The alerts should appear each time a client is accessed and be easy to enter. Any new information system should allow for multiple client number and alert options to be recorded at one time, with the provision of a link to explanatory information.

7.2 Recording information

The current system for recording information on CPIS is cumbersome and time consuming for staff. Each piece of information must be entered into an individual document which is created and has client details entered into it. The recording of notifications and initial assessments is particularly problematic and has required central office assistance to manage client profiles and the creation of documents. In creating a new integrated client management system, the Department needs to completely rethink the framework for recording information, that has been limited up to this point by the available functionality of the existing programs.

At present there is no official manual that assists area office staff to record information on CPIS. Document "Help" screens that can be accessed within each document were developed in 1997 and have not been updated to reflect the changes that have occurred in the last seven years. The Child Protection Information Section produced individual modules for each type of document to assist staff record information in 2000 but use of these were never officially sanctioned for release to staff.

Notifications
Information recorded in a notification should represent a moment in time for the subject child. To the best of the workers ability it should be an accurate reflection of their current situation, who they are, who they live with, who are their "relevant people", the concerns, the context of the concerns and any other information relevant to the assessing of those concerns.

The Audit Team found significant errors in the recording of some Notification fields. The notification category currently defaults to "standard notification" and as a result many alternative care notifications are not being identified. Changes to the recording process could limit the number of errors made in this area. Existing departmental reporting systems can currently only identify foster carer notifications where the outcome of the initial assessment is recorded as substantiated or substantiated risk.

The Audit Team found that the foster carer's children and other children placed with the foster carers at the time of the notified concerns were regularly not recorded in the Relevant Persons Table or considered as possible subject children due to the alleged harm or risk of harm. An automatic prompt question could assist staff to make decisions regarding all the children in the foster carer household at the time of the notification. When a child is not considered to be a subject child, a brief rationale should be provided.

At present, the notified harm table in the notification has the option of "sexual". This is in direct contradiction with the initial assessment outcome options, which focus on harm to the child and do not include an option for "sexual harm". A change in title to this table needs to occur so that the "sexual" option can be legitimately included.

With regard to recording relationships for notifications, workers have to individually record relationships each time a notification is recorded. The development of genogram screens that could automatically be linked to notifications would promote consistency of recording and save an enormous amount of time in recording.

Screens should include clear 'instructions' for text and non-text fields that are deleted as the text fields are typed/selected - this is particularly relevant given lack of ongoing IT/systems training (particularly given high staff turnover) and a decision to no longer have manuals. Screens should have appropriate headings (non repetitive) and staff should be guided or prompted to complete all relevant screens.

The Audit Team found that there is no clear understanding of who should be included in the relevant persons table, in particular the male carer was often not included. The recorded concerns do not always match the recorded abuse type, some relevant fields are often not completed and there is a lack of clarity with recording notifications where a child is a person responsible and should also be a subject child.

The Audit Team has also found instances of area offices not recording information on relevant databases as part of a workload management strategy. This compromises the relevancy and accuracy of the databases. For example:

Examples from the Audit

- One area office does not complete court outcome forms which has made it difficult to ascertain whether child/ren are subject to current child protection orders; and
- Some area offices do not record Intakes electronically. This can result in intake information not being considered as part of child protection history. It is unclear whether this area office considers past Intake matters as part of their response to child protection information received.

The current external file referencing system used in CPIS is poorly designed and used inconsistently.

Initial Assessments

The existing initial assessment document contains a mix of text fields and tables. The format was revised several years ago and there have recently been changes to accommodate the differential response work completed by Child Protection Branch. In the audit process it became apparent that many workers are not clear about the purpose of each field and there are tables which are important but not mandatory. As a result, the standard of completion of these documents varies dramatically and key information is often difficult to locate easily.

The Audit Team recommends that a new information system be developed in a way that leads workers through the required steps of the assessment process and provides prompts for the activities that are required. The steps taken should be to be recorded and finalised as they are undertaken. This would avoid the current practice of completing one document with all information, that is often not completed and approved until months later.

In other jurisdictions workers are required to complete an assessment and investigation plan, which must be approved by a Team Leader. This ensures that appropriate actions are taken as part of the assessment and provides opportunity for departmental officers to plan.

For notified children in care, there should be additional prompts or the mandatory requirement for checks and completion of certain fields to promote more holistic assessments in these cases, than what is currently occurring. This may include obtaining information from the child's doctor, current and/or previous caseworker, the school, childcare or a recognised agency.

The provision to ensure adequate procedures for the assessment have been undertaken prior to approval should be a feature that is built into the current and/or future system. For example, fields recording the sighting and/or interviewing of subject children and the interviewing of all approved persons or person alleged responsible need to be mandatory. It should only be in exceptional circumstances that this does not occur, and in such cases an approved rationale for not doing so needs to be provided.

The system needs to have fields and must be completed that accurately reflect the start date of the assessment such as the initial action taken, rather than a blank field that will possibly be completed some time in the future.

In terms of approving the completions of assessments for alternative care notifications, consideration should be given to a higher level of approval, for example the area office manager or a senior resource officer or senior practitioner.

There was a range of inconsistency with the recording of harms and outcomes for initial assessments. While some of this inconsistency relates to practice and decision making, the Audit Team believes that the current options and process for completing these tables requires review to provide a less cumbersome process with more accurate outcome options. The "Nature of Harm or Risk of Harm Table" is often inconsistent with the assessment text, often misleading and is time consuming to complete. Reconsideration of the usefulness of this table is required given the difficulty workers appear to have with completing it, the issues with identifying a responsible person at times and the need to identify one person as the most serious person responsible which contradicts good practice. Given that the specific information recorded in the Behaviour Responsible and Resulting Harm fields is not collated or reported on, a rethink in terms of the process for collecting abuse outcome types is required.

Reconsideration of, or further clarification of the outcomes "Substantiated, "Substantiated Risk" and "Unsubstantiated" is required as these are regularly recorded inconsistently and incorrectly.

There seems to be a particular misunderstanding of the outcome "Substantiated Risk". The Audit Team has found overwhelming issues around the recording of harm and future risk of harm, in that it is used when the children were placed at risk as opposed to when the children are at risk of future harm. Also, there is no clear direction for staff around the use of three of the outcome options, "No assessment possible – client reasons", "Part assessment – no outcome possible (client reasons)" and "Unable to commence/complete (workload reasons)". The Audit Team found that they were used incorrectly and inappropriately by workers to the detriment of children's safety.

One possible idea for change is to have the worker answer a series of questions, such as "Was the subject child harmed?" "Is the subject child considered to be at risk of ongoing harm?" Is it likely that the subject child has been harmed but there is insufficient information to ascertain who was responsible?" This would lead to a more accurate outcome.

In addition to the above issues, there is regularly no clear rationale provided for a recorded outcome, or a rationale is provided for one subject child and not for other subject children. This issue needs to be addressed to ensure workers are clear in the purpose of their interventions.

An assessment is a specific piece of work that is recorded and finalised. The outcome of the assessment should inform future interventions with the subject children and the foster carers. In particular, this information should be used to inform a review of the child's current caseplan. Accordingly, the current "Ongoing Intervention Fields" would more usefully be attached to ongoing casework screens, than placed within the initial assessment document.

Recommendations concerning information systems

18. Information systems

It is critical to the Department's core business and day to day practice to have access to current and reliable data. It is recommended that:

- an updated and integrated client management system is urgently developed, that contains all departmental information (Child Protection, Carepay, Foster Carers, Youth Justice and Adoptions) and is accessible statewide in real time to all departmental officers, as appropriate. In developing the ICMS, the Department must have regard to the findings and recommendations of the Audit and incorporate these within the development of the ICMS;

- until the ICMS is in place (which may be two years) interim measures be put in place to address identified issues with regard to improving recording and retrieval of client information;

- there are hyper-links within the new ICMS to relevant policy and practice guides;

- an appropriate statistical model for the population base be developed specific to client and foster care information. The development of this model should be led by a post-doctoral statistician and staff with appropriate qualifications;

- consideration be given to changing the terminology of “Initial Assessment” and ceasing the practice of having “related notifications” linked to initial assessment documents;

- there is a removal of all central office recording of area office information (with sufficient resources to allow it to be undertaken at area office level) and electronic ownership of clients;

- the new system has the capacity to deliver on-line, instantaneous data reports that are accessible to all appropriate staff and able to be replaced historically;

- there is an urgent revision of the process for recording carer approvals and placements. The revised process should be integrated into any new system and designed with the ability to produce accurate numbers of foster carers and foster carer families, including information regarding who provides their support (the Department or relevant non-government agency);

- information management is urgently developed to track children by placements, matters of concern and notifications while in those placements;

- efficient on-line management reporting systems are urgently developed within area offices and regions and allows central office staff to access key performance measures for monitoring and reporting purposes;

- technology is developed to allow staff to e-mail/forward information they have recorded about a client to another area office;

- the new system should be “intelligent” in order to minimise recording errors and should follow current practice guidelines, not dictate them. For example, workers should be led

through the screens, which provide clear 'instructions' for text and the information recorded should be automatically linked to the client and their family;

- the current alerts system be reviewed and a range of new alerts included that identify particular issues for foster carers and for the safe placement of children;

- there is a complete review of the current format for recording assessment actions and outcomes. In particular a review of the Child Outcome Table, the Nature of Harm or Risk Substantiated Table and the Ongoing Intervention Fields.

Chapter Eight: Systemic matters

The Audit findings have shown that there are a range of systemic matters that impact on the safety of children and young people and the capacity of the Department to better assist them. These matters include health, education, integrated and multi-disciplinary services, the function of SCAN, broad based alternative care options, appropriate cultural responses and the vast and special needs of children who have been abused. By and large these findings highlight the need for better collaborative work between government departments and community engagement.

With respect to the safety of children and young people in care, there is a limited systematic approach to ensure that they have access to a range of comprehensive specialist health and behavioural assessment and intervention. For example, case notes subject to the Audit, record a range of physical and mental health issues for children and young people who have been harmed at home and for many of these children, these matters have largely not been attended to in foster care.

The Abused Child Trust presented information to the CMC public hearings that from a therapeutic point of view, current services are insufficient in scope and location. There is no specialist multi-disciplinary therapeutic service for abused and neglected children between Brisbane and Townsville, north of Townsville, west of Brisbane or in regional and remote Queensland.

8.1 Children subject to child protection proceedings

Within the Terms of Reference of the Audit, in particular Term Four, the adequacy of statutory requirements was considered. The *Child Protection Act 1999* was to be reviewed twelve months post proclamation, this has not occurred. When the Act is reviewed attention should be given to particular sections of the Act where the Audit findings have shown regular non-compliance within practice, for example:

- Section 5 welfare and interests of children being paramount
- Section 7 foster carers provided with support and training
- Section 14 Chief Executive to immediately authorise investigation when they become aware of harm
- Section 73 Chief Executive to have regular contact with children and parents
- Section 74 Charter of Rights – Chief Executive to ensure children receive written information
- Section 77 foster carers to allow authorised officers to have reasonable contact with children
- Section 83 additional provisions for placing Aboriginal and Torres Strait Islander children in care
- Section 88 Chief Executive to regularly review case plans (each 6 months).

The nature of child protection proceedings is onerous, whether it is in the Children's Court or before the Children;s Services Tribunal. The submission to the CMC by Legal Aid Queensland (LAQ) highlighted the need for Court preparation and documentation to be prepared by legal officers. The Audit findings also demonstrate the demand on FSOs to be quasi-lawyers which is concerning considering their training is not in law. FSOs are asked to

prepare a great range of legal documents for Court and Tribunal matters. This is an area that requires addressing immediately.

LAQ's submission stated that in preparing forensic assessment reports for the Children's Court, the Children's Services Tribunal and Courts exercising family law jurisdiction have shown the Department of Families inadequate methods of assessment of whether a child is in need of protection from harm. LAQ has found little evidence of active support, supervision and training of FSOs. In some situations FSOs appear unaware of departmental policy with a gap between practice and policy. Children and young people often appear to have very little contact with their case worker and have complained to LAQ about multiple case managers and workers having a high volume of workload. These issues are also the findings of the Audit.

LAQ also stated that their experience has been that there are many foster carers who provide an excellent level of care for children. Unfortunately some foster parents provide an unacceptably inadequate standard of care for the foster children in their home. The LAQ submission highlighted some cases of children living in unacceptable and unsafe circumstances. This was also the finding of the Audit.

8.2 Custody or guardianship orders in favour of a relative or other person/s

The Children's Court, pursuant to s59 of the *Child Protection Act 1999* can grant guardianship to a relative, another suitable person or the chief executive of the Department of Families. A range of policy sets out provision for assessing suitability of persons making application, and decision making when deciding child protection orders granting long term guardianship of a child. Further, s59(2) of the Act states that:

> *Before making a child protection order granting custody or guardianship of a child to a person other than the chief executive, the court must have regard to any report given, or recommendation made, to the court by the chief executive about the person, including a report about the person's criminal history, domestic violence history and traffic history.*

The Audit findings suggest that more stringent processes need to be undertaken before making such an order, for example, findings showed that:

- Child protection and criminal history checks were not always undertaken on the person making application
- Children are often not consulted about granting an order.
- On some occasions CPIS notes showed case notes or intake notes that ought to have been a notification and therefore were not assessed.
- The Audit on some occasions did not agree with a finding of unsubstantiated outcome and
- It would seem that a thorough review of the case needs to be undertaken prior to granting an order

8.3 Children Services Tribunal

The *Children Services Tribunal Act 2000* was proclaimed on 2 February 2001. The Children's Services Tribunal is empowered to determine decisions with a range of legislation. In particular, case plan decisions about children in care, and licensing and approval decisions about residential care services and foster carers under the *Child Protection Act 1999.*

In her submission to the CMC's Inquiry, the President, of the Tribunal highlighted a range of information about the role and function of the Tribunal and issues with respect to children and young people in alternative care. She has found that the legislation is not problematic as such, but the compliance with the legislation and current policy are matters dealt with by the Tribunal on a regular basis. This too, is a finding of the Audit. For example, there are delays in responding to notifications and matters that must be responded to immediately or where officers have downgraded Priority One ratings. The Tribunal has found that children's rights are often not regarded and their participation in decision making is rare.

The President commented that there have also been multiple examples before the Tribunal of concerns from foster carers regarding their dealings with the Department. Some of these issues expressed by foster carers have included not being included in any case planning, seen as an adversary, not receiving support or assistance from the Department and caring for high-needs children.

The Tribunal's submission to the CMC discussed matters about children and young people participating in the process. In particular, under s59 of the Act where review applications can be made on behalf of children. Experiences to date of the Tribunal, have shown these applications to be made by the child's foster carer and this highlights a jurisdictional area that requires some clarification.

The present under resourcing of the Tribunal highlights the under-valued nature of child protection and a lack of understanding of its importance. The capacity of the Tribunal is constrained and could provide a broader range of services for children and young people as well as the Department. For example funding restricts Tribunal panels travelling to geographical areas to convene proceedings. The President stated that inadequate staffing levels within the Tribunal registry means that they can not adequately respond to the great range of demands and inquiries made by children and young people, their families, foster carers and departmental staff.

A further concern that was found during the Audit process, is the inadequate training of departmental officers as to the role of the Tribunal, and the role of the Department in the proceedings. This includes information and training about presenting material and appearing before the Tribunal. There is a paucity of available information on the departmental policies and procedures (contained on INFONET directory) which has resulted in departmental officers being unclear about an appropriate response in respect of a particular issue.

During the Audit process consultation was had with some departmental officers and Tribunal members about their experience concerning Tribunal matters and raised the following:

- Departmental officers can be unclear of what information needs to be provided to the Tribunal. Cases in these forums rely upon written evidence, and therefore can be quite resource intensive.
- The Tribunal was often presented with late material or insufficient information from the Department
- Information provided to the Audit Team by some departmental officers was that they did not have support in their decision making by their managers, if the departmental decision was set aside some officers stated that they were blamed by managers for making the wrong decision in the first place.
- Some departmental officers stated that in situations where the Tribunal had set aside departmental decisions, they considered the Tribunal made a 'bad' or 'wrong' decision and

- It was reported to the Audit Team that in some circumstances insufficient information and evidence had been provided to the Tribunal and the panel set aside the Department's decision. This decision had then been considered to be the 'wrong' decision by departmental officers.

8.4 Monitoring and regulation for children and young people in foster care

There is less regulation of foster care than in residential settings. This is concerning when about 97% of children and young people in care are placed in foster care. This is a theme that has been found in a number of projects over a period of years. Most recently the audit of the Department's Regulations of Care Services under the *Child Protection Act 1999* (Department of Families, 2003f) identified foster care settings as an area of increasing risk with an insufficient regulatory regime to provide adequate safeguards for children in foster care. Key findings of the Report were that foster care is less regulated than residential care where community visitors from the Commission for Children and Young People visit children and young people in residential and detention facilities. Further, that any current regulation of foster care does not assess the quality of care provided to children in care, against the Standards of Care set out in the Act. By and large the FSO is assumed to be responsible for monitoring standards of care for each child through casework. The findings highlighted policy gaps in relation to children's rights, safety and wellbeing whilst in alternative care with no formal mechanisms to ensure child safety and wellbeing.

The Department's Executive Management Committee (EMC) decided in May 2003 that options outlined in the Report would not be pursued at that stage. However, two recommendations were made with regard to foster care:

- Child Protection Branch to advise whether additional action be required upon evaluation of the *Future Directions* trials relating to alternative care; and
- Child Protection Branch to raise with EMC in the near future information relating to a quality assurance system being implemented to monitor children's safety in care.

Commission for Children and Young People
The Commission for Children and Young People provides community visitors to attend at residential facilities for the purpose of promoting and protecting the rights, interest and wellbeing of children and young people. The Community Visitor Program has not been evaluated by the Commission, however, an administrative review of the program was conducted in November 2001. The Audit Team has not seen a copy of the review, but the Commission advised that the review concluded that the program had been well developed, and identified some program management issues for improvement. The Commission advised that these issues were subsequently addressed. The review did not identify any systemic issues as the program had been operational for only a short period at that time. The findings were not available to the Foster Carer Audit Team and there has been no other evaluation of the program since 2001. Therefore the Audit Team is not able to comment on the effectiveness of the community visitor program.

Within the *Commission for Children and Young People Act 2000,* the Commissioner for Children and Young People has all necessary or convenient powers to perform the Commissioner's functions. In performing the Commissioner's functions and exercising powers, the Commissioner must act independently, promote and protect the rights, interests and wellbeing of children and is not under the control or direction of the Minister (s17).

Section 15 of the *Commission for Children and Young People Act 2000,* provides for the Commissioner's functions which include receiving, seeking to resolve, monitor and

investigate complaints about services provided to certain children by service providers (s15(a)). The complaint must relate to a service provided or required to be provided to a child who is the subject of an order under the *Child Protection Act 1999* or while the chief executive (Department of Families) is taking action under this Act to ensure the child's protection (s32).

The Commissioner can monitor and review the way in which service providers respond to complaints about services provided by them to certain children (s15(b)). Section 15(e) provides for the function to monitor and review laws, policies and practices that relate to service delivery and impact upon children. Within s15(k) the Commissioner has the function to conduct independent inspections of visitable sites. "Visitable sites" is set out in s64, where community visitors visit and promote and protect the rights, interests and wellbeing of children residing at

(a) residential facilities,
(b) detention centres, and
(c) authorised mental health services under the *Mental Health Act 2000*.

During the Audit process a range of community based organisations were consulted with respect to the monitoring and regulation of foster care. Representatives from five organisations, CREATE Foundation, the Abused Child Trust, Foster Care Queensland, Bravehearts and PeakCare expressed views that the Commission for Children and Young People was the appropriate agency to provide this function. The experiences of these organisations with the Commission had been quite positive in the past and representatives expressed that the Commission's functions could be expanded to provide advocacy and monitoring for children and young people in foster care.

The Commissioner for Children and Young People presented information to the Crime and Misconduct Commission's Public Hearings for the Inquiry into Foster Care that the current regulation powers of the Commission were inadequate under the *Commission for Children and Young People Act 2000*. The Commissioner recommended among other things, that the Commissioner's powers should be expanded to include children and young people in foster care homes where there are six or more children placed, or alternatively be based on an agreed criteria or be random.

The Audit Team does not recommend that placements of six or more children be the only sites visited by the Commission, as this would disadvantage those children where five or less children are placed, who would be excluded from visits by the Commission. Further, the Audit Team considers that six or more children placed in one household, plus the foster carers own children, are too many children in one placement.

The Audit Team has found that many children who have been harmed have challenging behaviours and require extra care and nurturing. The Audit has found that as of 30 June 2003, there were 74 foster carer families with 6 or more children placed with them (excluding their own children). In some homes there are between 8 and 12 foster children. It has been apparent in some initial assessments audited by the Audit Team that there were too many children placed with carers, with children sleeping on lounges or in garages due to a lack of beds. Some of these children are therefore placed at greater risk of neglect and other harms. (See the Audit recommendation 3 with respect to the number of children in placement).

The Commissioner for Children and Young People also recommended that the Commission should be expanded to enable it to fulfil its oversight, advocacy and investigation functions more effectively.

NSW Office of the Children's Guardian
The New South Wales Office of the Children's Guardian (OCG) is a Government Department and an independent organisation that reports directly to the Minister for Community Services. It has been set up to promote the best interest and rights of children and young people in out of home care in NSW. The OCG is seen as one of the most significant reforms in out of home care in NSW and is unique in Australia. It was a recommendation in the Report of the Review of the *Children (Care and Protection) Act 1987* and also in the Woods Royal Commission (1997).

The OCG is responsible for all children and young people in care under the *Children and Young Persons (Care and Protection) Act 1998*. Its functions include promoting the best interests of all children and young people in out of home care and ensure their rights are promoted, regularly reviewing case plans for each child or young person in out of home care, accrediting designated agencies and monitoring their responsibilities under the regulations.

The Children's Guardian can also make special reports to Parliament and is responsible for all children and young people in the care of the Department.

The establishment of a separate body and structure to provide advocacy and monitoring for children and young people in foster care would not necessarily be the best use of resources. Particularly when the Commission for Children and Young People already provide a service for children and young people in residential and detention facilities. Further to this, a number of community based organisations have expressed an interest in the Commission providing an expanded service for children and young people in foster care. The expansion of the Commission to incorporate a monitoring function for children and young people in foster care, with similar functions of the Office of Children's Guardian would therefore seem sensible.

Office of the Community Advocate, ACT
The Department of Education, Youth and Family Service (Australian Capital Territories) undertake Special Appraisals in response to allegations of abuse in care. The Allegations of Abuse in Care procedures are outlined in the Family Services Policy and Procedures Manual. Of note is at the conclusion of a Special Appraisal, a report is forwarded to the Office of the Community Advocate. This report outlines the allegations, the Outcome Report, the final advice or actions in relation to the person whom allegations were made against, the final advice to the care facility or agency and any internal review decision.

These procedures could be considered by the Commission for Children and Young People in any future monitoring of children and young people in care.

Recommendations concerning systemic matters

19. Integrated services

It is recommended that:

Queensland Health and Department of Families develop a system to provide children and young people who are in care (or are subject to statutory intervention) priority access to health, dental and behavioural services, including a medical card which goes with the child.

20. Children subject to child protection proceedings

It is recommended that legal officers be employed in each region to assist with the preparation of documentation for court and Tribunal proceedings, provide advice to FSOs and in some circumstances attend at such proceedings.

21. Custody or guardianship applications in favour of a relative or other person/s

It is recommended that children and young people be consulted and involved in considering custody or guardianship orders. Further, that consideration should be given to appointing a separate legal representative for the child or young person in some circumstances, when an application is made.

It is recommended that the Operations Directorate conduct a thorough review of the case, including an assessment of CPIS information recorded within case notes, intake notes and outcomes recorded, prior to granting an order.

It is recommended that a report be provided to the court that details relative or other persons suitability as a guardian/custodian of a child. The report should include all history checks as well as a written assessment of the proposed carer's suitability.

22. Children Services Tribunal

It is recommended that further and adequate funding and resources be provided to the Children Services Tribunal to respond to current inquiries and demands to the registry and to better ensure that children and young people participate in the appeals process and receive legal representation where necessary. This funding and resources to the Tribunal should also include the provision of training and education to departmental officers and other groups supporting applicants appearing before the Tribunal.

It is recommended that training and support be provided to FSOs presenting and/or appearing before the Tribunal about the procedures of the Tribunal and the preparation of documents and information.

It is recommended that FSOs be provided with legal assistance from legal officers employed by the Department, and that the legal officers would prepare the Tribunal documentation and in some circumstances, appear before the Tribunal (see also recommendation that the Department employ legal officers in each region).

Where a review application is made under Section 59 of the *Children Services Tribunal Act* 2000, that the child or young person be granted legal aid for a separate representative.

23. External monitoring of children and regulation of foster care

Commission for Children and Young People

It is recommended that:

- the Commission for Children and Young People provide advocacy for and systemic monitoring of children and young people in alternative care. The Commission must be able to sight and speak with children and young people in their foster care settings. The *Commission for Children and Young People Act 2000* therefore should be amended accordingly. In particular, s64 could be amended to include *(d) foster care settings at "visitable sites";*

- a variation of some of the key functions of the Office of the Children's Guardian in NSW be undertaken within the Commission for Children and Young People. For example, the Commission would provide oversight of case plans, visit and speak with, and have access to data concerning children and young people in alternative care. The Commission would therefore require additional funding to be able to expand and undertake these functions;

- a consultation process with the Department, the Commission, Children Services Tribunal, CREATE Foundation and other relevant stakeholders including Indigenous agencies and foster care agencies occur, to decide on suitable arrangements and the appropriateness of the community visitors scheme to take on the function of advocacy and monitoring by the Commission. The consultation process should include an amendment to any existing protocol regarding the sharing of information;

- staff employed by the Commission for Children and Young People to undertake the advocacy and monitoring for children and young people in care must have child protection experience and practice frameworks.

CREATE Foundation

The Audit Team endorses the recommendation of the Queensland Government, contained in its submission to the CMC that the funding be increased to CREATE Foundation to expand its systems advocacy and monitoring role for children and young people in care.

Chapter Nine: Implementation

The recommendations of the Audit would need to be implemented over a period of time. However, it should be noted that some of the findings of the Audit require high priority. They are as follows:

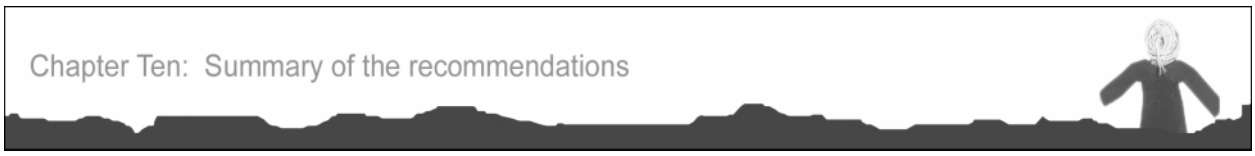
- employ additional FSOs within the next 12 months to achieve a ratio of one FSO per 15 children in alternative care;
- to ensure responses to identified policy issues, it will be necessary to employ additional policy officers within the Child Protection Branch, Policy Directorate, and these officers would specifically focus on progressing the implementation of policy-related recommendations.
- recruit legal officers in each region;
- provide adequate training for Family Service Officers and Team Leaders in
    - identifying sexual abuse
    - conducting thorough investigations and assessments
    - developing and implementing clear caseplans
    - supervision and support for Family Service Officers
- as an interim measure while the ICMS is being constructed, put in place an information system to report on the number of matters of concern and notifications with respect to alternative care;
- develop a greater range of strategies through intensive family support to safely support children to remain with their natural families;
- develop a greater range of placement options in alternative care for children and young people;
- amend and improve policy and practice around recruiting, training and supporting foster carers;
- develop a communication strategy to convey a summary of the Audit findings to area offices.

Recommendation concerning implementation

24. Implementation

It is recommended that the above recommendations be implemented as a high priority with a clear plan for implementing detailed recommendations contained in the Audit Report.

It is recommended that an independent committee comprising of members from the Department of Families, Department of the Premier and Cabinet, Treasury, the Commission for Children and Young People and stakeholders from community organisations oversee the implementation of the recommendations from the Audit Report.



Recommendations concerning foster care and the placement of children

1. Placement options

It is recommended that attention be given to providing intensive family support services to assist and strengthen families to safely keep children with their natural parents.

It is recommended that:

- small residential homes should be available for large sibling groups and young people who do not wish to have, or cannot cope with family based care or who are transitioning to independent living;
- The Department consider the implementation of Family Group Conferencing as a means of diverting children from the child protection system, increasing diversity in alternative care options and relieving pressure on the foster care system;
- the department develop a clear policy framework which proactively seeks support options (eg placement, respite and social contact) within the child's family and community, eg the use of Family Group Conferencing. This policy framework should be developed in consultation with the Departments Alternative Care Committee.

2. Assessment, approval, training and support for foster carers

It is recommended that the Department:

- review and amend relevant policies with respect to determining foster carers' suitability, having regard to foster carers own children, non-household members likely to have ongoing or significant levels of contact with children;
- develop and implement clear standards and policy frameworks regarding the training and support to be provided to, and attended by, all foster carers. This should include the roles and responsibilities of persons or agencies responsible for the training and support of foster carers;
- develop and implement clear standards for the review of relative carer and limited approval carers including their compliance with legislative provisions;
- amend the 'Foster Carer Agreement' policy and procedures to include all foster carer approval types and monitor the 12 monthly review of the Agreements, to ensure that it is undertaken. A standardised Foster Carer Agreement proforma needs to be developed;

- amend the legislation to ensure that standards and monitoring requirements apply to all foster carer types;

- review the draft Sharing the Care training and include content that covers the issues identified by the Audit with clear information about listening to children and taking their disclosures of harm seriously;

- clearly articulate to foster carers the standards of care required for children and young people in foster care;

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3. The number of children and young people placed with foster carers

It is recommended that the Department:

- develop and implement policy that places restrictions on the number of children and young people or sibling groups that can be placed with all approved foster carers at any one time;

    - the policy should take into consideration the findings of this Audit and have regard to best practice developed within child care as to restrictions on the number of children in foster care;

- the formula should state standards for the placement of children and young people with foster carers including specific requirements relating to:

    - The number of carers' own children,
    - Children and young people with high support needs,
    - Children and young people that have been sexually abused, or have sexually abused other children and the placement of more than one sibling group with a foster carer.

Recommendations concerning investigating and assessing child protection notifications and responses to outcomes

4. The recording of child protection notifications

It is recommended that the Department:

- amend FSO training to include information on specific procedures and recording requirements associated with notifications involving foster carers;

- amend policy to require that all children and young people placed with foster carers are recorded as subject children, irrespective of the nature of the notified concerns;

- the current *Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care* policy is amended to reinstate the 24 hour commencement time frame for all notifications relating to children and young people in alternative care;

5. Initial assessments

It is recommended that the Department:

- develop a comprehensive training package that includes quality assurance tools such as check lists for Team Leaders and other staff responsible for the approval of Initial Assessments, as a matter of priority, to improve the assessment of notifications and the recording of initial assessments. This training is to be available on a regular basis to departmental officers.

- develop and implement training for all FSOs in relation to investigating and assessing of notifications involving foster carers with particular emphasis on risk assessments and the concepts of future harm.

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6. Central specialist unit for assessment of notifications with respect to foster care

It is recommended that a central specialist unit be established (possibly within the Operations Directorate) with staff to:

- provide advice, training and support to specialist departmental officers in each region who will be responsible for the recruitment, assessment, approval and re approval of foster carers and the management of matters of concern.

- develop systems to oversight all aspects of the management of matters of concern, including the investigation and assessment of notifications with respect to foster carer. This will require the development of a database for the collation of data and the formulating of protocols;

- provide assistance (in the form of advice) in relation to the development of action plans after there has been a substantiated or substantiated risk outcome;

- analyse data, monitor and report on trends relating to matters of concern. This is to involve the ongoing use of the Foster Carer Audit database.

The role of the Unit would be to improve current practice to ensure its objectivity and focus on best practice. It is important that Unit staff are not involved in day to day casework matters.

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7. Policy regarding investigating and assessing notifications on foster carers

It is recommended that:

- the Child Protection Procedures Manual is updated and re-implemented as a critical tool for FSOs undertaking the broad range and complex requirements of child protection work. It should include chapters specific to the regulation of care and monitoring. The Manual should also set out the role of the FSO, who has casework responsibility for the

case and foster carers, in the investigation and assessment, to ensure that there is no conflict of interest in the investigation process.

- the investigation and assessment of child protection notifications involving foster carers be conducted in liaison with the recommended special investigation unit;
- the Department amend its *Child protection notification response – initial assessment* policy to include factors specific to formulating assessments in circumstances involving notified foster carers;
- all foster carers in the household are included in the investigation and assessment process, with all reasonable attempts made to interview and include other persons alleged responsible for harm/risk of harm;
- investigation and assessment requirements are clearly specified in relation to decisions about:
    - children or notified foster carers who are Indigenous,
    - the involvement of Police and the outcomes of their investigations,
- the development of a training module specific to the investigation and assessment of alternative care notifications that must be attended by departmental officers responsible for such investigations and assessments;
- the Department implement formal monitoring and evaluation processes to ensure compliance with investigation and assessment processes.

8. Identifying sexual abuse indicators

It is recommended that:

- all departmental officers attend training prior to undertaking assessments that provides a comprehensive overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it;
- all foster carers are required to attend training that provides a sufficient overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it, prior to their initial approval;
- all foster carers are provided with appropriate information at the time of placement outlining any sexual abuse history or issues for the child;
- there are limits placed on the number of children with a sexual abuse history that can be placed together. Consideration should be given to restricting the placement of children with a sexual abuse history together with children who do not have a history of sexual abuse;
- foster carers are supported and provided with strategies for their family to be able to respond appropriately to children who have been sexually abused.

9. Responding to substantiated or substantiated risk outcomes of notifications concerning foster carers

It is recommended that the Department develop policy and procedures specific to:

- the purpose and requirements of intervention with children and young people following substantiated and substantiated risk outcomes, including support, access to therapy and the updating of case plans and case decisions. Policy and procedures are to include provision of support for children and young people when they are moved to a new placement.

- the purpose and requirements of intervention with notified foster carers following substantiated and substantiated risk outcomes, including consideration of the removal of children and young people and the suitability of individuals approved to care for children and young people;

- review of Foster Carer Agreements following every substantiated or substantiated risk initial assessment outcome in relation to foster carers; and/or other persons responsible for harm where these persons are related to, or in regular contact with foster carers;

- training modules specific to the purpose and nature of intervention following substantiated or substantiated risk outcomes, including relevant policies and procedures, that must be attended by departmental officers; and shared family care service staff;

- The Department must implement formal monitoring and evaluation processes to ensure compliance and related policies and procedures.

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10. Appropriate management of the behaviour of children and young people in foster care

It is recommended that the Department:

- give urgent attention to developing ‘best practice’ standards and indicators associated with the legislated Statement of Standards;

- develop an advanced training module that incorporates appropriate discipline and behaviour management strategies, that must be attended by foster carers, departmental officers and shared family care staff;

- prioritise the implementation of a clear policy framework for responding to foster carers who contravene legislated standards;

- automatically include (as conditions of all Certificates of Approval) the requirement that foster carers provide care in a manner consistent with the Statement of Standards; and do not use corporal punishment or techniques that humiliate, frighten or threaten children in ways that are likely to cause emotional harm;

- amend the legislation with respect to relative carers and limited approval carers so that they are subject to the same regulation and monitoring as approved foster carers, that would similarly enable the provision of conditional Certificates of Approval.

Recommendations concerning child-focussed practice

11. Child-focussed practice frameworks

It is recommended that:

- there is a systematic approach to ensuring children and young people in care can participate in decisions about their lives and that the philosophy of the Department's child protection framework is child-focussed;
- departmental officers become more skilled in communicating with children and young people;
- children and young people must be consulted and involved in the development of case plans, placements and in their transition from care. A copy of their case plan should be provided to them with an updated copy as the plan progresses or changes;
- children and young people in the guardianship of the chief executive be provided with information about the *Charter of Rights,* advocacy services and complaints procedures upon entering care and regularly throughout their time in care;
- that policy clearly articulates, and practice dictates that children and young people in alternative care have access to a support person during the assessment of notifications;

The Audit Team endorses the recommendation of the Queensland State Government contained in its submission to the CMC that the role of the CREATE Foundation be expanded to provide independent views and representation to the Department of Families based on the views of children and young people. The Government submission recommended that funding be increased to CREATE Foundation to expand its systems advocacy role.

12. Aboriginal and Torres Strait Islander children and young people

It is recommended that:

- alternative care services for Aboriginal and Torres Strait Islander children and young people should be developed and funded at a greater level to ensure safety and equity in the provision of alternative care services;
- a range of initiatives be implemented to address alcohol, violence and child protection issues in isolated communities;
- the Coalition Of Attorneys General collaboration should be expedited in relation to child protection, and identify what gains could be made in the Cape York trial sites project;
- Recognised Agencies under the Act must be funded adequately, and their staff trained and supported to enable them to respond to requests made for advice and involvement in case planning;

- the Department in consultation with Recognised Agencies develop indicators and measures regarding standards of care required of Indigenous foster carers.

13. Contact with children and young people

Given that an overwhelming finding of the Audit was that there was a significant lack of direct contact between the FSO and the children and that home visits are a critical factor in the prevention of harm, it is recommended that the Department:

- adequately resource and prioritise alternative care to ensure that the Department is able to fulfil all of its responsibilities as outlined in the *Child Protection Act 1999*;

- amend departmental policy to articulate that children and young people are visited frequently in their home environment, with a minimum requirement of once a month when subject to short-term child protection orders and once every two months when subject to long-term child protection orders;

- provide training to departmental officers with regard to the purpose and function of home visits for children and young people in alternative care.

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14. Case planning

It is recommended that the Department:

- incorporate into the new Integrated Client Management System a bring-up system to ensure effective monitoring and compliance with the six monthly review requirements of *the Child Protection Act 1999*;

- provide ongoing training to Family Services Officers and Team Leaders about the Case Management framework covering areas such as:

    - the purpose of Case Management,
    - maximising the participation of children and young people in case planning decision,
    - the development of recorded case plans which clearly articulate the basis for the professional judgement of appropriate departmental intervention.

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15. Professional decision making

It is recommended that the Department develop:

- ongoing training in the area of professional decision making in child protection targeted at Team Leaders and Family Services Officers. The training among other things, should address the emotional and intellectual challenges of decision making in child protection. It should also include information on building and maintaining child protection worker's emotional resilience;

- training for Team Leaders in relation to supervision that addresses the professional development needs of departmental officers and enables critical review of decision making.

16. Caseloads of Family Services Officers

It is recommended that the Department:

- develop a caseload formula to set maximum caseload limits per FSO. This formula should take into account the factors outlined in the body of the report;
- employ additional FSOs within the next 12 months to reach a ratio of one FSO per 15 children in alternative care and accordingly ensure an appropriate increase in Team Leader positions.
- amend policy to require that every child in alternative care has an allocated FSO.

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17. Recommendation concerning staff training and professional development

It is recommended that:

- consideration be given to developing partnerships with relevant Universities in order to inform the structure and course content regarding statutory child protection. Curricula must provide appropriate skills base, including components of human and child development and the importance of record keeping as part of professional practice. There should also be post graduate studies in child protection;
- a consortium be developed between relevant Government departments including the Commission for Children and Young People, Youth Legal Aid and the Children's Issues Committee of the Queensland Law Society. It is also recommended that consideration be given to funding through the partnership consortium of a Chair in Children and Young People at a particular University to raise the profile and give greater importance to the needs of child protection and youth justice in Queensland;
- the Department provide a range of appropriate training to new departmental officers working in frontline child protection. Course content needs to be relevant and current for FSOs, Team Leaders and area office managers;
- that greater support and supervision be available to staff to assist them professionally and emotionally in the high level of stress and the management of vicarious trauma.

Recommendations concerning information systems

18. Information systems

It is critical to the Department's core business and day to day practice to have access to current and reliable data. It is recommended that:

- an updated and integrated client management system is urgently developed, that contains all departmental information (Child Protection, Carepay, Foster Carers, Youth

Justice and Adoptions) and is accessible statewide in real time to all departmental officers, as appropriate. In developing the ICMS, the Department must have regard to the findings and recommendations of the Audit and incorporate these within the development of the ICMS;

- until the ICMS is in place (which may be two years) interim measures be put in place to address identified issues with regard to improving recording and retrieval of client information;
- there are hyper-links within the new ICMS to relevant policy and practice guides;
- an appropriate statistical model for the population base be developed specific to client and foster care information. The development of this model should be led by a post-doctoral statistician and staff with appropriate qualifications;
- consideration be given to changing the terminology of “Initial Assessment” and ceasing the practice of having “related notifications” linked to initial assessment documents;
- there is a removal of all central office recording of area office information (with sufficient resources to allow it to be undertaken at area office level) and electronic ownership of clients;
- the new system has the capacity to deliver on-line, instantaneous data reports that are accessible to all appropriate staff and able to be replaced historically;
- there is an urgent revision of the process for recording carer approvals and placements. The revised process should be integrated into any new system and designed with the ability to produce accurate numbers of foster carers and foster carer families, including information regarding who provides their support (the Department or relevant non-government agency);
- information management is urgently developed to track children by placements, matters of concern and notifications while in those placements;
- efficient on-line management reporting systems are urgently developed within area offices and regions and allows central office staff to access key performance measures for monitoring and reporting purposes;
- technology is developed to allow staff to e-mail/forward information they have recorded about a client to another area office;
- the new system should be “intelligent” in order to minimise recording errors and should follow current practice guidelines, not dictate them. For example, workers should be led through the screens, which provide clear 'instructions' for text and the information recorded should be automatically linked to the client and their family;
- the current alerts system be reviewed and a range of new alerts included that identify particular issues for foster carers and for the safe placement of children;
- there is a complete review of the current format for recording assessment actions and outcomes. In particular a review of the Child Outcome Table, the Nature of Harm or Risk Substantiated Table and the Ongoing Intervention Fields.

Recommendations concerning systemic matters

19. Integrated services

It is recommended that:

Queensland Health and Department of Families develop a system to provide children and young people who are in care (or are subject to statutory intervention) priority access to health, dental and behavioural services, including a medical card which goes with the child.

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It is recommended that the Operations Directorate conduct a thorough review of the case, including an assessment of CPIS information recorded within case notes, intake notes and outcomes recorded, prior to granting an order.

It is recommended that a report be provided to the court that details relative or other persons suitability as a guardian/custodian of a child. The report should include all history checks as well as a written assessment of the proposed carer's suitability.

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22. Children Services Tribunal

It is recommended that further and adequate funding and resources be provided to the Children Services Tribunal to respond to current inquiries and demands to the registry and to better ensure that children and young people participate in the appeals process and receive legal representation where necessary. This funding and resources to the Tribunal should also include the provision of training and education to departmental officers and other groups supporting applicants appearing before the Tribunal.

It is recommended that training and support be provided to FSOs presenting and/or appearing before the Tribunal about the procedures of the Tribunal and the preparation of documents and information.

It is recommended that FSOs be provided with legal assistance from legal officers employed by the Department, and that the legal officers would prepare the Tribunal documentation and in some circumstances, appear before the Tribunal (see also recommendation that the Department employ legal officers in each region).

Where a review application is made under Section 59 of the *Children Services Tribunal Act* 2000, that the child or young person be granted legal aid for a separate representative.

23. External monitoring of children and regulation of foster care

Commission for Children and Young People

It is recommended that:

- the Commission for Children and Young People provide advocacy for and systemic monitoring of children and young people in alternative care. The Commission must be able to sight and speak with children and young people in their foster care settings. The *Commission for Children and Young People Act 2000* therefore should be amended accordingly. In particular, s64 could be amended to include *(d) foster care settings at "visitable sites";*

- a variation of some of the key functions of the Office of the Children's Guardian in NSW be undertaken within the Commission for Children and Young People. For example, the Commission would provide oversight of case plans, visit and speak with, and have access to data concerning children and young people in alternative care. The Commission would therefore require additional funding to be able to expand and undertake these functions;

- a consultation process with the Department, the Commission, Children Services Tribunal, CREATE Foundation and other relevant stakeholders including Indigenous agencies and foster care agencies occur, to decide on suitable arrangements and the appropriateness of the community visitors scheme to take on the function of advocacy and monitoring by the Commission. The consultation process should include an amendment to any existing protocol regarding the sharing of information;

- staff employed by the Commission for Children and Young People to undertake the advocacy and monitoring for children and young people in care must have child protection experience and practice frameworks.

CREATE Foundation

The Audit Team endorses the recommendation of the Queensland Government, contained in its submission to the CMC that the funding be increased to CREATE Foundation to expand its systems advocacy and monitoring role for children and young people in care.

Recommendations concerning implementation

24. Implementation

It is recommended that the above recommendations be implemented as a high priority with a clear plan for implementing detailed recommendations contained in the Audit Report.

It is recommended that an independent committee comprising of members from the Department of Families, Department of the Premier and Cabinet, Treasury, the Commission for Children and Young People and stakeholders from community organisations oversee the implementation of the recommendations from the Audit Report.

Glossary of Terms

Alternative care

The term "alternative care" is used throughout this report to refer to children and young people who are placed away from their parents or usual carers when an assessment has indicated that separation of the child or young person from their family is unavoidable to ensure the child or young person's safety. Children and young people placed in alternative care can be subject to assessment orders, child protection orders or be subject to placements with parental consent. Alternative care can be either family-based care ie with a foster carer or residential care.

Approved foster carer

An approved foster carers refers to a person who holds a certificate of approval as an approved foster carer.

Cases notified

Cases notified refers to the number of children who are the subject of child protection notifications. A child notified more than once during the period is counted once for each notification.

Certificate of approval

A certificate of approval means a certificate of approval granted under Section 134 of the *Child Protection Act 1999*.

Charter of Rights for a Child in Care (charter of rights)

The Charter of Rights for a Child in Care is established under the *Child Protection Act 1999*, and outlines the State's responsibilities for a child in need of protection who is in the custody or under the guardianship of the Chief Executive under the Act.

Child

The *Child Protection Act 1999* defines a child as an individual under 18 years of age. For the purpose of this report, the term "child and young person" has been used where possible otherwise the term "child/ren" is taken to include young people.

Child protection notification

A matter constitutes a child protection notification when information indicates that a child or young person has been harmed or is at risk of harm and does not have a parent (or foster carer) or other family member in the household willing and able to protect the child or young person from the harm.

Child Protection Act 1999

The *Child Protection Act 1999* underpins the statutory responsibilities of the Department of Families and provides for the protection of children and young people in Queensland.

CPIS (Child Protection Information System)

The Department of Families computer based recording tool. This is a Lotus Notes based system that provides a discrete database for each area office, that has an interface with FamYJ.

Distinct children

The term 'distinct children' refers to the number of children subject to a child protection notification. A child is counted once only, regardless of the number of notifications during the period.

Duty of care

The Chief Executive of the Department of Families has a duty of care to ensure that a child in alternative care is cared for in a way that meets the Statement of Standards, and that the Charter of Rights for a Child in Care is complied with.

Emergency placement

An emergency placement is one type of Shared Family Care placement, and placements can be for children and young people who are placed with the consent of parents or who are taken into custody by the Chief Executive. Children and young people subject to assessment or child protection orders may also require emergency placements in situations such as foster placement breakdowns.

Executive Management Committee (EMC)

EMC is the principal advisory body to the Director-General of Families who, in turn, provides advice to the Minister for Families. In carrying out this role EMC makes recommendations regarding: approval of strategic directions; clear and specific definitions of expected business outputs including timelines for delivery; visibility and free flow of information including promoting effective communication among staff; monitoring and review of strategic indicators of organisational performance; approval of new departmental policy and procedures or changes to existing policy/procedures; approval of positions to be adopted by departmental representatives on external bodies; and management processes for performance evaluation and promotion emphasising horizontal collaboration for departmental officers in the Senior Executive Service.

FamYJ (Families and Youth Justice)

This is a state-wide electronic system that includes:

- key client information from intakes, notifications and initial assessments from CPIS
- Youth Justice client information and Youth Justice Orders
- Child Protection Order information
- Information on foster carers, approvals and placements.

Foster carer

The term foster carer is used throughout this report to refer to carers who have been approved to care for a child or young person (irrespective of type of placement) by the Department of Families and have an approved carer, limited approval carer or relative carer status.

Harm

Harm to a child or young person is defined within the provisions of s9 of the *Child Protection Act 1999*, as any detrimental effect of a significant nature on the child or young person's psychological or emotional well-being. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation.

Initial assessment (investigation and assessment)

When a notification is recorded in relation to children and young people in alternative care, a departmental officer undertakes an investigation and assessment of the

protective needs of the child/young person. The outcome of the investigation and assessment is recorded as an Initial Assessment on CPIS.

Licensed care service

A licensed care service means a service, operated under a licence, to provide care for children in the Chief Executive's custody or guardianship.

Limited approval carer

The term limited approval carer refers to a person who has not been fully assessed or trained but is approved for a particular child or young person, for a specific purpose, for a defined period of time.

Matter of concern

A "matter of concern" is any concern/s raised in relation to the standards of care provided to children and young people in alternative care. The departmental policy "Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care" was implemented on 01/10/03 and replaced the rescinded Standard of "care issues and notifications of harm for children and young people in alternative care" policy. If a matter of concern is raised in relation to the care provided to children or young people in alternative care, it is responded to through either casework or an investigation and assessment.

Priority rating

When a notification is recorded, a departmental officer prioritises the matter with a rating of 1, 2 or 3 (with 1 being the most serious and urgent). Departmental policy between December 2001 and 1 October 2003, stated that for a notification with respect to a child who is in alternative care, the matter must be allocated a priority rating of 1 requiring commencement within 24 hours.

Protective advice

When a notification is received with respect to children and young people in the general community, the level of harm or risk of harm is not deemed significant, and an initial assessment involving contact with a child/young person and their family is not warranted, protective advice in the form of information, resources, referral and advice may be provided to the notifier. Protective advice is not used as a departmental response when a notification is received regarding children and young people in alternative care because of the Department's duty of care to ensure that legislated standards of care are complied with.

Recognised agency

A "recognised Aboriginal or Torres Strait Islander agency", for an Aboriginal or Torres Strait Islander child, means an entity that, under an agreement between the State and the entity, is the appropriate entity to be consulted about the child's protection.

Risk assessment

Risk assessment is a critical component of child protection and refers to an assessment of the likelihood of future harm to a child or young person. Risk assessment is an ongoing process that occurs for children and young people throughout their contact with the child protection system.

Relative carer

The term relative carer refers to a person related to the child or young person or a member of the child or young person's community and considered family or a close friend.

Shared Family Care

Shared Family Care refers to the provision of out-of-home care to children with protective needs by approved foster carers in their own homes for which they receive departmental foster allowances.

Shared Family Care agency/service

A Shared Family Care service is a non-government agency responsible for the recruitment, training, assessment and support of foster carers.

Standard of Care Issue

Prior to 01/10/03, when a matter did not constitute an allegation of harm or risk of harm to a child or young person in alternative care, but there were concerns that a carer was not providing care that met the required standards as outlined in the *Child Protection Act 1999*, it was referred to as a Standard of Care Issue. The matter was raised with the carer but was not defined, recorded or responded to as a child protection notification.

Statement of Standards/standards of care

Section 122 of the *Child Protection Act 1999* prescribes the chief executives responsibility to ensure that a child or young person placed in a residential care service or with an approved foster carer is cared for in a way that meets the Statement of Standards. Subsection (2) prohibits the use of corporal punishment in relation to children and young people in alternative care.

Initial assessment outcomes[7]

- **Substantiated** - The outcome of an initial assessment is recorded as "Substantiated" if, in the professional opinion of the officers concerned, there is reasonable cause to believe that the child or young person has been harmed and there are no risk factors to indicate future harm; or the child has been harmed and there is a likelihood of future harm.

- **Substantiated risk** - The outcome of an initial assessment is recorded as "Substantiated risk" if, in the professional opinion of the officers concerned, there are reasonable grounds for believing that a child or young person has not experienced harm but there is a high likelihood of future harm (due to the presence of identified risk factors).

- **Unsubstantiated** - The outcome of an initial assessment is recorded as "Unsubstantiated" if the information gathered does not indicate harm or likely future harm to a child or young person. Both the notified allegations and any new concerns noted during the assessment are considered in this decision.

- **No assessment possible (client reasons)** – Where an assessment is not able to be commenced due to reasons related directly to the client ie the client's whereabouts are unable to be determined, an outcome of "no assessment possible (client reasons)" is recorded.

[7] Other outcomes of initial assessments were introduced in April 2003 as part of the Differential Response trials.

- **Part assessment – no outcome possible (client reasons)** – Where an assessment is partially carried out but not completed due to reasons related directly to the client, an outcome of "Part assessment – no outcome possible (client reasons)" is recorded.

- **Unable to commence/complete – workload reasons ("workload managed")** - In March 2000, the Department introduced a policy to allow for the administrative closure of initial assessments that, for workload reasons, could not be responded to within set timeframes. This outcome was not intended for use with respect to notifications on children in foster care due to the Department's duty of care. This policy was rescinded in April 2003.

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