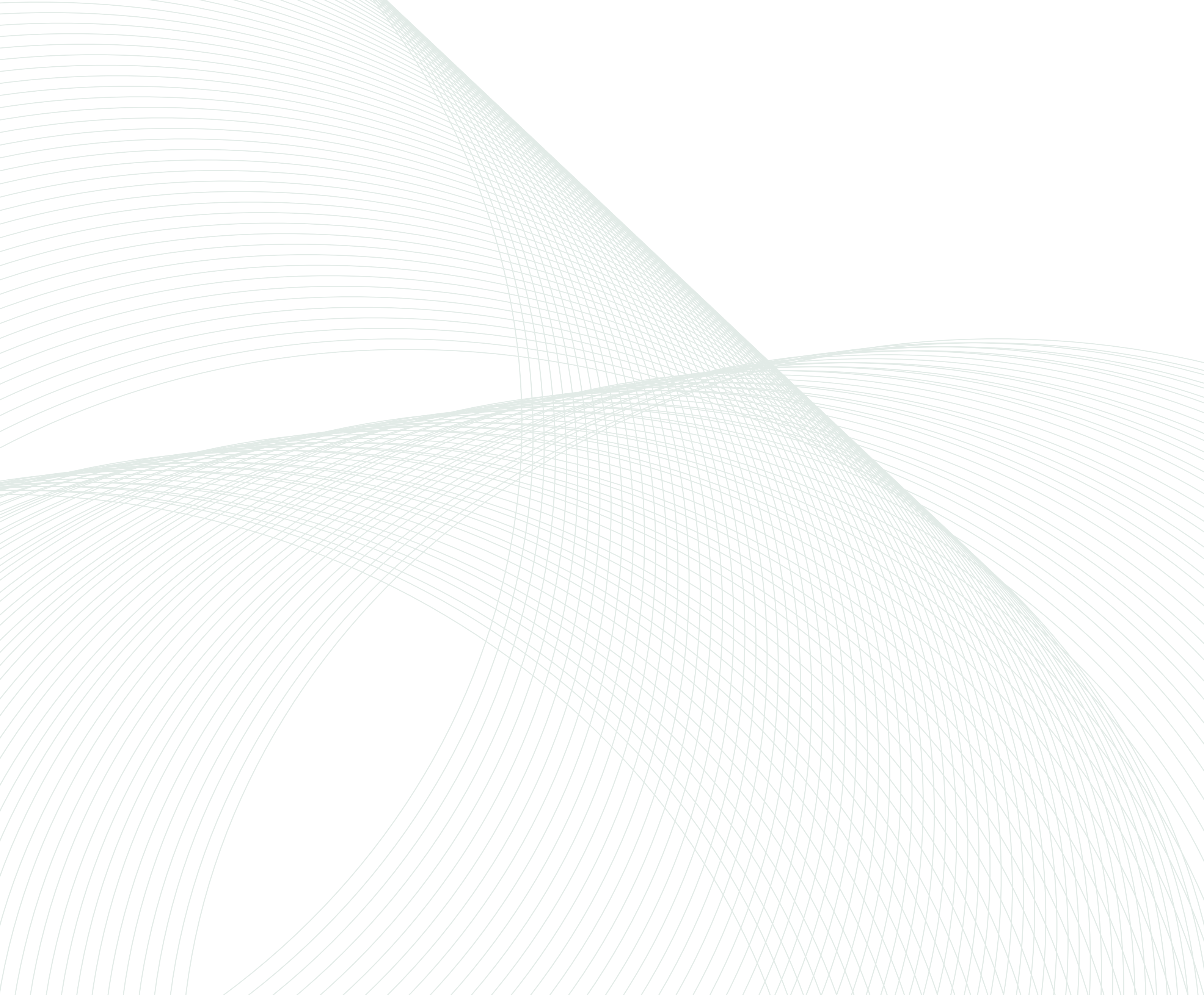


Part 7: System governance

Chapter 21:

Regulation and oversight

Chapter 21: Regulation and oversight

Key points

- Regulation and oversight are essential functions in the system for protecting Victoria's vulnerable children and young people. External scrutiny of service delivery can provide independent assurance that services are well managed, safe and fit for purpose, and that public money is being used properly.
- The Department of Human Services' (DHS) current approach to regulating community service organisation (CSO) performance does not do enough to identify, address and prevent the major and unacceptable shortcomings in the quality of out-of-home care. In seeking to reduce the regulatory burden on CSOs, DHS has failed to maintain an adequate level of external scrutiny of CSO performance. In particular, it is unacceptable that:
  - all CSOs are subject to the same cycle of one independent external review every three years, regardless of their performance; and
  - there is no program of unannounced inspections to act as a quality assurance mechanism to prevent incidents or concerns from arising.
- The Inquiry recommends that DHS should adopt a risk-based approach to the regulation of CSO performance.
- Given that DHS relies on CSOs to deliver services that are central to DHS achieving its core objectives, the Inquiry recommends that DHS retain responsibility for the regulation and monitoring of the CSOs, provided this function is independent and subject to independent oversight.
- The Inquiry considers there to be insufficient independent oversight of Victoria's system for protecting vulnerable children. The Child Safety Commissioner has limited powers and functions compared with commissioners and guardians in other states and territories.
- The Inquiry recommends that the Government establish a Commission for Children and Young People. The new Commission would oversee and report to ministers and Parliament on all laws, policies, programs and services that affect the wellbeing of vulnerable children and young people. The Commission would replace the existing Child Safety Commissioner, but retain the Commissioner's current roles and functions. The Commission would also assume the powers currently granted to the Ombudsman under section 20 of the *Children, Youth and Families Act 2005*.
- The data reported by DHS and external agencies do not provide the basis for a comprehensive assessment of the performance of child protection, out-of-home care and family services, in particular with regard to their effect on the incidence and impact of child abuse and neglect. The Inquiry recommends improved public reporting to help ensure government agencies are accountable for their actions, and to support continuous improvement in individual services and across the sector.
- The Child Safety Commissioner and the Victorian Child Death Review Committee make an important contribution to overseeing the system through reviewing child deaths. However, the Inquiry recommends that the current two-stage review arrangements be streamlined into a single process undertaken by the proposed Commission for Children and Young People.

21.1 Introduction

Regulation and oversight are essential functions in the system for protecting Victoria's vulnerable children and young people. External scrutiny of service delivery can provide independent assurance that services are well managed, safe and fit for purpose, and that public money is being used properly. In this way, regulation and oversight are essential to ensuring that the delivery of services for vulnerable children and young people and their families is fair and accountable to Parliament and the public (Crerar 2007, p. 4).

Regulation and oversight have an important role to play in improving the transparency of the overall system. Reporting the outcomes of regulatory and oversight activity can provide Parliament, ministers and departments with additional information about the performance of the system and outcomes for clients. This can support government efforts to focus services more effectively on client needs. External scrutiny can also be a catalyst for improvements in the way that individual providers deliver services (Crerar 2007, p. 18). Effective regulation and oversight are therefore to the long-term benefit of vulnerable children and young people and their families.

Several submissions to the Inquiry maintained that the unhelpful nature of some media reporting and the public debate concerning the system for protecting Victoria's vulnerable children had contributed to a loss of public trust and confidence in the system (for example, Gippsland Centre Against Sexual Assault submission, p.5). Transparent regulation and oversight, with better public reporting or information about the performance of the system, is fundamental to restoring and maintaining public trust.

The Inquiry considers regulation and oversight to be separate and distinct functions within the system for protecting Victoria's vulnerable children.

Regulation

Regulation is one of the key instruments available to government to achieve its social, economic and environmental objectives and to respond to community needs (Victorian Competition and Efficiency Commission 2011, p. XXIII). While there is no single definition of regulation or the range of measures and mechanisms that it comprises, it is commonly held that government regulation involves an intentional measure or intervention by a government agency that seeks to influence the behaviour of individuals, businesses and not-for-profit organisations (Freiberg 2010, p. 21).

Many government regulators employ a narrow conception of regulation that focuses on legal instruments such as primary and delegated legislation. Under broader definitions, a range of non-rule based mechanisms – such as economic incentives, education and information – are also considered to be forms of regulation that are used by government to achieve its goals.

The rationale for government regulation may be to raise economic welfare, or to achieve social or environmental objectives. Economic regulation generally seeks to improve economic outcomes by addressing market failures, whereas social regulation seeks to manage the risk of harm to individuals or the community, to pursue government's policy objectives, or to maintain public confidence and trust in government and the services in question.

This chapter examines the system of registration, monitoring, investigation and review of community-based family services (family services) and out-of-home care services delivered by community service organisations (CSOs) and individual carers on behalf of the Department of Human Services (DHS). The delivery of statutory child protection services, a form of regulation of the family's care for the child, is examined in Chapter 9.

The government is responsible and accountable for protecting vulnerable children and families and improving their wellbeing. To meet these responsibilities, the government funds CSOs to provide effective family services and out-of-home care. CSOs and individual carers play a critical role in responding to the needs of vulnerable children and their families. The processes put in place by government to fund and regulate CSOs and carers help to ensure Victoria's vulnerable children are protected from harm and that CSOs meet their obligations to deliver effective services.

Oversight

Oversight involves an external body reviewing the conduct and decisions of government agencies and public officials. The review may take the form of an investigation, inspection or audit and can be based on a complaint, a legal obligation or the oversight body's own discretion.

Oversight seeks to maintain the integrity of government agencies and public officials by holding them accountable for actions and decisions they make while carrying out their duties. Accountability is a keystone of representative government, as it both enhances public confidence in government and helps ensure government is responsive to the interests of the public (NSW Ombudsman 2010, p. 1).

In Victoria there are two primary oversight bodies that have the power to investigate, review and audit government agencies and public officials: the Victorian Ombudsman and the Auditor-General. The Child Safety Commissioner provides an additional layer of oversight regarding children in out-of-home care, on the basis that they 'are a particularly vulnerable group and require an extra voice on their behalf' (Parliament of Victoria, Legislative Assembly 2005a, p. 1,367). Many other jurisdictions have established commissioners for children and young people with broader oversight powers.

Prior to the 2010 election, the Victorian Government (then in opposition) committed to establish an independent Children's Commissioner who would report directly to Parliament and would be able to initiate reviews regarding children who have been abused or neglected (Victorian Liberal Nationals Coalition 2010, p. 19).

Structure of the chapter

This chapter addresses the Inquiry's Term of Reference relating to the oversight and transparency of the child protection, care and support system, and whether changes are necessary in oversight, transparency and/or regulation to achieve an increase in public confidence and improved outcomes for children. The chapter describes and assesses the existing regulatory arrangements that apply to the delivery of family services and out-of-home care, including the governance of those regulatory functions, and examines the oversight and transparency of the system for protecting Victoria's vulnerable children.

21.2 Regulation of family services and out-of-home care

The *Children, Youth and Families Act 2005* (CYF Act) provides for CSOs to deliver services on behalf of DHS to 'meet the needs of children requiring protection, care or accommodation' (s. 44). Chapters 8 and 10 describe how DHS engages CSOs to deliver family services and out-of-home care.

The regulation of family services and out-of-home care is a form of social regulation with several overlapping objectives:

- To reduce the risk of harm to, or to protect, vulnerable children and their families, with the priority on the child's best interests;
- To support government policies related to improving the wellbeing of vulnerable children and young people; and
- To contribute to public trust and confidence in the system protecting Victoria's vulnerable children.

The *Victorian Guide to Regulation* (Victorian Government 2011e, pp. 2-3) notes that it is not possible for government to guarantee a completely risk-free society, or to prevent every event that might cause harm. Risk-focused regulation is therefore concerned primarily with the management of *unacceptable risk* (Freiberg 2010, p. 13). Under a risk-based approach, rather than regulation involving a series of ad hoc and episodic responses to incidents as they occur, risk assessment and management become the central organising principles underpinning regulatory strategy.

The measure of unacceptable risk is the probability of harm. Regulators often make complex judgments in an environment containing a high degree of uncertainty. When making assessments of risk, regulators can overestimate or underestimate the actual degree of danger. Low probability events can occur. With the benefit of hindsight, it is easy to look back at an adverse event and overestimate how visible the signs of danger were (Munro 2011b, p. 18). This is sometimes described as hindsight bias.

Over recent years there have been significant changes in governments' understanding of good regulatory practice. There has been a shift away from prescriptive regulation – that specifies in relatively precise terms what is required to be done – towards more flexible approaches, such as performance-based regulation, which specifies desired outcomes or objectives but not the means by which they must be met (Freiberg 2010, pp. 88-89).

There are a number of factors that makes the regulation of family services and out-of-home care different to the regulation of most other markets. The government is the sole funder of the services, and clients often do not have the opportunity or capability to choose between service providers. In the case of out-of-home care, most services are provided by individual carers at arm's length from CSOs, and the CSOs effectively act as quasi-regulators of these carers. Part of the regulatory task, therefore, is to ensure there is adequate public accountability for the delivery of these services.

The capacity of the community sector has a bearing on the government's regulatory task. As described in Chapter 16, some CSOs are relatively large not-for-profit enterprises that receive significant funding from DHS and can be reasonably expected to have appropriate governance arrangements in place to provide for effective service provision and proper accountability. There are a significant number of smaller CSOs, however, that receive small amounts of funding and are more likely to have weaker governance and less capacity for quality assurance.

Victoria's approach to regulating family services and out-of-home care is similar to that adopted in other sectors serving vulnerable clients, such as residential aged care, home and community care, disability services, and early childhood education and care (see Table 1 in Appendix 14). Consistent with the trend towards more performance-based approaches, these regulatory systems typically consist of four main elements:

- Registration, licensing or accreditation of service providers;
- A set of performance standards that service providers must meet;
- Monitoring and review of service providers' performance against the standards; and
- Some system of sanctions for noncompliance.

Most other Australian states and territories adopt a similar approach to Victoria to regulating out-of-home care, involving licensing or accreditation of providers, approval or registration of foster carers, and monitoring of providers' compliance with a set of performance standards. In 2011 the Commonwealth, states and territories agreed to national standards for out-of-home care, that aim to ensure children in need of out-of-home care are given consistent, best practice care, no matter where they live (Department of Families, Housing and Community Services and Indigenous Affairs 2011).

The regulatory framework applying to family services and out-of-home care in Victoria is made more complex by the number of related processes that DHS administers in order to fulfil its other roles and responsibilities. Several of these processes also constitute a form of regulation. These include:

- Registration and disqualification of carers;
- Investigation of critical incidents;
- Investigation of abuse in care and quality of care concerns; and
- Monitoring of CSOs as a result of their service agreements.

Figure 21.1 illustrates the connections between these processes, and illustrates how issues are escalated if they are not addressed by the CSO.

21.2.1 Registration and monitoring of standards

Registration of CSOs

Under the CYF Act, the Secretary of DHS may register a CSO to provide: out-of-home care services; community-based child and family services; or other prescribed categories of service (s. 47). To be eligible for registration, a CSO must:

- Be established to provide services to meet the needs of children requiring care, support, protection or accommodation and of families requiring support; and
- Be able to meet the performance standards that apply to CSOs under the Act.

CSOs are registered for a period of three years. The register of CSOs containing contact details and the category of registration is publicly available on the DHS website.

As at June 2011, there were 107 CSOs on the DHS register. Fifty-six CSOs were registered to deliver out-of-home care and 88 CSOs were registered to deliver community-based child and family services. Thirty-seven CSOs were registered to deliver both out-of-home care and community-based and family services. A further 18 'light touch' CSOs are not required to be registered because they receive less than $100,000 from DHS to deliver family services.

Performance standards

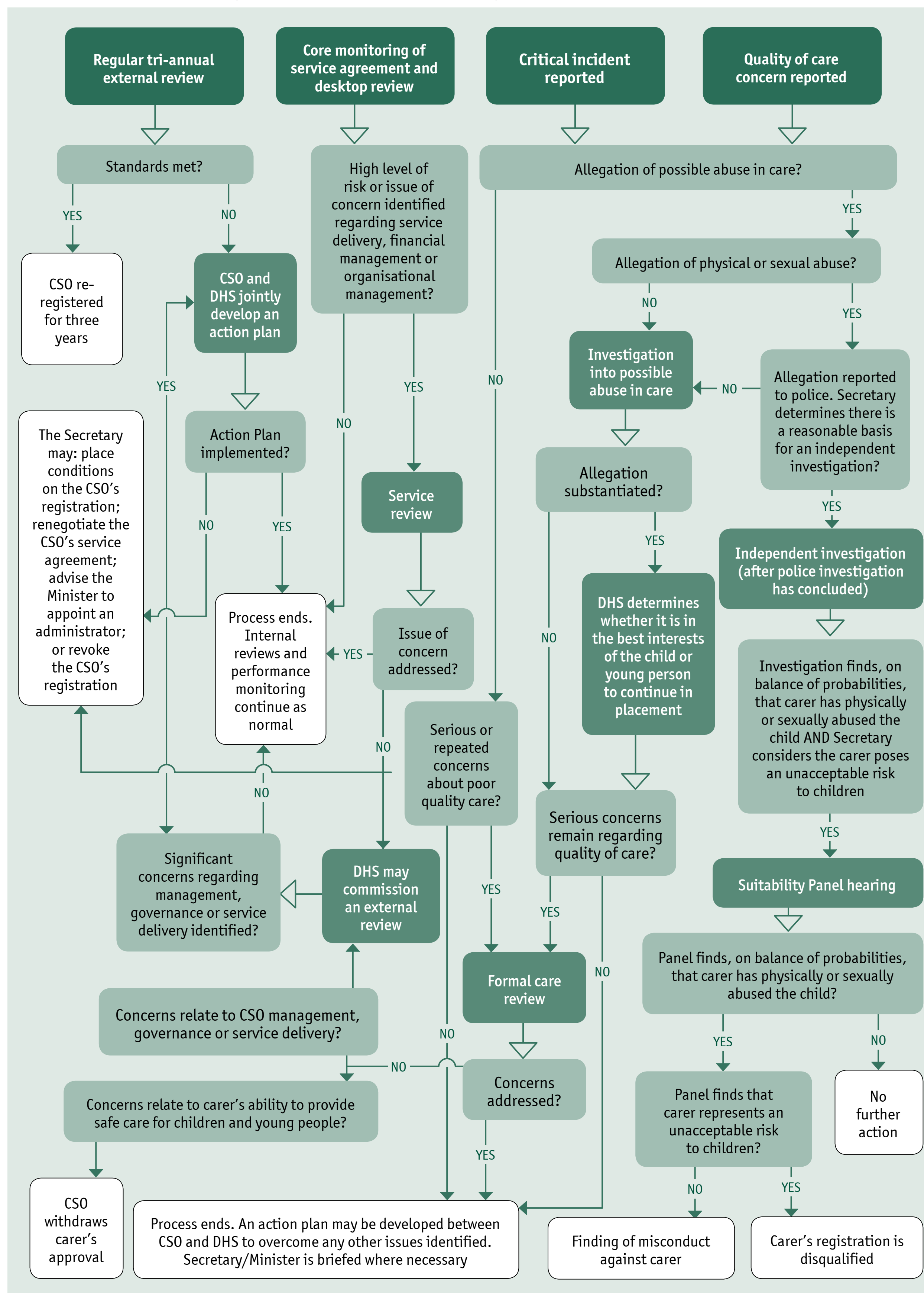
The CYF Act allows the Minister to determine performance standards to be met by registered CSOs. The standards came into effect in May 2007, and apply to both family services and out-of-home care services. They were developed with the aim of:

- Ensuring consistency in quality for family and out-of-home care services;
- Setting an organisational framework to help support CSOs to provide quality services for children, youth and families;
- Defining the standards of care/support that children, youth and their families can expect;
- Providing guidance about best practice approaches to support services to achieve their organisational goals; and
- Enabling services to monitor and review performance on an ongoing basis that can inform service improvement (Victoria Government Gazette 2007).

Table 2 in Appendix 14 summarises the standards and performance criteria that apply to CSOs.

DHS has announced that in July 2012 it will implement a single set of standards to apply to all funded organisations delivering out-of-home care and family services, homelessness assistance services and disability services (see Table 3 in Appendix 14). The DHS standards will replace the performance standards that currently apply to these service providers. The DHS standards comprise four standards and 16 criteria – a significant reduction on the eight standards and 37 performance criteria under the existing standards.

Figure 21.1 Victoria's system for regulating family services and out-of-home care



Source: Adapted from DHS 2007, pp. 12-14

The intention is to reduce the regulatory burden on funded organisations, so that for the purposes of registration, they need only be independently reviewed once every three years regardless of the number of departmental programs they are funded to provide. The Inquiry's concerns regarding this arrangement are discussed in section 21.2.8.

In addition to performance standards, section 61 of the CYF Act requires registered CSOs to:

- Provide services in a manner that is in the best interests of the child;
- Ensure the services provided are accessible and made widely known to the public; and
- Participate collaboratively with local service networks.

Monitoring and review of standards

The CYF Act grants DHS extensive powers to monitor and review the performance of registered CSOs. This includes the power to:

- Visit a CSO at any time to:
  - inspect its premises, documents and records;
  - see any child who is receiving services;
  - make inquiries relating to the care of children; and
  - make any other necessary inspections regarding the management of the CSO (s. 64); and
- Undertake inquiries relating to the performance of a CSO (s. 62); and
- Conduct an independent review of the performance of a CSO (s. 63).

In practice, most CSOs are subject to an external review once every three years, as part of their re-registration process. DHS appoints a panel of independent organisations to undertake external reviews. DHS does not regularly conduct unannounced inspections of CSOs. An irregular external review of a CSO may be commissioned if an issue of concern is identified and not addressed by the CSO. The circumstances in which this may arise are discussed in section 21.2.3, section 21.2.4 and section 21.2.5.

Terms of reference for an external review

External reviews evaluate the quality of services provided by a CSO in relation to the performance standards. Other terms of reference for an external review would depend on any identified concerns regarding the CSO. Terms of reference can include:

- Examination of client management system and safety polices;
- Suitability of corporate governance arrangements;
- Evaluation of strategic and business planning and management;
- Evaluation of effective management of funds; and
- Examination of specific client or community complaints (DHS 2007, p. 13).

A number of sources are used to inform external reviews, including:

- Desktop reviews examining the CSO's most recent internal review report and other documents;
- On-site inspections;
- Client and staff file reviews;
- Interviews with staff, volunteers and board members; and
- Interviews with clients (DHS 2011n, p. 13).

The first external reviews following the introduction of the performance standards were completed between May 2009 and March 2010. External reviews of 99 CSOs were undertaken. The reviewers' contracts with DHS expired following this period, and no further external reviews were undertaken in 2010 or 2011. New organisations were engaged in 2011 to undertake a second round of external reviews, prior to the introduction of the DHS standards.

In the years that CSOs are not subject to an external review, they are required to undertake a self-assessment, or internal review, in order to show they meet the standards. DHS has published an *Evidence Guide* (DHS 2011h) to assist CSOs to prepare for both self-assessments and external reviews. DHS states that:

> This mix of internal and external reviews provides an integrated quality improvement and quality assurance process that enables a CSO to both internally assess its strengths and use emerging practice to reflect on and refine the way services are delivered, and to have an external critique of its service delivery that builds community confidence (DHS 2011h, p. 1).

The results of CSOs' internal reviews are provided to DHS to allow DHS staff to work with CSOs to improve the quality of services provided. The reviewers submit the findings of external reviews to both the CSO and DHS. The performance summary and action plan arising from the internal and external reviews of out-of-home care providers are also provided to the Office of the Child Safety Commissioner, together with regional summaries of key issues and a report identifying statewide trends.

Where an external review finds that the CSO is meeting the performance standards, it is eligible for re-registration for a further three years. If an internal or a regular external review finds that a CSO is not meeting certain registration standards and the review identifies concerns about a CSO's governance, management or service delivery, in the first instance DHS will consider whether it can work with the CSO to address these concerns. The CSO and DHS will jointly develop an action plan that addresses the standards identified as not yet being met. If the concerns are more serious, DHS can apply a range of actions to address the issue (DHS 2007, p. 13). These are discussed in section 21.2.6.

In the external reviews conducted in 2009 and 2010, nine of the 99 CSOs were found not to be meeting one or more standards. As this was the first time that some CSOs had had their performance externally assessed, DHS sought to support all CSOs to demonstrate how they were meeting the registration standards to maintain its registration. The nine CSOs were re-registered on the condition that they complete an action plan within six months to address the standards they did not meet. The CSOs were reassessed by the independent reviewers with respect to those standards only. All nine CSOs were assessed to have met or part met the relevant standards, and the conditions on their registration were therefore removed (DHS 2011n, p. 21). DHS advised the Inquiry that one of the nine CSOs has since been subject to a service review (see section 21.2.5). As of December 2011, the CSO was implementing an action plan to address the issues identified in the service review.

In July 2011 DHS established a Standards and Registration Unit to undertake the registration, monitoring and review of CSOs in family services, out-of-home care, disability services and homelessness support. This dedicated regulatory unit was introduced by DHS as part of its transition to a single set of DHS standards, and as a response to the Victorian Ombudsman's finding – discussed in section 21.2.9 – that there was a conflict between DHS responsibility for regulating CSOs and its reliance on the same CSOs to meet DHS' statutory obligations.

Initially the unit will manage the review of CSOs against existing performance standards. It will develop a DHS Quality Standards Framework and a consistent registration policy for funded organisations, including integrating the registration requirements under the *Disability Act 2006* and the CYF Act. From July 2012, the unit will manage CSO compliance with the new DHS standards. It will be responsible for:

- Registration of funded organisations;
- Managing independent review bodies and ensuring quality procedures are in place for reviews;
- Responding to compliance issues in partnership with regions;
- Representing Victoria in the development of national quality frameworks;
- Evaluating independent review reports to identify trends in performance against standards; and
- Training funded organisations and departmental staff in relation to the DHS Quality Standards Framework.

21.2.2 Registration and disqualification of carers

Screening and registration of out-of-home carers

The screening of out-of-home carers is the responsibility of CSOs, with DHS responsible for maintaining a register of carers.

The CYF Act requires out-of-home care providers to have regard to a person's suitability before approving them to act as a foster carer, or employing or engaging them as a carer or as a provider of services to children in residential care facilities (such as a private tutor) (ss. 75-76). This includes checking the person's criminal record and history and consideration of their suitability and fitness, health, skills, experience and qualifications. The CSO must also check whether a person is disqualified from registration as an out-of-home carer. All kinship carers are assessed by DHS and are required to have a criminal records check and a Working with Children Check.

The CYF Act requires DHS to keep a register of home-based foster carers, lead tenant carers and residential carers (s. 80). Kinship carers are not required to be registered. Out-of-home care providers are required to ensure all carers' details are placed on the register and updated or removed as required. The carer register can be accessed by CSOs but is not publicly available. Only currently approved or employed carers are kept on the carer register.

These arrangements effectively give CSOs a role as the quasi-regulator of carers. DHS does not require proof of a CSO's ability to screen and monitor carers, nor does it regularly monitor CSOs' compliance with their responsibilities, other than through its general monitoring of CSO performance against the standards. The existing CSO standards include a standard relating to pre-employment and pre-placement checks of carers. The DHS standards that will apply from July 2012 are broader and do not specifically refer to screening and monitoring of carers but include a criterion that services are provided in a safe environment for all people, free from abuse, neglect, violence and/or preventable injury. It will be important that the DHS standards are applied in such a way that specific requirements such as the screening and registration of carers continue to be monitored.

Disqualification of out-of-home carers

If there is an allegation of physical or sexual abuse against a registered carer involving a child or young person in his or her care, the CYF Act requires DHS to report the allegation to police (s. 81) and determine whether there is a reasonable basis for conducting an independent investigation (s. 84). An independent investigation is a separate process from an Investigation of Abuse in Care, which can investigate allegations of any form of abuse (see section 21.2.4). DHS has established a panel of authorised independent investigators to undertake these investigations and to report all findings directly to the Secretary. An independent investigation does not proceed until any police investigation has been concluded (s. 97, CYF Act).

Following the independent investigation, the Secretary must decide whether to refer the matter for hearing by the Suitability Panel. The Suitability Panel is established under the CYF Act to determine whether a person should be disqualified from being placed on the register of out-of-home carers (s. 101). Up to six panel members are appointed by the Governor-in-Council on the recommendation of the minister. The Chairperson of the Panel must be a legal practitioner, with other members appointed with regard to the need for the Panel to have expertise in law, social work, psychology, the treatment of sex offenders or any other discipline required for the Panel to perform its functions.

The Secretary can only refer a matter to the Suitability Panel if the investigation contains a finding that, on the balance of probabilities, the carer has physically or sexually abused the child, and the Secretary considers that the person poses an unacceptable risk of harm to children.

The Panel must first determine whether, on the balance of probabilities, the allegation that the person has physically or sexually abused the child is proved. If the Panel finds that an allegation is proved, it must make a finding of misconduct against the person and then determine whether, on the balance of probabilities, the person poses an unacceptable risk of harm to children. If the Panel does find the person poses an unacceptable risk of harm to children, the person is disqualified from registration as an out-of-home carer. Decisions of the Suitability Panel are not made public.

DHS advised the Inquiry that the Suitability Panel heard one case in 2009-10 and nine cases in 2010-11. Two cases resulted in the carer being disqualified. One case resulted in a finding of misconduct against the carer but no disqualification. The remaining seven cases were not proven.

A person may apply to the Victorian Civil and Administrative Tribunal (VCAT) for review of a finding or determination of the Suitability Panel. A person may also apply to the Suitability Panel for the removal of disqualification. An application for removal of disqualification must set out the way in which the applicant's circumstances have changed and why the applicant no longer poses an unacceptable risk of harm to children.

The Inquiry received a submission from the Suitability Panel in late December 2011, too late for the Inquiry to consider the issues it raises. The submission is published on the Inquiry's website.

21.2.3 Investigation of critical incidents

DHS requires that all incidents that involve or impact upon clients and staff are reported to the department and investigated. Reporting of incidents is compulsory to ensure DHS meets its legal obligations, insurance obligations and public expectations of accountability.

The responsibility for the management of an incident rests at the local level. As out-of-home care includes care delivered directly by DHS, care delivered by CSOs and kinship care, incident reports can be the responsibility of departmental staff, CSO staff, kinship carers or lead tenants. Home-based caregivers and residential staff are required to report incidents to their CSO, while kinship carers and lead tenants report incidents directly to DHS. Incident report forms are primarily completed by the most senior member of staff or carer present at the time of the incident, with a representative of the agency management reporting on action taken in response to the incident to address any safety risks and what will be done to prevent the incident from happening again.

Incident reports are graded according to the degree of impact on clients and staff, and the potential future risk to clients and DHS. There are three categories of reportable incidents. Category one incidents are those that have the most serious outcomes such as a client death or serious injury to a client or staff member, allegations of sexual or physical assault of a client or staff member, or have the potential to involve the minister or be subject to a high level of public or legal scrutiny. Category two incidents involve events that seriously threaten clients or staff but do not meet the category one definition. In contrast, a category three incident has minor impacts on clients and staff with the significance of the incident not extending beyond the workplace or facility, such as minor neighbourhood complaints, minor property damage, or an injury not requiring medical treatment (DHS 2010a, pp. 15-17).

In 2010-11 there were 1,134 category one critical incidents reported to DHS relating to child protection clients. This represented a 82 per cent increase on 2008-09, when there were 621 category one critical incident reports. There were 912 category one critical incidents reported in 2009-10. It is not known how many clients were involved in incidents, as this was not recorded for 72 per cent of incidents.

The most common type of critical incidents are shown in Table 21.1. A range of low-frequency incidents accounted for the remaining 32 per cent of incidents, including 27 client deaths.

Table 21.1 Category one incidents by incident type, 2010-11

Incident type	Proportion of total category one incidents
Alleged physical assault	27%
Alleged sexual assault	21%
Attempted self-harm or suicide	6%
Dangerous or sexual behaviour	6%
Poor quality of care concerns	5%
Drug and alcohol use	4%
Breach of privacy and confidentiality	4%

Source: Unpublished DHS data

Forty per cent of category one critical incidents involving child protection clients involved clients of residential care. There were 452 category one critical incidents involving clients of residential care in 2010-11, representing almost one incident for each of the 454 children in residential care in June 2010. In contrast, 280 incidents (25 per cent) involved clients of home-based care, representing one incident for every 16 children in home-based care in June 2010. One-third of incidents involved child protection clients in juvenile protective services, and 2 per cent involved clients in secure welfare services (unpublished DHS data).

DHS undertakes quarterly analysis of critical incident data but does not currently report publicly on critical incidents. Up to 2009-10, the Child Safety Commissioner also produced a quarterly report on category one critical incidents involving clients of out-of-home care, until the Commissioner determined this was duplicating the analysis of DHS. The Office of the Child Safety Commissioner continues to collect and monitor critical incident data, which it uses to reconcile DHS' data. The Commissioner continues to identify concerns for individual clients, together with any emerging themes or patterns. The Inquiry considers that DHS should report annually on critical incidents, including a breakdown by region, by incident type and by the placement or service type in which incidents occur. The Inquiry's recommendation on this issue can be found in section 21.3.2.

DHS Regional Directors are responsible for ensuring that all relevant DHS managers and CSOs comply with the *Department of Human Services Incident Reporting Instruction* (DHS 2010a). The responsibilities of DHS regional staff include:

- Ensuring accuracy in categorising and investigating incidents to identify lessons and make recommendations for reducing risk to future clients and staff;
- Systematically reviewing incidents and investigating where appropriate, focusing on the root cause of the incident rather than the immediate event; and
- Undertaking compliance checks to assess the ongoing implementation of incident reporting policy. A compliance check will involve a review of documentation, data analysis from information systems and discussions with staff to determine the extent of compliance with the policy.

Other DHS staff have the following roles and responsibilities:

- DHS Program and Service Advisers are responsible for ensuring CSOs are aware of and comply with the incident reporting instruction;
- Where the department holds case management or statutory responsibility for clients, the case worker or case manager is responsible for ensuring that an appropriate planned response is undertaken to a critical incident, and that the CSO has informed all relevant authorities;
- Divisional program managers are responsible for reviewing incident data in consultation with regions, to inform policy development, practice and policy implementation; and
- The Service Delivery and Performance Division oversees the quality of reporting, compliance, and the identification of systemic issues arising from reports and referral.

Where incidents are considered to be of a serious nature and appear to be the result of problems with management systems or practices, the Secretary may commission an external review of the CSO (see section 21.2.1).

21.2.4 Quality of care concerns

Quality of care concerns refer to a broad range of concerns about the care given to a child or young person living in out-of-home care. Concerns can range from minor quality issues through to possible physical or sexual abuse.

Quality of care concerns can be raised by any person, including the children and young people themselves. Information can also be raised by people who have left care, including adults reporting quality of care concerns from their own experience living in out-of-home care as a child or young person, or by a query from the Office of the Child Safety Commissioner. Information may be received by DHS, CSOs or the police (DHS 2009b).

DHS has published *Guidelines for responding to quality of care concerns in out-of-home care* (DHS 2009b). The guidelines describe the approach that DHS and CSOs should use when responding to all issues that may be reported as quality of care concerns. The concerns can range from minor quality issues to possible physical or sexual abuse. All concerns about possible physical abuse or sexual abuse, neglect or poor quality care of a child or young person must be screened by DHS in consultation with the responsible CSO to determine the exact nature of the concern and the most appropriate response.

The guidelines outline four possible responses to quality of care concerns:

- Take no further action – if it can be clearly established that the report of the concern is inaccurate or there is no basis for concerns about the safety of the child or the quality of care the child is receiving;The CSO manages concerns by supporting and supervising the carer – if there are issues to be addressed that do not warrant an investigation or formal care review (the guidelines indicate that this will be the most appropriate response to the majority of quality of care concerns);
- Conduct an investigation into allegations of possible abuse in care; or
- A formal care review – when there are serious or repeated concerns about possible poor quality care provision that do not involve an allegation of possible abuse or neglect.

The current DHS database does not allow for the recording of all quality of care concerns reported to DHS. As a result, DHS reports only the number of investigations undertaken, and the number of formal care reviews (this data is discussed below). The Inquiry considers this to be inadequate. The Inquiry considers that DHS should record and report on the number of quality of care concerns raised, the number of investigations of abuse in care and the number of formal care reviews, including the outcomes of investigations and reviews and their timeliness. There should be breakdowns by region, by allegation type or quality of care concern type and by placement type. The Inquiry's recommendation on this issue can be found in section 21.3.2.

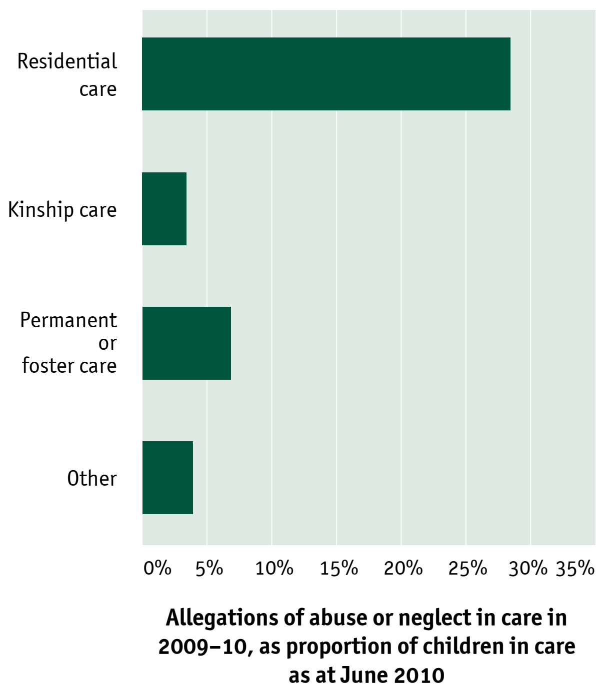
Investigations of abuse in care

Investigations into allegations of possible abuse or neglect are led by DHS and conducted in partnership with the CSO. There may also be a police investigation. There is a range of procedures in place to ensure coordination or cooperation between the police, DHS and CSOs throughout the investigation process.

In 2009-10, there were allegations of possible abuse or neglect relating to 363 clients in out-of-home care, about 4.4 per cent of clients who spent time in out-of-home care that year. These allegations related to 279 reported incidents. About 61 per cent of allegations related to physical assault and 15 per cent related to sexual assault (DHS 2011e, p. 2).

Figure 21.2 shows that children in residential care were much more likely to be involved in allegations of possible abuse or neglect than children living in other placement types. Overall in 2009-10 there were 131 allegations involving children in residential care, 154 involving children in permanent care or foster care, 77 involving children in kinship care and one allegation involving a child in a lead tenant placement (DHS 2011e, pp. 5-6).

Figure 21.2 Allegations of possible abuse and neglect in out-of-home care, by placement type, Victoria, 2009-10



Source: DHS 2011e, pp. 5-6

The guidelines require DHS investigations to be completed within 28 working days of the allegation being received by the department. However, only 51 per cent of investigations into possible abuse in care in 2009-10 were completed by June 2010, and only 61 per cent of the completed investigations were completed within the required 28 day period (DHS 2011e, p. 9). DHS advised the Inquiry that some cases were delayed by lengthy police investigations, while for others there was a delay in child protection managers endorsing the reports due to competing work requirements.

Of the 185 investigations that were completed in 2009-10, 56 (30 per cent) were substantiated (DHS 2011e, p. 7). This substantiation rate is substantially lower than the rate for child protection investigations (52.7 per cent in 2009-10) (see Chapter 9).

When an investigation finds an allegation of abuse or neglect in home-based care is substantiated, DHS determines whether it is in the best interests of a child or young person (including other children or young people residing in the placement) to continue in that placement. The decision to remove a child or young person from a placement may take place at any time before, during or after an investigation. When an allegation of abuse or neglect in residential care is substantiated, it is the carer who would usually be removed from the residential unit, rather than the child or young person. When an allegation of abuse or neglect has been substantiated, DHS and the CSO also decide how to address any remaining quality of care concerns that were not determined to be abuse or neglect.

In 2009-10, 48 investigations resulted in a carer's approval being withdrawn, representing 26 per cent of completed investigations. Forty-six investigations (25 per cent) resulted in a change in placement for the child or young person. A total of 130 allegations were reported to police, resulting in 40 police investigations (DHS 2011e, pp. 7-8).

In 2009-10, 129 completed investigations did not substantiate the allegations of abuse in care. When the investigation finds the allegation is not substantiated, there are three possible outcomes:

- A formal care review – if serious concerns remain about the capacity of a carer to provide care to an appropriate standard (this occurred just four times in 2010-11, representing 3 per cent of unsubstantiated allegations);
- The CSO manages concerns by implementing recommendations made as a result of the investigation (33 per cent of unsubstantiated allegations); or
- No further action (64 per cent of unsubstantiated allegations).

Of the 129 allegations that were not substantiated:

- 83 (64 per cent) required no further action;
- 42 (33 per cent) required the implementation of recommendations made as a result of the investigation, for example, regarding the CSO's support and supervision of the carer); and
- Four (3 per cent) were referred to a formal care review (DHS 2011e, p. 7).

Formal care reviews

The purpose of a formal care review is to comprehensively assess the nature of a significant or repeated quality of care concern (including allegations of abuse or neglect) and to develop an action plan to address the concern where possible, or to withdraw a carer's approval. The DHS *Guidelines for responding to quality of care concerns in out-of-home care* state that:

> While the objective of a formal care review is to address quality of care concerns so that placements are not disrupted and carers continue in the role, in some circumstances a formal care review may recommend that the carer should not continue in the role if it is not possible to ensure the safety, stability and development of children or young people in their care (DHS 2009b, p. 102).

Where an incident has been reported or an allegation received by DHS that involves a performance issue by the CSO, this can also be investigated as part of a formal care review.

Formal care reviews are conducted jointly by the DHS Child Protection Unit manager, the DHS Quality of Care Coordinator and the CSO. The CSO has lead responsibility to coordinate and complete the review. The review must determine whether:

- The quality of care concerns have been addressed and no further action should be taken;
- The concerns should be addressed by implementing an action plan over a three-month period; or
- The concerns identified have not and are unlikely to be addressed and there are concerns about the carer's ability to provide safe care for children and young people. If this is the assessment of the review panel, it is the responsibility of the CSO senior regional manager to determine the most appropriate course of action to take with respect to the carer's ongoing role within the organisation.

In 2009-10 formal care reviews were held as a result of quality of care concerns relating to 159 clients in out-of-home care, which amounted to about 1.9 per cent of clients who spent some time in out-of-home care that year. The concerns related to 94 reported incidents. The most common issues of concern involved the use of inappropriate discipline (31 per cent), carer compliance with standards (18 per cent) and inadequate supervision of the child (15 per cent) (DHS 2011e, p. 11). Allegations of assault by one child or young person against another child or young person in care are excluded from this data.

Almost two-thirds of formal care reviews related to permanent carers or foster carers (103 reviews or 65 per cent). This represented one review for every 22 children in permanent care or foster care in June 2010. Thirty-four reviews (21 per cent) related to residential carers, representing one review for every 13 children in residential care in June 2010. Kinship carers were involved in only 16 reviews, representing 10 per cent of all reviews and one review for every 136 children in kinship care at the end of June 2010. Six reviews (4 per cent) related to other people, including people known to the carer (DHS 2011e, p. 11).

Only 86 (54 per cent) of the 159 quality of care reviews were completed in 2009-10. Sixty-three reviews (75 per cent) found evidence of quality of care concerns. Of these 63 reviews:

- 24 reviews (38 per cent) required no further action as the concerns had been addressed;
- 27 reviews (43 per cent) required an action plan to be implemented to address the concerns; and
- 12 reviews (22 per cent) resulted in the carer's approval being withdrawn (DHS 2011e, p. 15).

The DHS guidelines describe the objective of an action plan as ensuring the safety, stability and wellbeing of children placed with the carer (DHS 2009b, p. 109). The review panel should detail the specific quality of care concerns to be addressed, how they are to be addressed (including tasks, roles, responsibilities and timelines), and the required outcomes. Action plans should also address any wider CSO management or service delivery issues found in the review (DHS 2007, p. 11).

The review panel is required to review the carer's progress against the action plan within three months. If quality of care concerns still exist, the panel must determine whether it is likely that the carer has the capacity to make the required improvements within a further three-month period, or if the carer is unable to provide an acceptable level of care to children and young people placed with them. If the carer is unable to address the concerns, it would be usual for the CSO to determine that the carer can not continue in their role.

If a formal care review substantiates concerns regarding the performance of the CSO and the review panel finds that further action is warranted, the Secretary may commission an external review of the CSO (see section 21.2.1).

21.2.5 Performance monitoring and desktop review

DHS monitors organisations that receive funding through service agreements. Each CSO delivering family services or out-of-home care has a service agreement with DHS that outlines the agency's service requirements and the associated funding it receives to deliver those services. CSOs have a single service agreement with DHS, even if they receive funding from other DHS program areas.

Under the DHS monitoring framework, DHS works in partnership with CSOs to monitor organisation service sustainability, to assist in early identification of risks, and to ensure the ongoing provision of human services and avoid the costs of service failure. Monitoring coordinators, usually a Program and Service Adviser located in a DHS regional office, are responsible for implementing the framework.

The framework is made up of three core components:

- Core monitoring – regular monitoring of all CSOs, in terms of their financial sustainability, service delivery and client safety and wellbeing;
- Desktop review – an annual review of the overall performance of all CSOs in the previous year, including service delivery, financial management and organisational management. This is conducted by DHS with no CSO involvement. The review comprises a short series of questions designed to consider key areas of risk. Only a few questions relate to performance. For most CSOs, the review will indicate that current service delivery and the relationship with DHS are adequate; and
- Service review – where the desktop review identifies a high level of risk or issues of concern, DHS and the CSO will meet, jointly raise issues or concerns, and develop solutions. This is a service review. An action plan may be developed as a result. Service reviews are undertaken in partnership and are not adversarial or punitive (DHS 2007, p. 3).

Between July 2010 and September 2011, service reviews were undertaken for four registered CSOs and three 'light touch' agencies. Sanctions arising from these service reviews are discussed in the following section.

If concerns raised in the service review are addressed, the process will finish and core monitoring will continue as normal. Where concerns are not addressed, the Secretary may commission an external review of the CSO (see section 21.2.1).

21.2.6 Sanctions available to the Department of Human Services

When an external review or other review process identifies serious concerns about a CSO's governance, management or service delivery that DHS and the CSO have not been able to resolve through implementation of an action plan, the Secretary can take the following actions:

- Request the CSO to develop a joint action plan in partnership with DHS to overcome the identified issues;
- Place conditions on the CSO's registration – possible conditions could include CSOs having to demonstrate compliance with certain standards in a set period or for the CSO to be reviewed at a future date;
- Renegotiate funding to be received for certain services through the CSO's service agreement;
- Advise the Minister to appoint an administrator; and
- Revoke the CSO's registration – a consequence of the revocation of registration would be the cessation of funding of the CSO, in compliance with the conditions of the service agreement.

DHS (2007, p. 13) indicates the action taken by the Secretary will depend on a number of factors, including:

- The success of other strategies to improve performance, including the development and implementation of prior actions plans by the CSO and the strength of communication between the department and the CSO;
- The CSO's circumstances and if it is likely to be able to swiftly and appropriately remedy the problem;
- The CSO's internal planning and whether it wishes to continue to provide the service or focus on other functions;
- The performance issue and whether it places children or youth safety, stability and development at risk; and
- Whether serious breaches of registration standards and requirements are unresolved.

The chief executive officer or board of the CSO will be consulted regarding the Secretary's decision. DHS will also consult with other organisations from which the CSO receives funding, including other divisions of DHS, the Commonwealth and other states. These discussions will help to determine the most appropriate strategy to improve the performance of the CSO.

Appointing an administrator

If the Minister is satisfied that a registered CSO is inefficiently or incompetently managed, the Minister may recommend to the Governor-in-Council that an administrator of the CSO be appointed. The appointment of an administrator is considered where other options have been exhausted or where there are reasonable grounds for believing an action plan cannot be agreed or implemented.

On the appointment of an administrator, the members of the board or other governing body of the CSO cease to hold office. The administrator may exercise all the powers and is subject to all the duties previously held by the board (ss. 67-69, CYF Act). The appointment of an administrator allows the CSO to continue to deliver services, and funding continues to be provided by DHS.

If DHS and the administrator consider the CSO is meeting service delivery standards, the Minister can recommend to the Governor-in-Council that the appointment of the administrator be revoked. A new board or committee of management is then elected in accordance with the CSO's constitution.

Recent actions taken against community service organisations

DHS advised the Inquiry that, since 2007, nine CSOs have had conditions placed on their registration, as discussed in section 21.2.1. There have been no administrators appointed to CSOs, and no CSO has had its registration revoked.

In 2011 funded out-of-home care services and family services delivered by two CSOs were transferred to other CSOs. These actions followed service reviews of the agencies. In one case, the legal entity governing the CSO remains registered, as other bodies under its structure continue to provide services. The other CSO had its out-of-home care services transferred to other CSOs but remains registered as it continues to deliver family services. A service review of a third CSO has also resulted in action by DHS, and DHS advisers have been appointed to work with the CSO to improve its management and service delivery.

21.2.7 Performance of regulatory framework

Drawing upon the *Victorian Guide to Regulation* (Victorian Government 2011e) and the work of the United Kingdom (UK) Better Regulation Task Force (2005, pp. 26-27), the Inquiry has assessed Victoria's regulatory arrangements for out-of-home care and family services against five principles of 'good regulation' that test whether any regulatory system is fit for purpose:

- Accountability – regulators must be able to justify decisions, and be subject to public scrutiny;
- Consistency – government rules and standards must be joined up and implemented fairly;
- Transparency – regulators should be open and keep regulations simple and user friendly;
- Proportionality – regulators should only intervene when necessary (remedies should be appropriate to the risk posed, and costs identified and minimised); and
- Targeting – regulation should be focused on the problem, and minimise side effects.

Overall, the Inquiry considers that the regulatory framework for out-of-home care and family services performs well in terms of accountability and consistency, although there is scope for greater scrutiny and reporting of regulatory decisions. Reforms are required to improve transparency, proportionality and targeting.

Accountability

The principle of accountability requires all those affected to be consulted before final decisions are taken. There should be effective complaints and appeals procedures, and regulators should have clear lines of accountability to the Minister, Parliament and the public (Better Regulation Task Force 2005, pp. 26-27). The enforcement of regulation should be monitored, with the results being reported to the public on a systematic basis (Victorian Government 2011e, pp. 3-2), though it is noted that privacy laws and restrictions on identifying people involved in court orders may place some constraints on public reporting of child protection outcomes.

DHS advises that it consults with CSOs regarding any significant regulatory decisions. CSOs can apply to VCAT for a review of a decision by the Secretary to refuse to register or to revoke the registration of a CSO. Similarly, carers can apply to VCAT for a review of findings of misconduct or disqualification by the Suitability Panel.

Like all government activity, the regulation of family services and out-of-home care is potentially subject to parliamentary and public scrutiny via the Victorian Ombudsman and the Victorian Auditor-General. While the *Child Wellbeing and Safety Act 2005* (CWS Act) grants the Child Safety Commissioner responsibility for monitoring out-of-home care services, these powers do not extend to oversight of the regulation of out-of-home care services. The Commissioner does not oversee family services. The oversight responsibilities of the Commissioner are considered in detail in section 21.3.1.

DHS does not, as a matter of course, publish its regulatory decisions concerning, for example, the placement of conditions on a CSO's registration, the appointment of an administrator, or the revocation of registration. The outcomes of these decisions may be announced by the Minister. The Inquiry considers the accountability of the system would be further enhanced if DHS published regulatory decisions regarding such matters and explained how and why those decisions were reached. The Inquiry's recommendation on this issue can be found in section 21.3.2.

Consistency

The principle of consistency requires regulators to be consistent with each other, and work together in a joined-up way. Regulation should be predictable in order to give stability and certainty to those being regulated. DHS should apply regulations consistently across Victoria (Better Regulation Task Force 2005, pp. 26-27).The Victorian Ombudsman's 2010 investigation of out-of-home care reported that representatives of the sector had stated that:

> ... the several compliance regimes imposed on community service organisations in relation to various services they were funded by government to provide often overlapped and that this resulted in unnecessary burden (Victorian Ombudsman 2010, p. 54).

DHS has responded to this issue by introducing a single set of service quality standards to apply to all funded organisations delivering out-of-home care and family services, homelessness assistance services and disability services from July 2012. The aim is to reduce red tape by streamlining accreditation, monitoring and evaluation processes, and to help to ensure a consistent quality of service no matter which DHS-funded service people access.

The Standards and Registration Unit in DHS central office is administering the standards. External reviews of CSOs will be conducted by a panel of approved independent review bodies. These arrangements will help to ensure consistent application of the standards across Victoria.

Transparency

The principle of transparency requires the objectives of regulation to be clearly defined and effectively communicated to all interested parties. CSOs should be made aware of their obligations, with law and best practice clearly distinguished. CSOs should be given the time and support to comply, and the consequences of noncompliance should be made clear. Regulators should clearly explain how and why regulatory decisions have been reached (Better Regulation Task Force 2005, pp. 26-27).

While DHS has been diligent in publishing a number of documents to describe the regulatory processes applying to out-of-home care and intensive family services and the obligations of CSOs, the transparency of the regulatory system is compromised by its complexity. Section 21.2 shows that there are five separate regulatory processes applying to CSOs and carers. Responsibility for these processes is dispersed across DHS. The number of different types of investigation or review is even larger. As shown in Figure 21.1, there are many instances where one investigation or review process will give rise to a second or third review process.

The Inquiry considers that the transparency and effectiveness of the regulatory system would be enhanced if DHS were to simplify, reduce duplication and improve the coordination of regulatory processes.

Proportionality and targeting

The closely related principles of proportionality and targeting require regulations to be focused on the problem and proportionate to the risk of harm to children and young people. As the regulator, DHS should focus primarily on those whose activities give rise to the most serious risks. Where appropriate, regulators should adopt a 'goals-based' approach, with CSOs given flexibility in deciding how to meet clear, unambiguous targets (Better Regulation Task Force 2005, pp. 26-27).

DHS' regulatory activity is not informed by a systematic analysis of the risk posed by CSOs and, as a result, is not targeted to where it is needed most. It does not, for example, consider factors such as the size of the CSO or its track record in meeting performance standards. All CSOs are subject to the same cycle of one independent external review every three years. This cycle will be maintained under the new DHS standards. While irregular external reviews may be commissioned if an issue of concern is identified and not addressed by the CSO, this is likely to occur only after a critical incident, a quality of care concern or an allegation of abuse in care. Inspections of CSOs are almost exclusively in response to an incident or allegation, rather than acting as a quality assurance mechanism to prevent incidents or concerns from arising.

In addition, the available evidence suggests that DHS often does not respond to issues of concern in a timely fashion. Section 21.2.4 shows that, despite the requirement for investigations into possible abuse in care to be completed within 28 days, only half of the investigations in 2009-10 were completed by June 2010, and only 57 per cent of the completed investigations were completed within the required period. A similar proportion of quality of care reviews had been completed by the end of the year.

The Inquiry considers these arrangements to be inadequate given that, as demonstrated in Chapter 10, there are major and unacceptable shortcomings in the quality of care and outcomes for children and young people placed in out-of-home care.

One approach to applying a risk-based approach to regulation is known as *earned autonomy*. An earned autonomy approach has been adopted by a number of regulators to ensure their effort is focused on monitoring higher risk agencies. For example, under the *National Quality Framework for Early Childhood Education and Care*, which will come into effect in 2012, the number and frequency of inspections of an early childhood education and care service will depend on the service's record and any events associated with a risk or change in practice that indicate a service might not be meeting quality standards (Early Childhood Development Steering Committee 2009, pp. 7-8). It is anticipated that the frequency of assessments of services will be as follows:

- Excellent or high-quality services – every three years;
- National quality standard services – every two years;
- Foundation services – at least once each year; and
- Unsatisfactory services – more frequent visits.

The *National Quality Framework* also provides for state-based regulatory agencies to make unannounced inspections of services to complement the regular full assessments.

Scotland's new regulator of care, social work and child protection services, Social Care and Social Work Improvement Scotland (SCSWIS), is also applying a risk-based approach. The regulator states that it will organise its scrutiny and improvement activity, including inspections, around risk. Poorly performing services and high-risk services will be inspected more and improvement demanded. Better performing services will be inspected less often, but there will be more random inspections (SCSWIS 2011, pp. 3-4).

The recent Munro Review of Child Protection in the UK endorsed the role that inspection can play in improving the quality of services for children and promoting accountability. The Munro Review found that the proportionality of the UK's children's service inspection system would be improved through greater use of unannounced inspections instead of announced inspections, and adopting a risk-based approach to the programming of inspection. The Review found that these changes would reduce the need for preparation for announced inspections, thereby reducing regulatory burden (Munro 2011b, p. 83).

In its submission to the Inquiry, the Victorian Council of Social Service (VCOSS) emphasised that the reforms proposed by the Inquiry should not increase the regulatory burden on CSOs (VCOSS submission, pp. 51-52). Similarly, Jesuit Social Services argued that the administrative burden on CSOs could be more consistently proportionate:

> Where a large sum of money is involved it is naturally accepted that tender and acquittal processes will be comprehensive. Where tenders and acquittals are for lesser amounts ... there should be a proportionate reduction in the administrative processes whilst still meeting all requirements to be accountable for the expenditure of public money. There have been some positive developments in this area but inconsistencies are still experienced (Jesuit Social Services submission, p. 16).

21.2.8 Future regulatory approach

In seeking to reduce the regulatory burden on CSOs, DHS has failed to maintain an adequate level of external scrutiny of CSO performance. In particular, it is unacceptable that:

- All CSOs are subject to the same cycle of one independent external review every three years, regardless of their performance; and
- There is no program of unannounced inspections to act as a quality assurance mechanism to prevent incidents or concerns from arising.

Finding 20

The Department of Human Services' current approach to monitoring and reviewing community service organisations performance does not do enough to identify, address and prevent the major and unacceptable shortcomings in the quality of out-of-home care.

The Inquiry recommends that DHS should adopt a risk-based approach to the monitoring and review of CSO performance. DHS should assess the risk of CSOs not meeting performance standards, with a focus on the risk of harm to children and young people in their care. The frequency with which DHS reviews the performance of a CSO should be proportionate to the CSO's risk rating. Higher risk CSOs should be reviewed more frequently than once every three years. Support should be available to CSOs to meet performance standards and to raise the quality of service provided to children and young people in their care.

Complementing the regular program of performance reviews, DHS should also undertake unannounced inspections. All CSOs would be subject to inspections, regardless of their risk level. The purpose of the inspections would be as a quality assurance mechanism to prevent incidents or concerns from arising. Inspections would seek to assess the risk of harm to clients, and might involve a check of whether the CSO was meeting selected standards. It would not involve a full assessment of the CSO's performance.

DHS does not, as a matter of course, publish its regulatory decisions concerning, for example the placement of conditions on a CSO's registration, the appointment of an administrator, or the revocation of registration. The outcomes of these decisions may be announced by the Minister. The Inquiry considers the accountability of the system would be further enhanced if DHS published regulatory decisions regarding such matters and explained how and why those decisions were reached.

Recommendation 85

The Department of Human Services should adopt a risk-based approach to monitoring and reviewing of community service organisation performance, involving greater use of unannounced inspections and reviewing the performance of higher risk agencies more frequently than lower risk agencies.

21.2.9 Governance of regulatory functions

This section considers whether DHS is the most appropriate agency to undertake the core regulatory functions of registering, monitoring and reviewing the performance of CSOs delivering family services and out-of-home care.

The CYF Act places significant responsibility for the protection of children at risk on the Secretary of DHS (see Chapter 9). DHS is also responsible for implementing the broader policy objectives of the government. As a consequence, DHS has multiple responsibilities for the planning, delivery, funding and regulation of family services, statutory child protection services and out-of-home care. In some instances, the Secretary also is the legal guardian of children placed in out-of-home care.

The multiplicity of responsibilities held by DHS is not unique to Victoria. The equivalent regulatory tasks are undertaken by a departmental regulator in most states and territories. The exception is New South Wales, where the independent Children's Guardian is responsible for the accreditation and quality improvement of statutory out-of-home care agencies.

Ombudsman recommendation

The 2010 Ombudsman investigation into out-of-home care found that there is a conflict between DHS' role in regulating CSOs and its reliance on those same CSOs to meet its statutory responsibilities (Victorian Ombudsman 2010, p. 57). The Ombudsman considered that any finding by DHS that a CSO is providing an inadequate standard of care may reflect that DHS has failed to meet its obligations in regard to those children that the Secretary has personal statutory responsibility. Such a finding may also raise issues regarding DHS' contract management and resource allocation.

The Ombudsman's view was echoed by the Centre for Excellence in Child and Family Welfare and VCOSS in their submissions to the Inquiry (Centre for Excellence in Child and Family Welfare, p. 24; VCOSS, p. 51).

The Ombudsman recommended that DHS:

> Transfer the function of registering community service organisations to an independent Office which has no reliance on the services being provided by the agency being registered (Victorian Ombudsman 2010, p. 58).

DHS did not accept the Ombudsman's recommendation. In response to the Ombudsman, the Secretary disagreed that there was a conflict between DHS' multiple roles, on the basis that DHS' regulatory and funding activities have a common objective of achieving quality services for children, youth and families. The Secretary also argued that the creation of a new regulatory body for out-of-home care was not cost-effective given the small scale of the sector (Victorian Ombudsman 2010, p. 58). More recently, as discussed in section 21.2.1, the Secretary has sought to separate the registration, monitoring and review of CSOs from the funding of CSOs within DHS, with the creation of a dedicated Standards and Registration Unit.

Principles of good governance of regulators

In 2010 the Victorian Government released a framework for good governance of Victorian regulators (Department of Premier and Cabinet (DPC) 2010). The framework is concerned primarily with the external governance of regulators – the roles, relationships and distribution of powers and responsibilities between Parliament, the Minister, the department, the regulator's governing body and regulated entities.

The framework provides an objective basis for assessing the adequacy of the governance arrangements applying to the regulation of family services and out-of-home care. The framework consists of six sets of principles of good governance that should apply to all regulators. The principles are:

- Role clarity;

- Degree of independence;
- Decision making and governing body structure for independent regulators;
- Accountability and transparency;
- Engagement; and
- Funding.

The full list of 34 principles is shown in Table 4 of Appendix 14.

The concerns raised by the Ombudsman relate primarily to the degree of independence of DHS as the regulator. In discussing this principle, the good governance framework provides the following guidance on the threshold issue of whether regulatory decisions are best made by an independent regulator or a departmental regulator (DPC 2010, pp. 9-10):

- Independent regulatory decision making, at arm's length from ministers and their departments, is preferable where there is a need for the regulator to be seen as independent, to maintain public confidence in the objectivity and impartiality of decisions. This is likely to be important when the decisions of the regulator can have a significant impact on regulated entities or other parties; and
- A departmental regulator is likely to be more appropriate where the regulatory function is closely integrated with other departmental functions and there are benefits to retaining the specialist knowledge and expertise within government.

A further consideration is the role clarity of DHS as the regulator. Granting a regulator responsibility for service delivery, funding of regulated entities or industry development functions as well as its regulatory functions can present conflicts of interest that may reduce the regulator's effectiveness, divert resources and management attention away from the regulatory task, and undermine public confidence in the system. The framework requires that a regulator should hold potentially conflicting functions only if there is a clear public benefit in combining these functions and the risks of conflict can be managed (DPC 2010, p. 20).

The Inquiry is also concerned that the lead role given to CSOs in conducting formal care reviews in partnership with DHS is not appropriate. As CSOs are the employers of residential carers and approve foster carers, this may require CSOs to investigate themselves.

Future governance arrangements

The Inquiry has considered the recommendations of the Ombudsman and the Secretary's response to the Ombudsman in the context of the government's framework for good governance of Victorian regulators. The Inquiry has concluded that where a government agency such as DHS relies on CSOs for the delivery of services that are central to the agency achieving its core objectives, it is appropriate that the agency be responsible for the regulation and monitoring of the CSOs. Allowing an external agency to register and monitor a CSO could allow DHS to avoid responsibility for the performance of a CSO.

The Inquiry therefore recommends that DHS retain responsibility for regulation of out-of-home care services and family services, provided that:

- The regulatory function is independent and structurally separated from those parts of the Children, Youth and Families Division responsible for child protection and family services policy and funding of CSOs;
- The director of the unit reports directly to the Secretary; and
- DHS is subject to independent oversight of the conduct of its regulatory function by the Commission for Children and Young People recommended in section 21.3.3.

Recommendation 86

The Department of Human Services should retain responsibility for regulating out-of-home care services and family services. This function should be independent and structurally separated from those parts of the department responsible for child protection and family services policy and funding of community service organisations. The director of the unit should report directly to the Secretary.

The Inquiry considers that CSOs have a potential conflict of interest in leading formal care reviews, which they conduct in partnership with DHS. While it is appropriate for CSOs to use their own internal processes to address minor issues related to placements and carers, DHS should have lead responsibility for the review of serious or repeated quality of care concerns. CSOs would support DHS in undertaking the reviews. This would bring the formal care review process into line with investigations of possible abuse or neglect in care.

Recommendation 87

The Department of Human Services should take lead responsibility for formal care reviews.

21.3 Oversight and transparency

> We cannot continue to have reviews in Victoria every few years (Mr Justice Fogarty 1993).

Despite Mr Justice Fogarty's comment 19 years ago, Victoria's system for protecting vulnerable children has continued to be subject to a large number of reviews and inquiries in the intervening years. As discussed in Chapter 9, the cumulative impact of these reviews and inquiries, together with ongoing media coverage, has been to contribute to a sense of perpetual review and a sector and workforce in crisis.

> Creating a space where a child welfare system can be accountable but have a degree of protection from sensationalist media coverage could create a more open system that is better able to expend effort interrogating its own processes and performance and supporting practice enhancing research (Connolly submission, p. 2).

An objective of oversight and transparency arrangements should be to provide for regular independent scrutiny and public reporting on the performance of the system. Regular external oversight and reporting can be an important part of a system that supports continuous improvement in individual services and across the sector.

21.3.1 Existing oversight arrangements

A number of government agencies have roles, powers and responsibilities for overseeing the delivery of family services, statutory child protection services and out-of-home care. These are summarised in Table 21.2 and then explored in more detail.

DHS Child Protection Standards Compliance Committee

In 2010 DHS established a Child Protection Standards Compliance Committee to:

- Improve the department's operational compliance with child protection legislation, regulations, practice standards and guidelines; and
- Review and comment on the systems the department has in place to monitor compliance and carry out targeted compliance checks.

The Committee was established in response to the recommendation from the Ombudsman's 2009 investigation into the statutory child protection program that DHS establish arrangements for the independent scrutiny of the department's decision making regarding significant wellbeing and protective intervention reports.

The Committee advises the Secretary on DHS' compliance with child protection practice standards and guidelines, and submits an annual report to the Secretary on the progress of the Committee's work.

The Committee is chaired by an independent chair with expertise in the fields of monitoring and accountability. The panel includes seven other independent members and two DHS officers - the Principal Practitioner, Child Protection and the Deputy Chief Psychiatrist, Children and Youth Mental Health.

Victorian Ombudsman

The Victorian Ombudsman is an independent officer of the Victorian Parliament who investigates complaints about state government departments, most statutory authorities and local government. The Ombudsman is responsible to Parliament, rather than the government of the day, and can only be dismissed by Parliament.

Table 21.2 Government agencies with oversight of family services, statutory child protection services and out-of-home care

Agency	Role
DHS Child Protection Standards Compliance Committee	Advises the Secretary on DHS' compliance with child protection practice standards and guidelines
Victorian Ombudsman	Broad powers to investigate complaints about government agencies
Auditor-General	Audits the performance of government agencies
Child Safety Commissioner	Reports to the Minister on the performance of out-of-home care services Conducts inquiries in relation to deaths of children who were clients or recent clients of child protection at the time of their death Conducts inquiries into other child protection clients at the request of the Minister
Victorian Child Death Review Committee	Reviews the deaths of children and young people who were clients of the Victorian statutory child protection service at the time of their death or within 12 months of their death
State Coroner	Investigates particular categories of deaths

The Ombudsman investigates complaints about administrative actions and decisions taken by government authorities and about the conduct or behaviour of their staff. Complaints can be made to the Ombudsman by any member of the public. The Ombudsman will not usually intervene until the aggrieved person has raised their concerns with the responsible government authority.

The Ombudsman's powers to conduct investigations are deliberately broad. Unlike specialist review tribunals or commissions, the Ombudsman reviews the lawfulness of agencies' actions or decisions, as well as the reasonableness and fairness of these actions in the circumstances (Victorian Ombudsman 2011a).

Victoria's system for protecting vulnerable children has been a significant source of complaints to the Ombudsman over many years (Victorian Ombudsman 2009, p. 8). In addition to the Ombudsman's general investigation power over government agencies, since 2007 the CYF Act (s. 20) has given specific powers to the Ombudsman to investigate:

- CSOs that are registered to deliver family services and out-of-home care;
- Officers of CSOs who are authorised under the CYF Act to act on behalf of the Secretary;
- Independent agencies that are authorised by the Secretary to conduct external reviews of CSOs; and
- Independent investigators who are authorised by the Secretary to investigate an allegation of abuse against an out-of-home carer.

The Auditor-General

The Auditor-General provides independent assurance to the Victorian Parliament on the accountability and performance of the Victorian public sector. The Auditor-General is an independent officer of Parliament appointed to examine and report to Parliament and the community on the efficient and effective management of public sector resources, and provide assurance on the financial integrity of Victoria's system of government. The Auditor-General's functions, mandate and powers are set out in the *Audit Act 1994*.

The Auditor-General fulfils his or her responsibilities by publishing a range of audit reports and publications. The primary publications are performance audit reports and reports on the results of financial statement audits. The Office's audit clients comprise over 600 public sector entities (Victorian Auditor-General's Office 2011a).

Child Safety Commissioner

The Child Safety Commissioner was established in 2004 to provide a strong and independent voice for children, to promote their safety and wellbeing and to provide advice to the Minister for Community Services and the Minister for Children. The Commissioner is appointed by the Premier for a specified period and can be removed from office by the Premier. The functions and powers granted to the Commissioner under the CWS Act are shown in the box.

Functions and powers of the Child Safety Commissioner

The functions and powers of the Child Safety Commissioner relating to out-of-home care, statutory child protection services, and other functions are outlined below.

The Commissioner's functions in relation to out-of-home care are:

- To promote the provision of out-of-home care services that encourage the active participation of those children in the making of decisions that affect them;
- To advise the Minister and the Secretary on the performance of out-of-home care services; and
- At the request of the Minister, to investigate and report on an out-of-home care service.

The Commissioner's functions in relation to statutory child protection services are:

- To conduct inquiries in relation to children who have died and who were child protection clients at the time of their death or within 12 months of their death; and
- To conduct inquiries in relation to a child protection client, at the request of the Minister.

The Commissioner's other functions are:

- To provide advice and recommendations to the Minister about child safety issues, at the request of the Minister;
- To promote child-friendly and child-safe practices in the Victorian community;
- To review and report on the administration of the *Working with Children Act 2005* and, in consultation with the Department of Justice, to educate and inform the community about that Act.

The Child Safety Commissioner must submit an annual report on the conduct of his or her functions to the Minister for Community Services. The report must be tabled in each House of Parliament.

As noted previously, the Victorian Government has committed to establish an independent Children's Commissioner who would report directly to Parliament and would be able to initiate reviews regarding children who have been abused or neglected. The future role of the Commissioner is considered in section 21.3.3.

A Bill to establish a Commonwealth Commissioner for Children and Young People was introduced to the Senate in 2010. An Inquiry into the Bill by the Senate Legal and Constitutional Affairs Legislation Committee recommended in 2011 that the Bill should not be passed, noting that the Australian Government is currently considering the role of a National Children's Commissioner under the *National Framework for Protecting Australia's Children*.

Victorian Child Death Review Committee

The Victorian Child Death Review Committee (VCDRC) is an independent, multidisciplinary ministerial advisory body that reviews the deaths of children and young people who were clients of the Victorian child protection service at the time of their death or within 12 months of their death. The VCDRC has 10 current members, including the DHS Principal Child Protection Practitioner, representatives of Victoria Police and the Coroners Court, and a number of independent members.

In undertaking its reviews, the VCDRC's role is to:

- Identify any themes, trends or patterns that emerge from the review process and advise the Minister for Community Services of their implications for policy and practice in child protection and related services; and
- Identify particular groups of child deaths that may benefit from further investigation and oversee a group analysis process to gain a more comprehensive understanding of the issues involved and best practice responses.

The VCDRC does not express an opinion about the factors leading to a child's death nor does it determine culpability. Responsibility for these matters rests with the State Coroner and Victoria Police. The primary source materials used by the VCDRC are the reports of the Office of the Child Safety Commissioner's inquiries into the deaths of children known to statutory child protection services. The Office also provides a range of administrative support services to the VCDRC, but the VCDRC operates as an independent ministerial advisory body. If the VCDRC identifies a theme or issue that is common across cases, it can request the Office of the Child Safety Commissioner to undertake a more comprehensive analysis of issues arising from a particular group of deaths. Since the inception of the VCDRC in 1995, seven such analyses have been undertaken. In 2011 the Office undertook an analysis of responses to the co-existence of family violence, parental substance abuse and parental mental illness (VCDRC submission, p. 8).

The VCDRC submits an annual report to the Minister for Community Services that is tabled in Parliament. This report is the means by which the number of deaths of children known to child protection becomes public.

State Coroner

The State Coroner is required to investigate any 'reportable death' that is in some way connected to Victoria. Reportable deaths include:

- Deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;
- Deaths of a person, who immediately before their death, was a person placed in 'custody or care';
- Deaths of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force; and
- Deaths that occurred during a medical procedure; or following a medical procedure where the death is or may be causally related to the medical procedure and the death would not reasonably be expected to occur as a result of the procedure.

The Coroner is also responsible for investigating 'reviewable deaths' which is defined to mean the death of a second child (under 18 years age) of a parent where the child lived in Victoria or where the child died in Victoria. The Coroner investigates reviewable deaths to find the identity of the child who died, the cause of their death and the circumstances, assess the family's health needs and assess with other agencies the needs of living siblings or any risk to other children.

The Coroner's Court performs three functions relevant to protecting Victoria's vulnerable children: it investigates and reviews the causes and circumstances of notifiable deaths and makes preventative recommendations for the future; it enables public education on such matters; and it contributes to relevant law reform. The Coroner's Court has an overall function of scrutiny of the system of child protection, where a death occurs, and of ensuring its transparency.

21.3.2 Transparency and reporting

Transparent reporting about the performance of the system for protecting Victoria's vulnerable children is essential to the maintenance of public confidence and trust in the system. Regular public reporting helps to ensure government agencies are accountable for their actions, and is an important part of a system that supports continuous improvement in individual services and across the sector. However, when considering what information should be reported publicly, the desire for transparency must be balanced by the need to protect the privacy of the children involved. There cannot be complete transparency at the individual level.

At present DHS itself reports limited data on the performance of family services, statutory child protection and out-of-home care, or on the outcomes of children in the care of the State. The main reporting by DHS is against the performance measures set out for DHS' outputs in the State Budget. These provide measures of the quantity, quality, timeliness and cost of statutory child protection services, out-of-home care and family services. The same performance measures are published in the DHS annual report. While these measures provide a useful indication of the volume of services provided to clients, they are poor measures of system performance and do not attempt to measure client outcomes in any meaningful way.

There is considerable external reporting of data on child protection, out-of-home care and family services, based on data provided by DHS. The annual *Report on Government Services* compares the performance of states and territories against the Productivity Commission's indicators of the effectiveness and efficiency of child protection services and out-of-home care. The report's performance indicator framework, presented in Chapter 9 of this Report, also provides for indicators of equity and access, but these are yet to be developed. The Australian Institute of Health and Welfare also publishes a comprehensive annual report on state and territory child protection, out-of-home care and family services.

Chapter 4 provides an overview of the available data on the performance of the system for protecting Victoria's vulnerable children. It finds that the available data do not provide the basis for a comprehensive assessment of the performance of child protection, out-of-home care and family services, in particular regarding the critical measure of their effect on the incidence and impact of child abuse and neglect. Chapters 8, 9 and 10 provide more detailed analyses of the performance of family services, statutory child protection and out-of-home care respectively.

Ombudsman findings

The Ombudsman has also found deficiencies in the transparency and reporting of information on the system for protecting Victoria's vulnerable children. In his 2009 investigation into the statutory child protection program, the Ombudsman found that:

> [T]he data provided in the department's reports to the Secretary, Department of Treasury and Finance and the Minister for Community Services is insufficient to allow recipients to adequately consider the performance of the department. Further the information that is reported is largely focused on compliance with timeframes, with little emphasis on measuring the extent of the department's success in exercising its duty of care to the children for whom it is responsible (Victorian Ombudsman 2009, p. 125).

The Ombudsman again raised concerns regarding transparency and reporting in his 2010 investigation into out-of-home care:

> I consider there is a lack of transparency and independent oversight in relation to the quality of care and safety being provided in the out of home care system. At present the department releases limited information regarding its performance in providing safe and appropriate placements. It does not report on quality of care investigations and reviews in its annual report and does not report publicly on any analysis regarding incident reports for children in out of home care. In my view, the community should have access to this information to assist it to understand the issues faced by the out of home care system (Victorian Ombudsman 2010. p. 12).

As a result of the recommendations of the two Ombudsman reports, from 2010-11 DHS has begun to publish the following additional data in its annual report:

- The proportion of child protection practitioners receiving regular supervision;
- The proportion of unallocated child protection clients;
- The proportion of children in out-of-home care who are aged under 12 years and placed in residential care;
- The number of investigations undertaken in relation to quality of care concerns; and
- The number of substantiated quality of care concerns.

The publication of this data is welcome and enhances the transparency of DHS' performance. However, there remains a fundamental gap in data on the impact of programs and services on the outcomes of vulnerable children, including the incidence and impact of child abuse and neglect. In addition, this chapter has demonstrated there is a lack of transparency and public reporting regarding DHS' regulatory activities.

The Vulnerable Children and Families Strategy

The whole-of-government Vulnerable Children and Families Strategy recommended by the Inquiry in Chapter 6 could play a critical role in improving transparency and accountability. The strategy could identify the indicators and performance measures to be used by government to measure its performance in protecting vulnerable children and families and improving their wellbeing. Chapter 20 recommends that a new Commission for Children and Young People monitor and publicly report on departments' performance.

The Inquiry also recommends that DHS should publicly report on its regulation and monitoring activities to ensure these are transparent and subject to adequate scrutiny. DHS should also publish its decisions to take regulatory action against CSOs, such as the placement of conditions on a CSO's registration, the appointment of an administrator, or the revocation of registration. DHS should explain how and why those decisions were reached.

The public reporting of information on DHS' monitoring and regulatory activities can play an important role in rebuilding public confidence and trust in the system for protecting Victoria's vulnerable children, as well as increasing the scrutiny on DHS' execution of these functions.

Recommendation 88

The Department of Human Services should produce a comprehensive annual report on its regulation and monitoring of community service organisations. This report should include information on:

- The registration of community service organisations and their performance against the standards;
- The registration and disqualification of out-of-home carers;
- Category one critical incidents;
- Quality of care concerns, investigations of abuse in care and formal care reviews; and
- Actions taken against community service organisations.

In addition to this annual reporting, the Department of Human Services should immediately publish any decisions to take regulatory action against community service organisations, such as the placement of conditions on a community service organisation's registration, the appointment of an administrator, or the revocation of registration.

21.3.3 Enhancing oversight and scrutiny

While the Child Safety Commissioner is often regarded as the independent scrutineer of Victoria's child protection program, the Commissioner's independence and oversight powers and functions are limited compared with commissioners and guardians in other states and territories. For example, Victoria's Child Safety Commissioner:

- Is the only commissioner or guardian employed as a public servant by the Premier rather than appointed as an independent officer by the Governor;
- Monitors only the provision of out-of-home care, unlike the Commissioners in New South Wales, Queensland and Western Australia, who have a much broader scope of responsibilities;
- Is unable to conduct own-motion inquiries, unlike the equivalent bodies in Queensland, South Australia and Western Australia; and
- Is the only such body in Australia unable to table a special report to Parliament on issues arising from its functions.

Table 5 in Appendix 14 summarises the roles, functions, inquiry powers and reporting arrangements of selected commissioners for children and child guardians in other Australian states.

Victoria's statutory child protection services are not subject to systematic independent oversight. The Child Safety Commissioner's powers do not include monitoring or review of statutory child protection services, and the Commissioner does not have the ability to initiate inquiries. While DHS is subject to investigation and audit by the Ombudsman and the Auditor-General, these do not provide the regular independent scrutiny and public reporting that is required to ensure DHS is meeting its obligations, or to support continuous improvement in service delivery.

Victorian Law Reform Commission proposal

In 2010 the Victorian Law Reform Commission (VLRC) proposed that the Child Safety Commissioner have additional responsibility for oversight and review of child protection services, with authority to investigate and report to Parliament and the Minister on the operation of the CYF Act (VLRC 2010, p. 416). The VLRC argued that:

> An independent body with specialist expertise in child protection can play a significant role in highlighting systemic problems in this key area of governmental responsibility. This step may overcome the need for so many external reviews by independent experts and statutory authorities such as the Ombudsman and this Commission (VLRC 2010, p. 410).

The VLRC proposed that the Child Safety Commissioner should also have the following additional powers and functions:

- Advocate for children and young people across government and throughout the community;
- Liaise with Victorian Aboriginal communities in order to ensure the Commissioner is able to effectively advocate for Aboriginal children;
- Promote awareness of children's and young people's rights; and
- Consult children and young people about the performance of the Commissioner's functions (VLRC 2010, pp. 417-419).

Finally, the VLRC proposed that the independence of the Child Safety Commissioner should be strengthened. It proposed that:

- The Commissioner be appointed as an independent statutory officer by the Governor-in-Council for a period not exceeding five years;
- The Commissioner be required to report to Parliament on an annual basis; and
- The Attorney-General be the Minister responsible for the Commissioner, in order to maintain an arm's-length relationship from DHS.

Ombudsman findings

The Ombudsman's 2009 Investigation into the statutory child protection program found most child protection cases receive limited if any external scrutiny (Victorian Ombudsman 2009, p. 14). The Ombudsman recommended that DHS establish arrangements for ongoing independent scrutiny of the department's decision making regarding significant wellbeing and protective intervention reports, with particular attention to:

- How the urgency of reports is categorised;
- The consistency of thresholds applied across regions; and
- The appropriateness of the thresholds applied by DHS (Victorian Ombudsman 2009, p. 17).

The DHS Child Protection Standards Compliance Committee is a welcome initiative in response to the Ombudsman's recommendation. The Inquiry considers, however, that the system for protecting Victoria's children would be enhanced if statutory child protection services were subject to independent external scrutiny from a body such as the Commissioner, as part of its broader oversight responsibilities.

The Ombudsman's 2010 investigation into out-of-home care services found that there are also limitations to the Child Safety Commissioner's capacity to provide independent scrutiny of out-of-home care. These include that the Commissioner:

- Has no coercive powers to investigate matters and relies on the cooperation of DHS and other agencies to perform his or her functions;
- Reports directly to the Minister; and
- Is unable to table a special report to Parliament on issues arising from his or her functions.

The Commissioner does not have any powers with respect to family services.

Stakeholder views

The Inquiry met with key stakeholders in the course of gathering information including the Victorian Ombudsman, the Child Safety Commissioner, the Chair of the Victorian Child Death Review Committee, the Queensland Commissioner for Children and Young People and the Western Australia Commissioner for Children and Young People.

The Child Safety Commissioner's submissions to the Inquiry and the VLRC review argued that the independent children's commissioner's legislated functions should be extended to include:

- A broad range of audit/monitoring and review functions to enable the Independent Commissioner to effectively consider how well vulnerable children are progressing;
- Undertaking own-motion reviews;
- Undertaking random case audits of child protection files;
- A formalised complaint function, primarily directed to providing information and referrals and facilitating access to existing complaints mechanisms, but also extending to monitoring of agencies' handling of complaints; and
- Reporting annually to the Victorian Parliament.

Several stakeholders expressed their support for an independent children's commissioner with expanded monitoring and reporting powers (submissions from Berry Street, p. 20; Centre for Excellence in Child and Family Welfare, p.30; The Salvation Army, p. 24). The joint submission by Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare submitted that:

> Victoria lags behind other jurisdictions and that the time has come for an independent Commissioner for Children to be established in the State of Victoria (pp. 80-81).

The Aboriginal Family Violence Prevention and Legal Service Victoria (AFVPLSV) argued that there is inadequate oversight of the situation of Aboriginal children in Victoria's system for protecting vulnerable children and inadequate independent systemic advocacy (AFVPLSV submission, p. 9).

The Child Safety Commissioner argued for the establishment of a community visitor program for children living in out-of-home care, commencing with community visitors for residential care. Similarly, Jesuit Social Services submitted that the Commissioner should coordinate community visitors to child protection residential units and youth justice centres (Jesuit Social Services submission, p. 27). The Salvation Army and Open Place submissions also supported monitoring of services by visitors independent of DHS (The Salvation Army, p. 10; Open Place, p. 4).

A Commission for Children and Young People

The Inquiry considers there to be insufficient independent oversight of Victoria's system for protecting vulnerable children. The Child Safety Commissioner has limited powers and functions compared with commissioners and guardians in other states and territories. As a public servant with no powers to conduct own-motion inquiries, there are also important constraints on the Commissioner's independence.

While the Ombudsman and the Auditor-General play an important role, they have responsibility for overseeing all government agencies. They cannot provide the specialist, regular oversight and scrutiny that is warranted by the vulnerability of the children in question and the statutory responsibilities of the Secretary of DHS.

The government's commitment to establish an independent Children's Commissioner is a step in the right direction, but the Inquiry considers that further changes are required. As discussed in Chapter 20, several government agencies are responsible for delivering services that support vulnerable children and young people but are not directly held to account. It is of particular concern to the Inquiry that there is no systematic independent scrutiny of statutory child protection services.

The Inquiry recommends that the government establish a Commission for Children and Young People. The new Commission would oversee and report to ministers and Parliament on all laws, policies, programs and services that affect the wellbeing of vulnerable children and young people. The Commission would hold agencies to account for meeting their responsibilities as articulated in the proposed Vulnerable Children and Families Strategy and performance framework.

The Commission will also identify and focus attention on the need for research programs that are anchored in improving service responses adressing the needs of children and young people.

The Commission would replace the existing Child Safety Commissioner, and retain the Commissioner's current roles and functions. To avoid duplication, the specific powers granted to the Ombudsman under section 20 of the CYF Act should be transferred to the Commission.

The Commission's powers and functions would be broadly similar to the New South Wales Commission for Children and Young People and the Western Australian Commissioner for Children and Young People. Like those bodies, the Commission would be required by legislation to give priority to the interests and needs of vulnerable children as it carries out its functions.

The Inquiry recommends the establishment of a Commission rather than a single Commissioner because the scope of these powers and functions are too broad to be carried out by a single office holder. A Commission would provide flexibility for the number of Commissioners to be adjusted in response to changes in the Commission's work program. The appointment of multiple Commissioners would also provide the Commission with a broader range of expertise. For example, the Inquiry has recommended the appointment of an Aboriginal Commissioner. The Commissioners would also require public administration and legal expertise, knowledge of the policy and service environment relating to children and their families, an ability to engage with children and young people and advocate on their behalf, and an understanding of the needs of children from culturally and linguistically diverse communities.

Table 6 in Appendix 14 summarises the governance arrangements for seven existing Commissions in Victoria. Each of the Commissions are independent bodies, with Commissioners appointed by the Governor-in Council. The Commissions can do all things necessary or convenient to perform their functions and achieve their objectives, with only minor caveats.

Given the expanded role of the proposed Commission and the greater use of unannounced inspections of CSOs recommended by the Inquiry in section 21.2.8, the Inquiry does not propose the adoption of a community visitor scheme at this time. This is, however, something that the Commission for Children and Young People could consider in the future.

Recommendation 89

The Government should amend the *Child Wellbeing and Safety Act 2005* to establish a Commission for Children and Young People, comprising one commissioner appointed as the chairperson and such number of full-time and part-time additional commissioners as the Premier considers necessary to enable the Commission to perform its functions. Commissioners would be appointed by the Governor-in-Council.

The Commission should have responsibility for overseeing and reporting to Ministers and Parliament on all laws, policies, programs and services that affect the wellbeing of vulnerable children and young people. The Commission would hold agencies to account for meeting their responsibilities as articulated in the Vulnerable Children and Families Strategy and related policy documents. The Commission would also retain the current roles and functions of the Child Safety Commissioner. The Commission would be required by legislation to give priority to the interests and needs of vulnerable children.

The Commission should have authority to undertake own-motion inquiries into systemic reforms necessary to improve the wellbeing of vulnerable children and young people.

The specific powers granted to the Ombudsman under section 20 of the *Children, Youth and Families Act 2005* should be transferred to the Commission.

21.3.4 Review of child deaths

Victoria has a two-stage system of examining the deaths of children who were known to child protection – that is, 'children who have died and who were child protection clients at the time of their death or within 12 months of their death' (s. 33, CWS Act). In 2010 there were 29 deaths of children known to child protection (see Chapter 4).

In the first stage, the Office of the Child Safety Commissioner conducts an inquiry in relation to the child's death. Under the CWS Act, the objective of the inquiry is to promote continuous improvement and innovation in policies and practices relating to child protection and safety. The inquiry must relate to the services provided, or omitted to be provided, to the child before his or her death (s. 33). There is no legislative timeframe for the completion of child death inquiries, but the practice has been for them to be completed within 12 months of notification of the death (VCDRC submission, p. 6). The reports arising from Child Safety Commissioner inquiries are provided to the Secretary, the Minister and the VCDRC.

In the second stage, the VCDRC undertakes independent, multidisciplinary review of child deaths. The VCDRC does not have any investigative role, and therefore relies on the reports of the Child Safety Commissioner and other available documentation. The VCDRC provides written advice to the Minister concerning each child death inquiry, including comments on the report's findings and recommendations (VCDRC submission, p. 7).

The Inquiry considers that while both the Child Safety Commissioner and the VCDRC make an important contribution to the review of child deaths, there would be merit in streamlining the current two-stage review arrangements into a single process. A single process would allow child deaths to be reviewed more quickly, allowing advice to participants, services, DHS and the Minister to be more timely and therefore more meaningful. It would also overcome the current unwieldy arrangement that sees the Minister receive two sources of independent advice regarding child deaths.

The VCDRC's submission to the Inquiry offers some support for the concept of a single child death review process:

> The establishment of an independent Children's Commissioner clearly provides opportunities for change to organisational arrangements concerning the VCDRC. A multidisciplinary review committee which considers individual CDI [Child Death Inquiry] reports could be convened and chaired by the Children's Commissioner. Alternatively, a multidisciplinary committee could retain the status of a Ministerial Advisory Council and be chaired by the Children's Commissioner (VCDRC submission, p. 27).

Consistent with the first suggestion of the VCDRC, the Inquiry considers that the VCDRC should cease to play its current review function. Instead, a multidisciplinary committee such as the VCDRC should be convened by the proposed Commission for Children and Young People. The committee would be consulted by the Commission during the course of its inquiries and provide advice regarding child deaths.

In his recent investigation into the child protection program in the Loddon Mallee Region, the Ombudsman recommended that the CWS Act be amended to broaden the circumstances in which a child death review is conducted. The Ombudsman raised the case of a death of an infant who was not within the legislative scope of the child death review process despite the infant's siblings having been the subject of 10 child protection reports to DHS. The infant was not 'known to child protection' because he was not born at the time of the reports, the last of which was made while the mother was pregnant. The Ombudsman found this represented 'a shortcoming in the current system of external scrutiny in the child protection system' (Victorian Ombudsman 2011c, p. 58).

The Inquiry endorses the Ombudsman's recommendation and notes that it has been accepted by DHS.

Recommendation 90

The Commission for Children and Young People should convene a multidisciplinary committee such as the Victorian Child Death Review Committee to provide advice to the Commission during the course of the Commission's inquiries into child deaths. This committee should replace the Victorian Child Death Review Committee.

21.4 Conclusion

The Victorian Government has a duty to meet the needs of vulnerable children and young people when the child's family is unable to provide satisfactory care and protection. It is essential that there is scrutiny of the actions of government – and the CSOs that act on government's behalf – to ensure they meet their responsibilities to protect vulnerable children and families and to improve their wellbeing.

The Inquiry has found that the regulation and oversight of Victoria's system for protecting vulnerable children need to be strengthened. The Inquiry's recommendations would result in DHS adopting an approach to regulating CSOs that assesses the risk of harm to children and targets its activity accordingly, so that more is done to identify, address and prevent the shortcomings in the quality of out-of-home care.

The recommendation that the government establish an independent Commission for Children and Young People with broad monitoring and reporting powers would introduce the regular, specialist oversight of government decisions and services that is currently lacking, and bring Victoria into line with New South Wales, Queensland and Western Australia. The Commission would play an important role in holding all relevant government agencies to account for meeting their responsibilities as articulated in the proposed Vulnerable Children and Families Strategy and performance framework.

The Inquiry considers the recommendations in this chapter to be important safeguards for ensuring the Victorian Government meets its responsibilities to vulnerable children, and that improved accountability and reporting can help to rebuild public confidence and trust in the system.