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Protecting Victoria's Vulnerable Children Inquiry
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Re: Submissions Protecting Victoria's Vulnerable Children Inquiry

Dear Sir/Madam

Thank you for this opportunity to make a submission to the Protecting Victoria's vulnerable Children Inquiry.

My background includes having worked for the State's Child Protection Services in the northern suburbs for over 19 years; leaving in the middle of 2010. I found this work personally and professionally rewarding. I often miss the daily drama and fascinating issues one had to deal with. (But I have found other interest in the training field) I've often encouraged younger people to consider child protection as career, as it provides a broad experience of human services. But to approach the work with an open mind and expect that it may be stupefying at times. I also have Diploma of Youth Work (1984) Bachelor of Art (1990) RMIT and Graduate Diploma of Economics from the University of New England (1998). And three sons of my own.

I'm conscious that your inquiry is to look at the policy and practice of child protection, not specific cases. I had drawn up a list of a few specific cases, which I felt illustrated major issues within the child protection system. They include failures to pursue investigations, children moved back and forth between placements, young people placed those with criminal histories, including sexual offense, a mentally ill child in foster care who was subject to an "exorcism," children removed from families without due process, safety plans that only existed in the authors imagination, failures to follow Departmental procedures regarding incident reports, placing a child with a carer who already had seven children, including four pre-schoolers case plans, carers not supported, and well, carers not supported. I could go on, but I suspect that your inquiry will receive legions of such submissions. I'll leave it that I am willing to provide details and documentation should you feel such would help your inquiry.

I'd like to limit my comments to workplace culture and include six recommendations for change. Even synthesising my experiences and understanding into a few pages proved taxing. I've also included a short essay that I wrote about legal, privacy and ethical issues within child protection that I hope will be of interest.

Recommendations

1. The members of the Protecting Victoria's Vulnerable Children Inquiry spend time with Child Protection workers, listening to them.

I have a lasting impression that Child Protective workers are considerate, intelligent and compassionate individuals, but collectively are defensive and indifferent. I attributed this to feeling under scrutiny; from the media, other public bodies (courts, Ombudsmen, parliament), inquires such as your own, and that that successes are private and failures very public. This is similar to issues experienced by Police forces; except the Police have traditions that allow them to confront the "Us Verse Them" attitude; through training, education and leadership. Child Protection Services is a comparatively immature institution and does not seem to have identified the problem, let alone develop means to confound it. I suspect there is a long learning curve ahead.

In 2009, the North and West Region established a professional advisory body to help explore options for change and improvement. This group incorporated individuals from welfare agencies and bodies which child protections services worked closely. This should have been a constructive exercise. However, the group did not include any representatives from the medical fraternity, lawyers, carers, etc – Those who may hold alternative view points. A representative from the group even told a staff meeting about the new initiatives and policies that were to be pursued. The answers seem to have been determined before any questions had been asked. They had not even take time to listen to the thoughts and ideas of their own staff.

If your inquiry were to do anything, you might model that reflection and new thinking are valuable of themselves. I am quite confident that you will spend time listening to Protective workers and managers; individually, and small and large groups. I suggest this will be more important than anything else your Inquiry does.

2. The Auditor-General review the Department of Human Services' statistics regarding child protection activity re: reports, substantiation, court orders and placements for fidelity and functionality.

The Department of Human Services has been keeping centralised figures on reports for over 25 years. In the mid 1980s the Department took about 5,000 reports a year. By the early 90s, the Department had assumed the entire role, which previously had been shared with Police, and received 10,000 reports, or 1 report for every 100 children. By the late 90s, with mandatory reporting it was 20,000; in 2000 it was 30,000; and now over 40,000 per annum (one for every 20 children). This is about 500,000~ 600,000 reports over 25 years. The number of children involved would be less because a number were reported more than once (officially 25%). Regardless, it was 210,000, with 150,000 under 18 years of age, when I check the Department's data base (as of 11 November 2007) This is far less than would be expected. I don't think this means that records are missing; it is just that with such a basic figure not quite right, one should not put too much weight of Departmental statistics. Although, the Department's practices "create" about 1:25 reports – nominally due to "new" information, but mostly to meet KPIs about times for "classifications." More likely the

Department is grossly undercounting the number of re-reports. I suspect that the about 6~8,000 infant reported each year are churned through the system until they “graduate” at 17 or 18 years. This is the equivalent of the Police investigating the same crime over and over again. This is another argument for diversion to support services. The massive growth in reports would also indicates that it is not an increase in children being at risk, but changes in practice and “supply induced demand.”

3. Establish a parallel quality assurance process to the Child Death Review committee to examine all outcomes of intervention, not merely deaths.

Victoria maintains a Child Death Review process, like most other jurisdictions within Australia and overseas. There are also various Departmental and statutory structures that look into serious incidents and deaths of children, eg, Coroner’s and Ombudsman’s office. Commonly such inquiries note reoccurring problems of poor communications between professionals, safety and case plans not implemented, optimistic assessments, failure to follow up on critical information, lack of timely decision making or reviews, downplaying changed circumstances or indicators of significant risk.

However, a foible with these types of reviews is that they look backwards at events. There are many more very similar cases where there are no adverse outcomes. This is, best summed up by the Latin phrase “Post hoc ergo propter hoc” (after this, therefore because of this). Except it rarely is! There are great limitations in scientifically predicating outcomes in child protection. We are looking at weak correlations at best. I wish we could determine in advance which child is likely to be harmed so could act decisively – but we can’t. We are in the position of the American asylum director who stated that 90% of his patients could safely live in the community – “now tell me which ones they are!” It is also counter-productive to “over-intervene” to try and “capture” all those whom may come to harm. One of the most consistent bodies of research is that children in alternative care have significantly less life outcomes, in terms of health, education and physiological harm than those with “good enough” parenting.

A common retort is that “one death (of a child) is too many.” We all feel this very human response. But this does not consider the concept of “Pareto efficiency” – a state where no one can be made better off without someone else being made worse off. That is, if we pursue trying to make a system that minimise “faults”, we risk moving resources to where they have minimal utility, and leaving more valuable work undone. The Department receives about 40,000 reports a year. In contrast NSW receives over 300,000 – a staggering one for every five children. Qld with a similar population to Victoria receives over 80,000 reports. The effort is processing this large number of reports, sifting the wheat from the chaff, means they do little more than recording, let alone conducting assessments and linking families into supports.

The actual incidents of child killing have declined by half over the past generation. The Victorian Child Death Review’s 2009 report noted that in the six previous years the number of children as a result of non-accidental trauma was: “one, two, none, none, one, none.” The Child Death committee actually misses those children killed who have had no involvement with Child Protection – You need to incorporate the figures from

the Coroner's office. But again it is a very tiny; 1~2 a year). To have so few deaths out of a population of 5 million is remarkable.

Victoria has long embraced a public health model for child protection. This is a broad based, primary care and support for families. We benefit from universal social security, medical care and public housing. We also have an extensive network of family supports to divert families from forensic intervention; with Families First, IYS, BIP set up by the Cain Government; Enhanced Maternal and Child Health, Early Childhood Intervention Services and Strengthening Families under the Kennet Government; and cumulating in the Children Youth and Families Act 2005, and implementation of Child First. Not to mention Victoria being one of the pioneers with Maternal and Child Health in 1909. The cumulation of these efforts is that almost every child has "good enough" parenting and is kept above a threshold of significant risk. We can't know which individual child's life has been saved, but on an actuarial basis we can work out how many have been saved. My back of the envelope calculations drawing on morbidly patterns of a generation ago indicates that at least 10~15 children's lives are saved each year and every year. We've actually done a fantastic at reducing harm, and best ensuring welfare for children and young people.

Thus, alongside review structures that look at serious incidents, there should be an independent quality assurance processes that examine what is working well. One of the biggest impacts on preventable child deaths in past decade has been initiatives regarding road trauma and drowning. I've always found that it strange that protective workers down play risks of such incidents when the likelihood of serious injury or deaths are respectively forty and thirty times greater than non-accidental trauma—*death is death!* I imagine that the current Child Safety Commission could incorporate this role alongside the Child Death Review Committee. It might be practical to move the Commission under the Ombudsmen's office, in the mode of the former Police Complaints authority. This would give the Commissioner access to more resources to undertake research. It would also appear hands off from the Department, and save some duplications of effort.

4. That at least half of any additional funding be targeted at family support role (I'd prefer it to be 90%). And any additional funding be tied to specific performance outcomes (existing funding should be as well!).

A few years ago I worked in a team responsible for about 110 children and young people; all in out-of-home care. Fortunately, the hundred odd school age children all attended school (not always the case). I calculated that it was costing on average about \$800 each year in education costs for each primary age child, and \$1100 for those attending secondary school (uniforms, text books, extra-curricular activities, camps, etc). The teams total client support budget was \$50,000; thus we could spend this twice over on education expenses alone. That was not including expenses for medication, therapy, sports, music lessons, interstate access and the sundry other need that it was expected to met. We would "beg, borrow and steal" (mainly from cares,). Thus, I have some sympathy with increasing child protections budget.

Equally, I was aware of Child Protections massive wastes in resources. This included tens of thousands of dollars on court application which had little merit (an ambit claim,

not model litigant approach), not to mention obtaining court orders only to deem the case lack priority to be allocated. A few years ago I noted that 1:10 of the Unit's clients had not been visited in 6 months; and 1:20 in 12 months. If we assessed that such an elementary monitoring as sighting the child was unnecessary, why spend thousands of dollars a day on legal expenses (not to mention total cost to public funds with Court time, legal aid, police). Less than half of court applications are successful. Most are negotiated to a lesser or no order at all. I have noted public discussion about diverting more cases from the Childrenscourt to a conciliation process, to save this cost and delays. However, it is the Department that is the primary driver of applications to the Court and most often adjourns proceedings. If the court were to have a reduced role, it would be much more likely that excessive interventions would take place. The Department already has the capacity to negotiate outcomes with families. What it should not have is *Carte blanche* to interfere in families' lives on an open ended basis. The Victorian Charter of Human Rights and Responsibilities states that a person should "not have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered."

I would deal with demand on courts by making any application subject to endorsement by at least Area Manager level. This is the same delegation required to approve placing children in foster care – used as a rationing mechanism to deal with scarcity of such placements. I would also have the Court Advocacy Unit directly managed all court applications, and workers only attend court if required as a witness. This is the same approach taken by Police Prosecutions. Protective worker attend every court hearing due to the legal requirement that the author of any report be present. However, this has been ignored for over a decade, and the practice has been to deploy any available worker. If workers are there to support families this practice may be understandable, but workers are often instructed not to have contact with families so they could not be accused of influencing their decisions. The Court Advocacy Unit has a culture of seeking to negotiate so as to avoid the very high cost of litigation. Thus, most matters are settled at the Directions stage when the Court Unit assumes a predominate role. If they took the role earlier, cases would likely be settled on more rigorous legal understandings. The merits or otherwise of pursuing a contest would be more stridently debated within the Department (between Court Unit and Regional Offices) rather than involve than the court, as at present.

An additional bugbear of mine was the number of supernumerary staff roles. For example, the Department maintained a Court Advocacy Unit (about 20 staff) with each Region also having its own court advisors. Too use the North and West Metro Region as an example; there are about 200 Protective workers in 2010. A general breakdown:

Intake and Investigation	50
Child Youth and Family Engagement	75
Case contracting & Permanent Care	20
Indigenous Unit	15
Total	160

In addition there are 8 Specialist Infant Protective workers SIPW (most of who are part-time) 12 Community Based workers (again, many are part-time) 2 drug and alcohol advisers, 2 IT trainers (to help with ungainly computer database), 3 Family

Group Conferencing Conveners, 2 court advisors and 5 project workers and sundry managers. There are also about a half dozen team leaders who do not have any allocated teams and perform various report writing functions with very little contact with clients or professions; basically writing up closure rationales based on other workers material. Specialist Infant Protective workers and Community Based Workers are important functions but it is a matter of priority as to whether it is more important than case management roles. There can be some clients having 3 or 4 workers allocated while others have none. Moreover, these consultancy roles are paid at a higher rate and are far less often vacant than case management positions. Why not reverse the pay parity?

On another occasion, a “project officer” (protective worker assigned to support or research roles – quite a few of those) undertook to create a “recipe book.” It was intended as a morale building exercise. I would have felt better if the project officer spent some time helping with cases so I could get home to cook for my own children at a reasonable time – I know that sounds puerile. Petty waste included purchasing of two large flat screen television in the North and West Region, ostensibly for training, but they sat unused in a corridor for 12 months – what about the “opportunity cost?” At the same times family support grants were being curtailed – often used to assist relatives and neighbours whom take children temporarily into their care.

However, the best illustration of potential waste is to compare Victoria’s child protection system with that of NSWs. They spend much more per-capita for atrocious outcomes (over \$800 million in NSWs compared with \$400 million as of 07/08), with respective population of children being 1.2 million compared with 1 million. In NSWs there are also a staggering 25,000 children in out of home care compared with 6,000 in Victoria (where we have half over half with kin placements). Moreover, as revealed by the Woods Royal Commission (2009) the care in NSWs is often grossly inadequate in terms of basic care, access to education and therapeutic treatment. Research has shown that almost all children removed from their parents care, return to their families; sometimes after years of intervention. More money does not directly equate with better outcomes. Non-government agencies also have significant capacity for waste due to their nebulous objectives, eg, parenting educators who have very few clients. But a greater proportion manages to drip down to direct services for clients. The welfare industry as a whole tends to “cry wolf” as an effective means of generating funding. I suspect you hear a lot of such during your inquiry.

5. Establish an industrial chaplaincy for Child Protection Services.

I have difficulty talking about support for staff. I once had 30 clients on my case load; and I was part-time. Not a single client was located in our offices’ catchment area (they ranged from Melton to South Melbourne, Ringwood, Narrandera, NSWs and Hanoi!) I sort advice from my supervisor and manager, only to be told that “everyone had high case loads.” I gave great heed in regularly seeing clients. One technique was to visit a few at the end of the day, and calling at one problematic family (child rarely went to school) on way to work most days – he got to school. But I was told I was abusing car use policy. And my own capacity to manage time was queried.

I was feeling distressed so contacted the Department’s support program (EAP; consultant psychologist for up to four sessions). The psychologist obviously only heard my side of the tale (I could well have been an incompetent worker). I was advised that

it must be difficult and try not to take it personally. I didn't find this much help. I merely wanted to regularly get home to prepare dinner for my own children – I had sole care as my wife had died many years previously.

At various times, the Department has instigated various support programs, sort advice from consultants and conducted reviews. I had suggested an industrial chaplain. While I may be an atheist I had fond memories of the chaplains during my adolescents in the Army. My father was also a lay-preacher and I had accompanied him as he visited the infirmed or grieving. As I see it, chaplains come to you, get involved, see how things are, empathise and listen. Therapists are useful too, but they are complementary and by their nature disassociated. I would have found comfort and support from someone coming by and asking after me, showing regard. Considering the monies spent on workforce development, consultancies and reviews over the years, a chaplaincy service would be one the cheapest and much more beneficial initiatives you could recommend. I imagine the Police and Fire Fighting Services would advise how best to establish a chaplaincy service.

6. Leadership

I am conscientious that any institution has a powerful sense of self-protection. I once studied public economics and learnt that when any organisation has a diffusion of objectives, it will choose they ones it most prefers or is comfortable (the Agent principal). Child Protection has some of the most complicated sets of objectives. Even the list of Best Principal objectives 10 (3) of the 2005 Act goes to the letter "r." Thus, any recommendations of your Inquiry risks being subverted, ignored or worse become the excuse why things cannot be done. I am mindful of the role of the Late Dr John Patterson in reforming Disability Services in the 1980s. It is competent leadership that will implement any recommendations from your inquiry and give robust advice to the Minister. I suspect that those Dr Patterson's character are very rare. But finding them is the key!

I apologise that my few pages has become so many words. I trust that whoever is assigned to review the many submissions will distil my own down to the few recommendation.

Thank you again. I wish you well in your Inquires work.

Yours faithfully

Russell Miles

Let the Right One In?

What do vampires and Child Protection workers have in common?
Neither can come into your home without being invited.

While most Child Protection Workers know about vampires not being allowed in (Buffy fans?) they don't seem to appreciate that this applies to themselves as well. The Children Youth and Families Act 2005, Section 241 allows Protection Workers to apply for a warrant. However, it is the Police who must execute it. A few years ago the Ombudsman observed that RSPCA inspectors had greater powers to enter properties than Protection Workers. Prima-facie evidence is required to obtain a warrant of abuse. But to obtain adequate evidence without access to the child is problematic. The Victorian Charter of Human Rights and Responsibilities states that a person should "not have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered." Mind you, the Charter also says that Children have the right to protection according to their best interests. Regardless, in overwhelming number of cases, families not only accept workers making inquiries but are pleased with offers of help.

Section 198 of the Act states that a person is not required to incriminate themselves. The Department of Human Services requires that parents be advised that records will be made of any conversation and these can be presented as evidence in any legal proceedings. But this is not as clear as "You don't have to speak with me." Most workers are reluctant to use such direct language as they are concerned parents will choose not to discuss matters. Families are often encountered in some turmoil; agitated parents, anxious children, barking dogs, perhaps an interpreter and inevitably at night. The Department's also assume that Section 198 does not apply during initial contacts with parents as this is deemed "information gathering," not an investigation. Although, this information does find its way into Court reports. Such information is amongst the most personal and sensitive compiled by any government agency; including medical and mental health conditions, criminal, financial, family histories, and recriminations within families. This information is routinely circulated to police, other authorities and non-government agencies. The information is intended to aid co-ordination of services, although it general exceeds any "need-to-know" criteria. Many parents are never told a report has been received about their children.

The Department receives 40,000 reports a year, so seeks to sort the wheat from the chaff and those that do not require any further action. In any year, less than 200 children are placed out of their parents' care on a longer term basis. The actual incidents of child killing have declined by half over the past generation. The Victorian Child Death Review's 2009 report noted that in the six previous years the number of children who died due to acts by parents, or non-accidental trauma in the reports parlance was: "one, two, none, none, one, none." Any death is regrettable, but to have so few out of a population of 5 million is remarkable. Moreover, the incidents of physical abuse have declined both in real terms over the past decade, and reports of sexual abuse have been static. Reports of exposure to family violence and neglect have risen, but mostly because previously such matters were given little heed.

Child Protection Workers are not that impeded by legislation. Section 205 (1) makes the broad statement that "A protective intervener must ... after receiving a protective report, investigate ... in a way that will be in the best interest of the child." Moreover, the Childrens Court is not bound by "rules of evidence." Rather, Magistrates have discretion to determine what weight might be given to any evidence. In criminal cases, evidence could be inadmissible if it was obtained inappropriately, eg, a statement made by a defendant who was denied legal advice. In the early 1990s, child protection authorities in NSW and Victoria conducted a mass apprehension of children in what became termed the "Children of God" case. The children were taken into care prior to a weekend, so that they would be incommunicado for a couple of days and before an initial court hearing on the Monday. This was to give workers time to interview the children. The

view was that the children would be more likely to disclose abuse while in a secure and safe situation, and not influenced by their parents. The lack of consent by the parents, access to legal advice or promptly bringing the matter before court were not grounds for disallowing any critical information gained in those initial days. Subsequent investigations found little indication of abuse, and the Department withdrew legal proceedings 18 months later; the children long since being returned to their parent's care.

Protection workers mostly seek to work with parents as that is the best way to ensure a child's safety and welfare. Workers must sensitively but decisively deal with matters such as a report from a school that a child has a bruise on their forehead, and where the family had also had another child who died of a long term congenital illness only a few months previous. However, workers can resort to interviewing children at schools or crèche without parents being aware, let alone giving consent. Schools have a "duty of care" and may be legally liable should they not cooperate with authorities. This is aside from requirements of mandatory reporting. Children sometimes seek help from neighbours, teachers and Police. There is no difference from a Protective worker asking a child if they might need help. But what might happen should a parent explicitly direct a school principle not to allow access to their child? This scenario has never been subject to any legal challenge. In almost all cases workers simply bamboozle parents that if they do not "co-operate ..." Parents can be directed to seek medical checks of their children, even full body examinations. Even though Section 233 of the Act actually prohibits older children being medical examined without their own consent.

Workers resort to such "bluff" as they feel they have an ethical duty to protect children. Parents are also told to have friends or relatives look after their children while further inquiries are made. Most removals are made in this manner and thus never come before any judiciary review. This is seen as inviting parents to take responsibility for the care of their own children. However, children and young people can be moved to circumstances that are little different. Only the most perfunctory assessments are made of alternative carers: usually a police records check and rarely any home visit with carers. With 1 in 5 adults born overseas, a Police check can have significant "gaps". While a written agreement is required for voluntary placements, part 3.5 of the Act only specifies this for "service providers," not kith and kin placements. Most parents do not know that the Act 10 (3) (g) states that "a child is only to be removed ... if there is an *unacceptable* risk of harm." Magistrates expect evidence to be "of consequence" or be of "considerable amount, or effect, or importance" to justify intervening in a family's affairs, let alone removing a child. Moreover, the Department reserves its scarce out-of-home placements for the most critical cases, and only a senior manager can approve their use. While the numbers of children needing alternate care has decreased, the numbers of foster carers has declined by a third in the past decade. In the end, parents could be unwilling to co-operate or seek legal advice. The case would most likely be closed, as there is usually insufficient evidence on which to base further inquiries; often mere allegations. It is hardly surprising that protective intervention mostly affect the lowly educated, disenfranchised and indigenous families.

Common law also expresses that parents have obligations, but no rights regarding their children. Children are individuals in their own right. While children are best nurtured and protected within a family, the broader community has obligations where families fail. Mostly families can be supported but sometimes children will be removed from their family. Child Protection deals with the most complex and intimate human relationships, often with limited information and little time. If Child Protection hasn't made a couple of mistakes by 10am it is a good morning.*

* With apologies to Aaron Sorkin in the voice of President Jed Bartlet