REPORT SUMMARY

CRIME AND MISCONDUCT COMMISSION

QUEENSLAND

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This document is based on the full report of the Inquiry into the foster care system in Queensland, *Protecting Children* (2004).

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Protecting children

AN INQUIRY INTO ABUSE OF CHILDREN IN FOSTER CARE

This document comprises the summary to the CMC's *Protecting children* (2004) report and a full list of the recommendations contained in that report.

Most Queensland families provide a safe, secure and caring environment for their children. However, each year a number of Queensland children come to the attention of authorities because of allegations and concerns about neglect, or physical, sexual or emotional abuse. These notifications of child abuse and neglect have increased in Queensland (and elsewhere) over the last decade.

In Queensland in 2002–03 there were over 31 000 notified cases of child abuse and neglect. Just over 4000 children were subject to some form of protective response, of whom the majority were under orders granting custody and/or guardianship to the Director-General of the Department of Families. Most of these children were placed in alternative or 'out-of-home' care, which is predominantly family-based care, either with foster carers or relatives.

Clearly, if a child has been abused or neglected to the point where they have to be removed from their home by the state, it is absolutely unacceptable for the state to then place them in an environment where they are further abused, at the very hands of those entrusted by the state with their welfare.

At the same time as dealing with cases of reported and substantiated abuse, the child protection system must focus on preventing any recurrence. In its 2003 Report on government services, the Productivity Commission published the following disturbing statistics (p. 15.16):

> In Queensland, the proportion of children who were the subject of a resubstantiation [that is, another incidence of substantiated abuse or neglect] within three months after an initial substantiation in 2000–01 was 10.4 per cent … the proportion who were the subject of a resubstantiation within 12 months was 24.8 per cent.

During 2003 information came to light, from a number of sources, indicating that the foster care and child protection systems in Queensland, as administered by the Department of Families, had failed many children. The evidence about such failures pointed, in some cases, to systemic failures over many years to prevent children placed in foster care being further abused or neglected. The CMC responded by undertaking two major misconduct investigations and an independent public inquiry: the Inquiry into Abuse of Children in Foster Care in Queensland.

During that inquiry's public hearings, Ms Gwenn Murray, an independent consultant appointed by the Department of Families in June 2003 to audit abuse notifications made against current Queensland foster carers, said:

> The Department of Families, I think, is dangerously becoming like one of the children for whom it has a statutory obligation … that is, it is like a neglected child. Major reforms need to be planned and implemented to ensure the safety and well-being of children and young people …

Other criticisms of the Department of Families advanced at the CMC Inquiry were often as severe. Although some critics may have failed to recognise the significant steps taken in recent times by the Queensland Government and the Department of Families to confront known shortcomings in the child protection and foster care systems, it is clear that the problems have existed for many years and that the department is perceived by many stakeholders to be in a state of crisis and incapable of responding adequately to child protection issues.

As a result of the evidence that it has gathered, the Commission can only conclude that the current child

protection system has failed Queensland children in many important respects. These problems are not merely ones of perception; they are longstanding problems of great substance. The adverse outcomes for children highlighted by the evidence before the Commission do not derive from a few unfortunate and atypical cases, reflecting poor decisions by individual departmental officers. Collectively, the evidence indicates organisational failure to equip officers at virtually all relevant levels of the Department of Families with the information or skills and resources to make the right decisions in the best interests of children in care in a satisfactory number of cases. The facts of the particular matters considered by the CMC underscore the ultimate effect of these systemic failings: they have human costs that should not be tolerated as part of any modern state-administered child protection service.

Everyone agrees that major change is required. In the Commission's view, this change should be effected through fundamental structural and organisational reform. A new and better approach is required. The Commission considers that this can most readily be achieved by creating a new department, the Department of Child Safety, exclusively focused upon protecting children. The Commission has come to this view as a result of the evidence arising from its investigations and the Inquiry.

Catalyst for the CMC Inquiry

In late May 2003, information was passed to a Department of Families area office outlining a disclosure by a woman who alleged that while in care with a foster family she was subjected to sustained and serious abuse by family members and others. The allegations included a complaint that she was sexually abused by one family member who had been an approved foster carer, as well as by visitors and friends of the family. The alleged sexual abuse included acts of sodomy and indecent dealing and of procuring the woman (then a child) to commit indecent acts with other children. The alleged abuse was said to have happened over a period of 13 years. The woman stated that other children in care with this family had also been subjected to sexual and physical abuse, and that some of these children still resided with the family ('family X').

Subsequently, documents relating to allegations of abuse involving other children placed with this family were made public. The material suggested apparent failures on the part of the Department of Families to deal with these allegations. Intense media interest was generated and questions were also raised as to the extent of the knowledge of and action taken by respective ministers responsible for the Families portfolio at the relevant times.

Inquiry methods

In early August 2003 the CMC commenced Operation Zellow, a misconduct investigation into the original allegations that:

- various employees of the Department of Families had failed in their statutory duties and obligations to protect children placed in the care of family X, and
- successive ministers and director-generals of the department had failed to act appropriately to protect children placed with family X.

As a result of the audit conducted by Ms Murray, further allegations relating to the handling of suspected abuse in another foster family ('family Y') came to light, and another CMC investigation, called Operation Ghost, was begun. That investigation is still continuing at this time.

The Commission also determined to examine systemic issues concerning the provision of foster care in Queensland and accordingly, on 14 August 2003, resolved to hold public hearings, supported by consultations and the receipt of submissions. The terms of reference of the Inquiry were as follows:

(a) To examine any systemic factors contributing to the incidence of any abuse of children in foster care.

(b) To examine the suitability of measures to protect children in foster care from abuse, and in particular:
   — the adequacy of systems and procedures to prevent and detect abuse
   — the adequacy of measures to respond to and deal with suspected abuse including abuse reported by foster carers.

(c) To make any recommendations as may be considered appropriate in relation to (a) and (b), including recommendations for any necessary changes to current policies, legislation and practices.

Submissions from interested parties and the public were called for on 16 August 2003. Public hearings were held over a two-week period commencing 13 October 2003.

Operation Zellow

The CMC investigated nine 'flashpoints' in the fostering history of family X.

'Flashpoints' are specific incidents where issues came to light that should have generated concern about the welfare of the foster children placed with the family. These flashpoints included several reports of alleged abuse upon foster children, notifications about incidents where three young children with the family were found to be suffering from gonorrhoea, and the circumstances surrounding some ministerial responses to letters raising complaints about the welfare of the children.

The Commission is of the view that in the majority of these matters the response of the Department of Families was completely inadequate. Over a period of many years, opportunities to act to protect the foster children were missed, time and time again. In relation to the gonorrhoea incident, the weight of the evidence is that the departmental officers, in determining to leave the children in care, were prepared to accept an explanation (advanced by one of the carers) to the effect that the three young children each contracted this disease from a contaminated face washer. In the circumstances, the

Commission considers that placing reliance on an explanation such as this, in determining what action should be taken (or not taken) for the children, was disgraceful and indefensible.

In another flashpoint, a child had been removed from her home where she had resided with her mother and stepfather, because of concerns about the risk of abuse to her. The child was placed in foster care with family X. Some time later the child complained that she had been sexually abused by her stepfather. Inquiries established that this man was then residing with the child at the foster family's house. At the risk of stating the obvious, the point must be made that this man was one of the people from whose care the child had been formally removed because of concerns about the risk of abuse.

Factors such as the lack of adequate records, retirements of relevant staff and the passage of time have hampered the Commission in making recommendations for disciplinary action against departmental officers, except in one instance. However, the difficulties in attributing fault among individual officers should not detract from the Commission's primary conclusion — that in many of the incidents investigated there was undoubtedly grievous fault.

The Commission's investigations did not establish evidence of official misconduct by the current or former ministers or directors-general.

The Inquiry

The evidence arising from Zellow reflected systemic problems and organisational failures that were addressed at length before the Inquiry and in the many submissions received. The Commission acknowledges the assistance afforded to it by all those who appeared at the Inquiry, forwarded submissions or made themselves available for consultations.

The following key questions were considered by the Inquiry under its terms of reference:

- Is the current system of responding to and dealing with allegations of abuse effective and sufficient to protect children, including children in foster care?
- Is the Department of Families able to meet its obligations to protect children, including foster children, from abuse?
- Are foster carers adequately selected, trained, resourced, supported and monitored?
- Can accountability, complaint and review processes be improved?
- Are the needs of Indigenous children in foster care being adequately met?
- Are there alternatives to, or modifications of, family-based foster care that might better meet the future needs of children?

The Commission's primary recommendation

A whole-of-government response

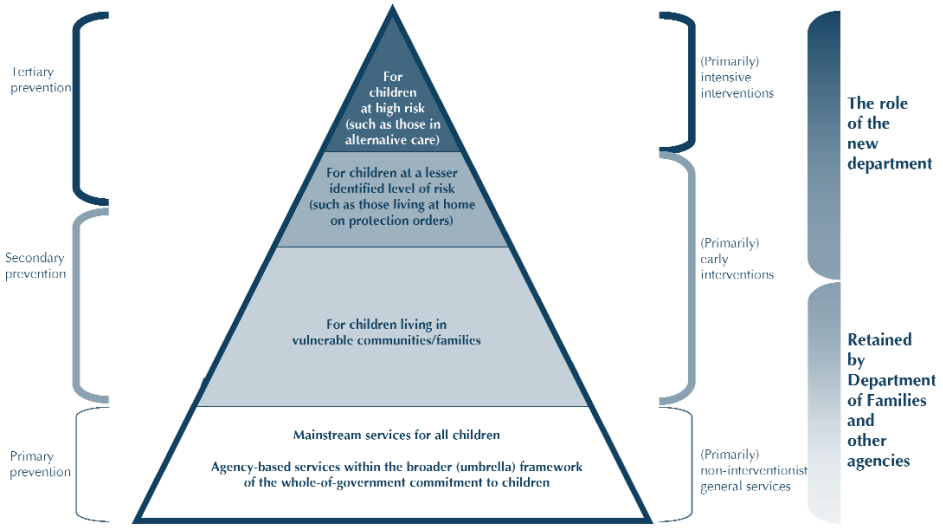
The *Child Protection Act 1999* states the fundamental principle that every child has a right to protection from harm. Children in foster care are a particularly vulnerable group but their need for protection cannot be met unless inadequacies in the broader child protection system are remedied. In turn, child protection cannot be separated from the provision of wider support for families and carers.

Effective protection of children requires a system that supports the development of all children as well as one that identifies vulnerable families for targeted interventions on behalf of at-risk children. No one agency can be expected to achieve all of this. A multi-agency, cross-government response is required.

The evidence from the Commission's investigations and Inquiry demonstrates that the child protection system in Queensland has failed to adequately protect all the children for whom it bears responsibility. The problems identified are significant and systemic. Although in part this failure reflects the incapacity of the broader system to implement an effective preventive program that reduces the need for children to be placed in protective care, it also reflects a lack of clarity and focus about the roles of the Department of Families and other key stakeholders in protecting children at risk. Additional resourcing alone will not provide a solution to this problem.

The evidence about the current system presents a bleak picture — not only for the wellbeing of children who need the state's protection, but also for those agencies that regularly interact with the department about child protection issues and for those departmental officers who are attempting to perform their present duties with professionalism and compassion.

Proposed scope of the Department of Child Safety



These problems have existed for many years across different governments and administrations. In evidence before the Inquiry, the current Minister for Families, the Honourable Judy Spence MP, and the current Director-General of Families, Mr Frank Peach, acknowledged the need for change. Mr Peach noted that the implementation of organisational change was a staged process, which has been ongoing for the two years that he and Ms Spence have held their positions, and which he saw would require a further five to seven years to fully implement. The Commission is of the view, given all of the evidence before it, that such a timeframe is unacceptable in terms of the harm that children would undoubtedly continue to suffer over any such period. Urgent reform is needed.

The immediate need is to better protect children by sharpening the focus on the safety and security of children at risk. The Commission is persuaded that the Department of Families is so overburdened, and its stakeholders so lacking in trust, that only through a new approach unambiguously directed towards meeting the needs of at-risk children will it be possible to make the necessary changes, and restore public confidence in the child protection system. This can most readily be achieved by way of creating a new department — the Department of Child Safety (DCS) — exclusively focused upon core child protection functions.

This primary recommendation is not an exercise in transplanting existing problems. Supported by the many other observations and recommendations contained in this report, it is designed to ensure that an adequate and better child protection system exists, through a specialist agency committed to:

- addressing the needs of children as its number one priority
- providing a broad range of options for case-managing children at risk of harm
- being the lead agency in a coordinated, whole-of-government response to child protection issues
- using effective and sophisticated intake, assessment and investigative procedures in responding to allegations of abuse and neglect
- adhering to best-practice standards in working with children in care, foster carers, biological parents, private care providers and other agencies involved in the provision of child protection services
- supporting staff through appropriate induction, training and professional development opportunities
- being open and accountable at all levels, both in its internal processes and through external and public scrutiny.

The call for a new department should not be seen as an attack upon the current workforce of the Department of Families. While the CMC's investigations have highlighted significant failings by various individuals, the Commission accepts that the majority of frontline child protection workers are caring and committed in their endeavours. Their work is often demanding and difficult. These staff deserve to be supported by an adequately resourced agency with a commitment to a new and revitalised culture of proper service to Queensland children. In this context, the evidence is

DCS service delivery staff

Function	FTE current needs	Basis of calculation
Intake	23	Department of Families received 31 068 notifications in 2002–03. It is assumed that each notification takes, on average, one hour to process, with an intake officer spending approximately six hours directly on work tasks.
Assessment required	167	In 2002–03 there were 27 218 notifications that assessment (CMC 2003). Department of Families data (monthly finalisation of initial assessments: area office by initial assessment details and monthly finalisation rate, Queensland, May to July 2003) indicate that its best-performing area completed initial assessments (IAs) of notifications at the rate of 13.6 per month per FTE during the period 1.5.03 to 31.7.03. Assuming a child safety officer (CSO) can complete 13.6 IAs per month, and assuming it is desirable to complete all assessments within 30 days, the DCS would need 167 CSOs to deal with the current number of notifications across the state (27 218 notifications/ 12 months/13.6 IAs).
Casework	292	As at 30 June 2003 there were 4380 children in alternative care. Based on a caseload of 15 children in alternative care per CSO, 292 CSOs would be needed to service existing children in alternative care.
CSO relieving staff	38	These staff would provide relief for CSOs doing intake, assessment and casework, when CSOs take leave entitlements. This measure takes into account 20 days recreation leave per officer per year, and assumes that a figure of 8% of the workforce reflects relief needs.
Team leaders	95	Using the current departmental measure of one team leader supervising five CSOs, 95 team leaders would be needed to supervise the 25 intake staff, 167 CSOs performing assessments and the 292 CSOs performing casework. In addition team leaders are, and will continue to be, drawn upon for special projects that are a routine aspect of a functioning child protection system.
Total current needs	**615**	**Existing frontline staff 455; extra frontline positions required 160.**

clear that there needs to be a significant increase in the current size of the child-protection workforce. The Inquiry has been given every indication that the majority of frontline staff would welcome the opportunity to work for such a department.

Structure of the report

The report is divided into nine chapters.

Chapter 1 provides background information about the CMC's investigations and the Inquiry, and the current child protection system in Queensland.

Chapter 2 reports on the CMC's Operation Zellow investigation in detail and the Commission's conclusions in respect of each of the nine flashpoints investigated. The chapter also contains information about the other CMC investigation, Operation Ghost, and some further disturbing matters recently referred to the CMC. As well, it reports on two child-death investigations carried out recently by the Queensland Ombudsman, and on Ms Murray's audit findings of the Department of Families. Those processes all produced evidence of systemic failings reflecting those identified in the CMC's Zellow investigation. The chapter concludes by summarising those systemic failings.

Chapter 3 relates some of the key themes and issues arising from the evidence before the public Inquiry. These are: the needs of children, workplace issues in the Department of Families, some specific foster care issues, enhancing accountability, protecting Indigenous children, and effecting change.

Chapters 4 to 9 contain the Commission's 110 recommendations for reform.

Chapter 4 outlines the Commission's recommended approach for responding to the needs of children in general, and those in the care of the state in particular. It explains the Commission's vision for a new strategic focus on children and the scope of the proposed Department of Child Safety. The chapter outlines how a whole-of-government response is required in this area, and recommends the formation of a Directors-General Coordinating Committee, and new positions of Director of Child Safety in relevant departments and other agencies.

Chapter 5 describes in more detail the key operational features of the proposed new department in terms of its focus and ethos, its funding base and recommended workforce numbers, the training and professional development of staff, the core child protection functions of the new department, its administration, and how proper levels of internal and external accountability can be achieved.

Chapter 6 describes how the new department would operate with other relevant agencies, including non-government agencies, concerned with the provision of child protection services. This chapter also contains information about the operation of the existing Suspected Child Abuse and Neglect teams (SCAN) teams and makes recommendations about enhancing the functioning of these important multidisciplinary teams. The chapter concludes with an examination of requirements for the mandatory reporting of suspected child abuse and neglect.

Chapter 7 sets out how the foster care system administered by the Department of Child Safety should work for children who are removed from their homes and placed in alternative care. The recommended framework includes detailed descriptions and recommendations about the department's interaction with non-government agencies providing care; placement options; foster care protocols (such as the recruitment and approval of carers); and casework for children in care. That final topic incorporates discussion and recommendations about the involvement by all relevant parties in casework (including children, foster carers and biological parents) and some discussion about long-term planning and placement options.

Chapter 8 examines some particular issues that affect Aboriginal and Torres Strait Islander children and communities who come into contact with the child protection system. The CMC consulted widely with Indigenous communities and representatives of relevant agencies during its Inquiry processes and identified some specific issues clearly relating to Indigenous children that are not present (or not to the same degree) for non-Indigenous children. However, the Commission envisages one overarching child protection system applying to all children, and therefore many of the recommendations made in this chapter need to be read in conjunction with those in the other chapters, which apply equally to Indigenous and non-Indigenous children.

Chapter 9 highlights some of the recommendations contained in the report for legislative reform and review.

The report concludes with a number of appendixes containing relevant data arising from the CMC's inquiry processes, a list of the recommendations made by Ms Murray as a result of her audit, and a full list of the recommendations contained in this report.

Concluding remarks

It cannot realistically be expected that any child protection system will be infallible. The problems revealed in this report are not unique; several other Australian states have recently undertaken wide-ranging reviews of their own child protection systems. Nevertheless, it must be accepted that the current system has failed. A new system must be embraced as quickly as possible.

It is the Commission's expectation that the adoption of the recommendations contained herein will be of clear and lasting benefit to, most importantly, the children of Queensland, particularly those in foster care, and to all people and organisations associated with the provision of child protection services.

To assess this, the Commission recommends that the Queensland Government review and report on the implementation of the report's recommendations in two years' time.

Recommendations

AN INQUIRY INTO ABUSE OF CHILDREN IN FOSTER CARE

Listed below are the 110 recommendations contained in the CMC's *Protecting children* report, divided according to report chapters.

Recommendation	Reason
CHAPTER 4: THE FUTURE FOR QUEENSLAND CHILDREN	
4.1 That a new Department of Child Safety be created to focus exclusively upon core child protection functions and to be the lead agency in a whole-of-government response to child protection matters.	*Only through an approach unambiguously directed towards meeting the needs of at-risk children will it be possible to make the changes necessary to deliver positive outcomes for vulnerable children, and restore public confidence in the child protection system.*
4.2 That a Directors-General Coordinating Committee, chaired by the Director-General of the Department of the Premier and Cabinet, be established to coordinate the delivery of multi-agency child protection services. **4.3** That a position of Child Safety Director (CSD) be established within each department identified as having a role in the promotion of child protection.	*Dedicated directors within departments, and a high-level coordinating committee, are essential for multi-agency cooperation, coordination and service delivery in a holistic and integrated child protection model.*
4.4 That the government maintain its commitment to developing primary and secondary child abuse prevention services.	*If the increasing levels of reported child abuse are to be controlled, a commitment to primary and secondary prevention is necessary.*
CHAPTER 5: THE DEPARTMENT OF CHILD SAFETY **Workforce numbers** **5.1** That there be a baseline increase of approximately 160 family services officers and team leaders to deal with intake, assessment and casework requirements. **5.2** That this increase be made progressively over the next two financial years and be in addition to other specific recommendations made in this report for the creation of specialist positions.	*The size of the current Department of Families frontline child-protection workforce is inadequate.*
5.3 That the DCS adopt an empirically rigorous means of calculating workloads and projecting future staffing numbers. **5.4** That frontline child-protection service staff numbers be increased annually in line with workload increases.	*The available data indicate that an increased workforce will be required to address expected increases in the child-protection workload in the foreseeable future.*
Management structure **5.5** That the current regional structure used by the Department of Families be critically reviewed, with a view to improving the ratio of direct service delivery staff to management and administration staff.	*The ratio of management and administrative staff to direct service delivery staff is unsatisfactory. The current regional structure appears unwieldy and may be contributing to an imbalance between frontline staff and management/administrative positions.*

Recommendation	Reason
Training and professional development of staff **5.6** That the DCS establish enhanced training and professional development processes for field staff as a matter of high priority. **5.7** That successful completion of induction training before assuming casework responsibilities be mandatory for DCS caseworkers. **5.8** That the DCS critically examine the possibility of forming partnerships with external agencies such as universities in developing and implementing an enhanced training and professional development program. **5.9** That DCS training incorporate appropriate and ongoing Indigenous cross-cultural training for all staff.	*The issue of enhanced training and professional development needs to be recognised by the DCS as an ongoing obligation of fundamental importance. The current situation, whereby staff can assume significant casework responsibilities before undertaking any induction training, is clearly unsatisfactory.*
Intake and assessment **5.10** That the DCS evaluate organisational models, including the use of dedicated officers, with a view to determining the most effective and efficient way of processing intake and assessment matters.	*Intake and assessment are specialist functions that may be best performed by dedicated workers, independent of those who carry out the clinical intervention process.*
Court matters **5.11** That the DCS consider whether there may be advantages in having all court preparation work undertaken by specialist staff.	*This work is of a highly important and specialised nature. It may best be performed by staff with specialist skills and experience.*
Investigations **5.12** That the casework and investigative functions of the DCS be vested, as far as is possible, in different staff members. **5.13** That the DCS employ staff with specialist investigative skills and an understanding of child neglect and abuse issues to investigate complex notifications about abuse of children in care.	*Investigations are a specialist function usually best performed by trained investigators. There are clear advantages in having the investigative process undertaken by staff not involved in day-to-day casework. Operation Zellow (see Chapter 2) starkly highlights the importance of thoroughly investigating reported child abuse.*
Prevention and early intervention **5.14** That the Department of Families (or some other agency separate from the DCS) retain responsibility for delivering prevention and early intervention services, including services for all children, and for programs targeting communities or families identified as vulnerable.	*One of the central aims of the new model is to return a clarity of focus and purpose to child protection in Queensland. The DCS will be an agency focusing exclusively on meeting the needs of children identified as being at risk, and will concentrate on early and intensive intervention in that context.*
Assisting biological parents **5.15** That child-centred casework and the provision of parental support be vested, as far as is possible, in different staff members.	*There is a potential conflict between a function that involves decision making in the best interests of the child and the provision of support to vulnerable parents.*
5.16 That, as a preventive response, 40 specialist FSO positions be created to work exclusively with parents whose children have already been the subject of a low-level notification and continue to reside at home. These positions should be filled progressively over the next two financial years.	*Under the current system, biological parents are not always receiving the support and services they require to provide appropriate environments for their children. A commitment to working with parents is in the interest of the individual children, supports the family unit, and has the potential to reduce the overall level of notification and the need for intervention in the future.*

Recommendation	Reason
Information systems and record-keeping **5.17** That the DCS continue and complete the upgrade of information systems begun by the Department of Families, as a matter of the highest priority.	*In the absence of adequate information and record-keeping systems, the DCS may fall victim to many of the current department's practice failures as outlined in the evidence before the CMC.*
Responding to ministerial correspondence **5.18** That the DCS prepare and promulgate a specific policy outlining the requirements for producing and approving ministerial correspondence and briefing material.	*The evidence from Operation Zellow underlines the clear need for the DCS to institute a policy to enhance the provision of full and accurate information to the minister and senior staff.*
Internal accountability **5.19** That, in addition to direct service delivery by front-line workers, the expertise of senior practitioners be drawn upon for providing specialist advice in complex cases and for routine reviewing of the clinical decisions made by frontline workers. Senior practitioners should embrace line management responsibility for these decisions.	*It is unreasonable to expect junior staff to accept total accountability for clinical decisions, which are all too often highly complex matters that warrant the attention of staff with high levels of expertise and experience. Extensively drawing upon the expertise of senior practitioners will be essential if the DCS is to provide a markedly improved quality of service.*
Complaints handling **5.20** That the DCS establish a unit and clear procedures for receiving, assessing and responding to complaints.	*The DCS needs to have the capacity to respond quickly and adequately to complaints made to it, in a manner that earns the confidence of clients and other stakeholders.*
External accountability **5.21** That a position of Child Guardian, to be situated within the Commission for Children and Young People, be established, whose sole responsibility would be to oversee the provision of services provided to, and decisions made in respect of, children within the jurisdiction of the DCS.	*In conformity with the view that child-protection needs to be the exclusive focus of a dedicated body, the CMC believes there should also be a dedicated body to oversee the DCS.*
5.22 That the powers granted to the Child Guardian be clearly set out in the legislation, and include the powers necessary to investigate complaints and enable proactive monitoring and auditing of the DCS.	*The current overseeing role of the Commission for Children and Young People is hindered by a lack of clarity in the specification and ambit of the powers of that office.*
5.23 That the Community Visitor Program of the Commission for Children and Young People be extended to cover all children in the alternative care system, including those in foster care. This program should be administered by the Child Guardian.	*The jurisdiction of the current Community Visitor Program is insufficient to meet the needs of children in the alternative care system. In particular, the current regime does not extend to children in foster care.*
5.24 That the jurisdiction of the Children Services Tribunal be expanded to allow the Child Guardian to refer decisions of the DCS or non-government organisations to the Children Services Tribunal for merit review, where the Child Guardian thinks it is warranted.	*This would allow decisions about which the Child Guardian may have some concern to be reviewed on their merits by a suitably qualified review panel constituting the Children Services Tribunal.*

Recommendation	Reason
Child-death reviews **5.25** That the new Department of Child Safety continue the practice of undertaking a review of all deaths of children in care, or who have been known to the department within the last three years. Steps should be taken to ensure that an appropriate degree of independence exists in the review process, and external consultants, experts and Indigenous advisers should be engaged in relevant matters.	*It is considered that completely divesting the DCS of any review responsibility for child deaths would not serve to promote the desired culture of transparency and accountability. It is also extremely important that the department with child-protection responsibilities becomes aware, as quickly as possible, of any systemic or procedural factors that might have contributed to the death of any child interacting with it, and that might expose other children to risk.*
5.26 That, following the establishment of the Department of Child Safety, discussions be held between the State Coroner and the relevant investigative agencies, with a view to developing protocols and other working arrangements directed to determining who is to be the lead investigative agency in different cases and how information can be appropriately exchanged between agencies.	*The development of such arrangements is necessary to avoid possible prejudice to investigations or coronial inquests, to reduce any duplication of effort, and to ensure that all relevant information is available to the agencies involved.*
5.27 That a new review body — called the Child Death Review Committee (CDRC) — undertake the detailed reviews of the DCS's internal and external case reviews. **5.28** That the jurisdiction of the Commission for Children and Young People be expanded to include the following roles: • to maintain a register of deaths of all children in Queensland • to review the causes and patterns of death of children as advised by investigative agencies • through a Child Death Review Committee, to review in detail all DCS case reviews, whether conducted internally or externally, regarding the deaths of children in care and those who had been notified to DCS, within three years of their deaths • to conduct broader research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable • to prepare an annual report to the parliament and the public regarding child deaths.	*Through a fuller understanding of the reasons why children in Queensland die, government action directed towards the prevention of child deaths should be better informed and more effective.*
CHAPTER 6: MULTI-AGENCY RELATIONSHIPS AND MANDATORY REPORTING **Whole-of-government approach** **6.1** That each department with an identified role in the promotion of child protection be required to publicly report each year on its delivery of child protection services.	*Mandatory annual public reporting of child protection activities is essential to improving accountability and service delivery in Queensland.*
6.2 That the Directors-General Coordinating Committee consider appropriate ways for the DCS and state government departments to interact with federal and local governments and relevant community groups.	*Such a range of participants is necessary to ensure that the Queensland child protection system is exposed to a variety of perspectives and expert opinions, and that it provides stakeholders with 'ownership' of strategies designed to improve service delivery to client children and their families.*

Recommendation	Reason
SCAN and the DCS: the new model **6.3** That the existence of the SCAN teams be enshrined in statute to reflect their important contribution to the child protection system.	*Under the new departmental model, the existence and operation of multi-agency SCAN teams are a core means of officially responding to cases of suspected child abuse in Queensland. The requisite commitment, response and service delivery required of agencies in this new model warrant the SCAN teams being recognised by statute.*
6.4 That the operation of SCAN teams be based upon agreement to a standard set of interdepartmental policies and procedures.	*It is critical that all departments are clear as to their role and responsibilities relating to participation in the SCAN process and that the roles and functions of SCAN teams across the state be standardised, as far as possible.*
6.5 That SCAN teams receive appropriate levels of funding to discharge their responsibilities effectively, including appropriate funds for proper record-keeping systems and SCAN team training.	*SCAN teams, as a core micro-level response to child abuse and neglect, need to be sufficiently funded to operate at high levels of effectiveness and accountability.*
6.6 That SCAN team recommendations are accepted by the DCS, except in instances where the DCS believes the recommendations are contrary to the best interests of the child, and that any departure from a SCAN team recommendation is reported to the Director-General of the DCS and made the subject of detailed 'exception' reporting.	*The SCAN teams constitute a panel of experts equipped to provide high-level advice on individual case-management issues. Non-acceptance of SCAN recommendations should therefore only occur where the DCS believes it can demonstrate that the advice is contrary to the best interests of the child. Exception reporting and supervision is needed to monitor and evaluate such views.*
6.7 That SCAN be a standing agenda item on the Directors-General Coordinating Committee.	*With child protection a priority for the Queensland Government, the progress of SCAN teams in Queensland should be subject to regular monitoring by the Directors-Generals Coordinating Committee.*
6.8 That full reviews of the functioning of SCAN teams occur regularly and that audits be conducted to measure compliance with policies and procedures, including official record-keeping systems.	*Reviews of SCAN functioning will provide benchmark data and a means for evaluating the teams' performance.*
Non-government service delivery **6.9** That a strategic framework for child protection be developed, articulating the range, mix and full cost of services required to respond effectively to clients' needs, particularly complex needs; and that the implementation of this framework be adequately resourced.	*There is a need for the development of an integrated service system that effectively responds to the identified needs of children.*
Resourcing **6.10** That alternative funding models that would more adequately meet the true needs of children, families and carers be investigated.	*If the current resource-driven funding models continue to apply, children will not have access to necessary services.*
Role of the DCS and the non-government agencies **6.11** That a more progressive and contemporary integrated service delivery model, which creates a partnership between government and non-government organisations to deliver better services for clients of the child protection system, be developed.	*An integrated service model is necessary for the provision of effective and efficient services for children, their families and their carers. This should build on the substantial amount of work that has already been undertaken by the Department of Families.*

Recommendation	Reason
Service delivery **6.12** That a quality assurance strategy is developed and implemented for all services (government and non-government) and a minimum standard be set for the licensing of non-government services.	*The DCS has a responsibility to promote the wellbeing and safety of children in the alternative care system and to require accountability for the acquittal of expenditure on behalf of the community.*
Mandatory reporting **6.13** That mandatory reporting of child abuse be extended to registered Queensland nurses by legislating under the Health Act. **6.14** That registered nurses receive appropriate training in their new responsibility.	*The expansion of mandatory reporting to Queensland registered nurses provides another essential point of contact for children who are subject to abuse or neglect. In rural, remote and Indigenous communities it is arguably nurse practitioners (registered nurses) who have substantially more contact with children than medical practitioners. It is crucial that cases of child abuse or neglect that come to the attention of the medical system, at all levels, are not overlooked.*
6.15 That section 76K of the Health Act be amended to make it mandatory for doctors and nurses to notify the DCS about their suspicion of child abuse.	*Given that the DCS will be the lead child protection agency in Queensland, it is important that reports about children in need of protection be made, in the first instance, directly to the DCS. A doctor or nurse should, of course, still be able to notify Queensland Health or the QPS (in addition to the DCS).*
CHAPTER 7: FOSTER CARE **Core functions** **7.1** That the Department of Child Safety be responsible for receiving and investigating notifications of child abuse and neglect, and take over responsibility for the final assessment and certification of *all* carers, and for assessing the appropriateness of carers' reapprovals.	*Receiving and investigating notifications requires the skills of a specialised, central department. The DCS should also assume responsibility for the final assessment of carers because it is the entity responsible for ensuring the welfare and protection of any children taken into its care.*
Placement options **7.2** That the placement needs of children and adolescents in care be identified and a broad range of options — including foster care, residential services, family-group homes, therapeutic foster care, intensive support, and supported independent living — be provided to best meet the needs of individual children.	*It is important that services match the specific, identified needs of children. Currently the placement needs of children and adolescents are not being adequately met, with some young people being forced to live in unsafe or unsuitable accommodation.*
7.3 That the effectiveness of these placement options in meeting the needs of different groups of children and young people be evaluated.	*Case planning should aim to match the child's characteristics with the type of placement option that evidence suggests is most likely to meet their individual needs. Acquiring information on the efficacy of particular placement options for children and young people would help to facilitate matching between children and placements, which would lead to less placement breakdown and better outcomes for children.*
Residential care **7.4** That the Department of Child Safety: • identify the extent of the need for residential care services • identify the type of children who would most benefit from these services • develop service models that meet children's needs in this area • identify the skills and training required by staff • monitor and evaluate residential care services.	*There are significant numbers of children who do not benefit from placement in traditional foster care and require placements in residential facilities.*

Recommendation	Reason
Therapeutic care **7.5** That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated.	*There is a clear unmet need for therapeutic services for children in care. Research shows that placement breakdowns because of children's behaviour point to a need for therapeutic intervention. During case reviews, children who are experiencing difficulties in traditional foster care placements should be identified (e.g. more than two disruptions because of the child's behaviour) and, where appropriate, should be either provided with therapeutic interventions or transferred into therapeutic care.*
Foster care **7.6** That a central registry be set up containing details of all carers, children currently in their care, and their availability for further placements. The registry should flag when carers are due for reapproval, whether they have been denied their initial approval or reapproval, and whether they have been, or applied to be, a carer in another state. Also, it should be possible for staff to search the registry by region, so that they can easily obtain an up-to-date list of carers and placements in their area. **7.7** That an audit of all current carers be conducted to obtain up-to-date data and determine their availability for placements.	*The current data provided by the Department of Families demonstrate that up-to-date records of carers and placements are not easily accessible. Because children are in the care of the department, there is an obligation to keep these data and use the system to improve efforts to monitor the foster care system.*
Respite care **7.8** That the DCS identify and implement new methods of recruiting respite carers. **7.9** That additional efforts be made to identify alternative respite options for children that could improve children's wellbeing, for example regular camps and school holiday programs. **7.10** That, to prevent carer burnout and limit placement breakdown, planned respite for carers be 'routine' and not have to be requested by carers. Plans for respite could be included in the child's case plan.	*The provision of adequate respite services is essential to maintain a viable foster care system which retains carers within the system and is therefore able to provide children with the stable placements they require for their continued wellbeing. Respite can also be seen as an opportunity for increasing children's social support network and exposure to strong adult role models.*
Voluntary care **7.11** That the *Child Protection Act 1999* be amended to regulate voluntary placements.	*Statutory protections available to children in foster care should be extended to voluntary placements.*
Foster care protocols — recruitment **7.12** That initial screening mechanisms be more efficient and rely on identifying the characteristics that are associated with continuing in foster care and providing good outcomes for children. **7.13** That efforts be made to recruit a more diverse group of carers, rather than continuing to concentrate recruitment efforts in lower socioeconomic areas. **7.14** That the DCS identify areas of high, unmet need and initiate recruitment drives to obtain more carers for specific types of children. Recruitment drives can be directed to areas of high need and focus on recruiting carers who can meet the needs of specific groups of children (e.g. teenagers, or children with special needs or challenging behaviours).	*It is necessary to improve recruitment efforts to enlist foster carers as there are not enough carers in the current system to match the needs of Queensland children.*

Recommendation	Reason
Foster care protocols — decisions about approval **7.15** That the DCS be responsible for the final approval of foster carers. Special attention should be focused on processes that give carers specific approval for numbers and types of children.	*There is a need to consider alternative approval processes that may provide a more thorough assessment of carers, which will increase the likelihood of successful placements for children and carer satisfaction. Processes that give specific approval could be used in initial efforts to match children with carers.*
Foster care protocols — retention of carers **7.16** That regard be had to relevant research findings in order to identify the factors that are most likely to result in successful placements, and to use this knowledge to develop practical processes for the recruitment of suitable carers.	*Although it is important to increase the recruitment and retention of foster carers within the alternative care system, it is also important to make these processes more efficient than those that are currently used to enlist carers.*
7.17 That structured exit interviews with carers be conducted. This information should be used along with regular surveys of carer attitudes, satisfaction and concerns, and other appropriate research initiatives to identify problems and devise systemic solutions.	*Exit interviews would be a way of learning the particular problems that discourage Queensland carers from continuing to foster.*
Foster care protocols — training **7.18** That a framework be developed for supporting relative care that includes enhanced screening and monitoring of carers and the provision of training opportunities and other support for carers. There should be an extensive consultation process, especially with Indigenous communities, in the development of the framework.	*It is important that children under child protection orders who are in relative care have the benefit of the same safeguards as other children in care.*
7.19 That all prospective foster carers undergo compulsory training in parenting. All training programs should be evidence-based and undergo ongoing evaluations of their effectiveness. **7.20** That foster carers be required to undergo ongoing training, identified and organised during yearly reviews of the foster carer by their agency support worker. Carers' reapproval should be contingent on the successful completion of this training. **7.21** That there be a tiered, multi-level approach to training and support of foster parents. The level of need of the foster carer and the children in their care should be assessed and the most appropriate level of training and support required should be provided. In this way, carers who deal with more difficult children, or those with special needs, would receive additional, more specialised training.	*Currently foster carers are not receiving adequate training for dealing with the challenging behaviour of many children who are entering care. This results in high levels of parenting stress and difficulty in retaining carers within the foster care system, which in turn results in children having more unstable placements. There is a clearly identified need for foster carer training to (i) use evidence-based training programs (ii) specifically include parent training and (iii) include a tiered level of training to match carers' competencies with the needs of different children. Effective training courses will improve carers' skills and abilities to deal with children's negative behaviour and so facilitate satisfying long-term outcomes for foster children.*
7.22 That caseworkers be well trained and supervised in evidence-based parenting practices so they can support foster parents with appropriate parenting advice. This training should occur within their pre-service university based courses and through in-service training.	*One of the important roles for caseworkers is to support the foster carers in providing competent parenting to the children in their care. Therefore these workers need to have a thorough understanding of effective parenting practices.*
Foster care protocols — support **7.23** That conditions and support for departmental carers be enhanced to ensure that they are not disadvantages in comparison with agency carers.	*It has been suggested that under the current system, departmental carers receive less support in their role as carers and are often given more difficult placements or greater numbers of children.*

Recommendation	Reason
Placement meetings and agreements **7.24** That tools and resources be developed by the DCS to ensure that placement meetings are initiated by departmental staff and completed in a timely manner, preferably before a child is placed with a carer. Carers should be consulted and agreements negotiated by the carers and the DCS, rather than dictated by the department.	*Placement meetings and subsequent agreements are essential for establishing the groundwork for a successful placement. While current policies and procedures do attempt to involve carers in a partnership with the department, their implementation is variable. Involving carers as an active partner in decisions about children in their care will increase carer satisfaction and provide better outcomes for children.*
7.25 That, during placement meetings, foster carers be provided with all relevant information about the child. When foster carers accept a child for placement they should be given copies of the child's medical and dental records and the child's Medicare details.	*It is essential that foster carers are provided with all relevant information about the child about to be placed in their care — including information about all dangerous propensities, whether the child has accused other carers of abuse, details of any maltreatment the child has suffered and the child's medical history — so that they can make an informed decision about accepting the placement.*
Disclosing confidential information **7.26** That the Child Protection Act be amended to incorporate specific obligations on the part of the DCS to disclose relevant information to carers. **7.27** That the Child Protection Act incorporate a general disclosure obligation on the DCS to inform other departments, government agencies and non-government agencies (including AICCAs) of all information reasonably necessary to ensure their cooperation, assistance and participation within the child protection system. The Act should provide examples of what sort of information will be provided. The person to whom the disclosure is made (the 'receiver') will be bound by the confidentiality provision contained in section 188. **7.28** That the department ensure that it has clear policies and procedures on disclosure of information and that it incorporate them in the training provided to departmental and agency staff.	*It is necessary to remove any perceived impediments to the disclosure of information about children in alternative care by departmental staff. There is an identified need to ensure that all DCS staff understand the legislative provisions about confidentiality and that the department's child protection functions are administered in a way that lessens the possibility of there being adverse effects upon children's protection and welfare, because of misguided decisions to withhold relevant information.*
Foster care protocols — case planning and review **7.29** That tools and resources be developed by the DCS to ensure that foster carers are included in children's case planning.	*It is important to recognise the valuable contribution that carers can make to case planning. Many carers will have detailed knowledge about the child, particularly when children have been in their care for substantial periods of time.*
Foster care protocols — additional support mechanisms for foster carers **7.30** That consideration be given to the DCS implementing mentoring programs for foster carers and children in foster care.	*Mentoring programs have been shown to facilitate good outcomes for children. Potentially they could provide a stable, positive, adult influence in a vulnerable child's life and indirectly give additional support to foster carers in meeting the needs of children in their care. They would also have the benefit of giving the carer regular brief periods of respite from the demands of parenting the child. The program could operate regardless of any changes in the child's placement, including reunification with parents.*

Recommendation	Reason
7.31 That the DCS ensure that an appropriate procedural framework is established for responding to allegations made against foster carers.	*It is important that foster parents have an understanding of departmental processes in dealing with such complaints.*
Remuneration **7.32** That foster carers receive appropriate remuneration to cover the actual costs of caring for a child, as well as receiving additional payments to attend training as required and pay the associated costs of child care and transport for such training.	*It will be easier to attract and retain carers in the foster care system if people are not expected to personally subsidise their caring. Also, the provision of adequate remuneration will reduce the financial burden and related stress on foster care families.*
7.33 That the DCS investigate introducing a tiered system for payments to foster carers that recognises the skills necessary to care for children with more complex needs.	*If a tiered payment system is introduced it could readily by linked to the tiered training system that has also been recommended. Additional payments would provide an appropriate recognition of the higher-level skills attained by specific carers and acknowledge their work with children who have special needs or more challenging behaviours.*
7.34 That the allocation of any additional payments (e.g. child-related expenses, high-support needs allowance) be on a needs basis, rather than on regional resource allocations. Children's needs and entitlements should be clearly detailed in the child's case plan.	*Under the current system there is considerable inconsistency in the availability of these additional payments. While the needs of some children are met, others appear to be denied funding because of resource limitations. There needs to be a consistent application of policies about entitlements, so that funding is based on the identified needs of the children.*
Case planning **7.35** That there be thorough, standardised, evidence-based case planning that is consistently applied and focuses on the best interests of the child. This issue needs to be addressed both in university training courses and in ongoing training provided to staff.	*The evidence indicates that the current standard of case planning is inadequate and lacks a coherent evidence base, which leads to poor outcomes for children.*
7.36 That all children have an identified and designated caseworker from the DCS who maintains regular contact with the child and is responsible for the development of a detailed case plan that focuses on both the short- and long-term needs of the child. The plan must be reviewed at least every six months.	*Children need regular access to a worker who represents their best interests and develops a comprehensive and evolving case plan for their long-term wellbeing.*
7.37 That the DCS adopt clear policy so that section 96 of the *Child Protection Act 1999*, which states that a family meeting should be organised for all children requiring protection, is followed. **7.38** That the Child Protection Act be amended to make it necessary for a case plan to be submitted to the court before an order is sought (as presently occurs in NSW and the ACT).	*All children in the care of the department should have a case plan. As a family meeting is essential in formulating this plan, this meeting must occur for all children including those on voluntary placements.*
7.39 That processes be implemented to ensure initial case planning is carried out promptly and case plan reviews are carried out every six months, as required under the *Child Protection Act 1999*; and that all stakeholders, but particularly the child, their family, and the child's carer, are invited to participate in every planning meeting.	*Under the current system, case planning is not being fully implemented. This recommendation, which comes from the Commission for Children and Young People, is designed to encourage the implementation of appropriate casework.*

Recommendation	Reason
Children's involvement in casework **7.40** That tools and resources for the participation of children and young people in case planning be developed and used to ensure their participation in planning processes that are in keeping with the principles of the *Child Protection Act 1999*.	*While children's rights to be involved and informed about decision making are specified in current legislation and policy, in practice such involvement often does not occur. Therefore it is necessary for the development of specific resources to ensure children's participation.*
7.41 That the DCS be required to implement procedures to ensure that all children are informed within 24 hours of entering care why they have been taken into care and what they can expect will happen to them. **7.42** That the DCS ensure that all children who are the subject of an assessment of risk of harm and/or enter into the care of the department are given the option of a support person whom they know and trust.	*It is important that children are able to maintain ongoing family relationships if possible, because a lack of contact may increase the sense of grief and loss that many children experience on entering care. For example, children are often particularly concerned about the welfare of their siblings, and efforts should be made to maintain these relationships. Foster carers often reported that, when siblings were placed with different families, visits only occurred if they were organised by the carers. When siblings remain with the biological family it is still important to enable the child to maintain contact, even in the most extreme situations where the child must be protected from parental contact during visits with siblings.*
Biological parents' involvement in casework **7.43** That tools and resources be developed by the DCS to ensure that the procedures for involving parents in casework (e.g. family meetings, planning agreements) are followed, and that their support worker be included in these processes.	*Despite policies and procedures to involve parents in their child's case planning, in practice parents have often been excluded from this process, and so it is important to implement mechanisms to facilitate their involvement. This is particularly important when the case plan involves reunification. If the parent is disengaged from the process, reunification is less likely to succeed.*
Reunification versus permanency planning **7.44** That the DCS evaluate research into the effect of reunification or permanency planning on children.	*Currently there is limited Australian research on the effects of reunification or permanency planning on children. Although there now appears to be growing interest in permanency planning in Queensland, the concerns about including an adoption option in permanency planning legislation suggests that any change need to be evidence-based and to consider the specific concerns of the Indigenous community.*
7.45 That an additional principle be inserted into section 5 of the *Child Protection Act 1999* clearly providing that any conflict that may arise between the interests of a child and the interests of the child's family must be resolved in favour of the interests of the child.	*There is nothing in the current Queensland legislation that emphasises that children's rights take precedence over parents' rights.*
Guardianship orders **7.46** That the DCS review the practices associated with granting long-term guardianship orders and short-term child protection orders (including custody orders).	*Although it is possible for the Children's Court to make an order granting long-term guardianship of a child to a member of the child's family or support network, or to a long-term carer, in practice, long-term guardianship orders are nearly always made in favour of the director-general. Given the evidence that these types of orders are more likely to lead to children drifting in and out of care and experiencing multiple placements, the Commission considers that this practice could be the subject of review by the DCS.*

Recommendation	Reason
CHAPTER 8: INDIGENOUS CHILDREN **Aboriginal and Islander Child Care Agencies** **8.1** That the government recognise the ongoing need for independent community-based Indigenous organisations, and that these organisations be provided with the necessary support and resources to provide culturally appropriate child protection services to the Indigenous community. This support should include training and professional development, as well as assistance complying with service agreements and accountability requirements. **8.2** That, where AICCAs have been de-funded, they be replaced by appropriate independent Indigenous organisations that have the support of their local community and that, wherever possible, these organisations employ staff with backgrounds in child protection.	*The new child protection system envisages a continuing role for independent Indigenous organisations, operating in an effective and culturally appropriate manner within local communities.*
8.3 That, in acknowledgment of the extent to which cultural factors draw AICCAs into the delivery of prevention services, the nature of both the service agreements and the funding of individual AICCAs be carefully reviewed.	*Clear links between funding and the performance of child protection services are necessary, in order to support the enhanced focus on child protection work in the new DCS. The evidence suggests that the lines between prevention initiatives and alternative care services are frequently blurred in Indigenous communities. AICCAs cannot realistically be expected to operate effectively in delivering child protection services unless expectations about their delivery of these different types of services are clearly delineated.*
Indigenous child placement principle **8.4** That DCS compliance with the Indigenous child placement principle be periodically audited and reported on by the new Child Guardian.	*The child placement principle constitutes a fundamental recognition of the important and unique aspects of Indigenous culture. Giving effect to this recognition is central to a viable child protection service.*
8.5 That the Indigenous child placement principle specifically state that a placement decision can only be made if it is in the best interests of the child.	*The best interests of the child should be paramount in any decision, regardless of whether the child is Indigenous or non-Indigenous.*
8.6 That in situations where Indigenous children are placed with non-Indigenous carers, the child protection legislation should specifically provide that contact be maintained with their kinship group, where that is in the best interests of the child.	*Separating any child from their biological parents is a dramatic intervention in the life of a child. The magnitude of this intervention should not be unnecessarily increased for Indigenous children by simultaneously removing the child from their cultural community.*
Recruitment of specialised carers (general and relative) **8.7** That, subject to consultation, provision be made for Indigenous carers to have enhanced access to respite care, and adequate training and support be made available to Indigenous carers (as recommended generally in Chapter 7). **8.8** That urgent attention be given to identifying ways of encouraging more Indigenous people to become carers.	*Fundamental to the success of child protection services for Indigenous children are the services of Indigenous carers equipped to draw upon various placement options to meet the full range of needs of children in care.*

Recommendation	Reason
Children and biological parents **8.9** That departmental policies and practices recognise the rights of children and biological parents and reflect this recognition in culturally appropriate ways that allow for all parties to be fully informed of, and involved in, case planning for children.	*It is undesirable to unnecessarily exclude biological parents from involvement in case planning because of a reluctance or inability to use culturally appropriate language and communication idioms.*
Issues from Cape York, the Gulf and Torres Strait regions **8.10** That the DCS provide culturally appropriate child protection services that take account of the drug- and alcohol-related problems besetting some remote communities. This will require the provision of specific support services to address the special needs of children requiring DCS intervention in these communities.	*Geographical isolation should not mean that children in remote communities have unnecessarily limited access to the range of protective services available to children in more populous regions. This is particularly important given that some of the very remote communities are faced with problems so serious that only major interventions by government can be expected to resolve their difficulties.*
Legislative changes **8.11** That the child protection legislation reflect the importance of Indigenous participation in decision making. So as to remove any ambiguity, the legislation should explicitly state the types of 'decisions' requiring consultation. The department, in consultation with Indigenous agency stakeholders, should develop an agreed protocol for sharing information about children and families involved in the child protection system.	*Indigenous people are entitled to informed participation in the decision-making process when Indigenous children come in contact with the child protection system.*
Placement decisions **8.12** That the DCS ensure its officers comply with the department's statutory obligation by consulting with an Indigenous agency before removing or placing an Indigenous child. A protocol (agreed between the department and the Indigenous organisation) must be developed to establish clearly how this consultation will occur.	*Indigenous people are entitled to informed participation in the placement of Indigenous children, to ensure that placements are not only in the best interests of the child but also, where possible, in accordance with the Indigenous child placement principle.*
Case-management plans **8.13** That the DCS consult with appropriate community representatives in the case-planning processes for Indigenous children.	*The involvement of Indigenous people in the case-planning process should ensure that the best decisions are made for the child.*
CHAPTER 9: LEGISLATIVE CHANGES **Notifications** **9.1** That the *Child Protection Act 1999* be amended to enable the department to intervene where it is suspected than an unborn child may be at risk of harm after birth.	*Some pregnant women need assistance and support before the birth of their child to reduce the likelihood of the child needing to be placed in out-of-home care after birth. The principle is that of supportive intervention rather than interference with the rights of pregnant women.*
Approval of individual carers **9.2** That the Child Protection Act be amended to ensure that it regulates the assessment and approval of all carers.	*Although assessment and approval processes for relative carers and limited approval carers are specified in policy, neither of these types of carers is required under the Act to be formally approved. In fact, the Act makes absolutely no reference to relative or limited approval carers.*

Recommendation	Reason
Case plans **9.3** That legislation require the development of a case plan for the care of all children on child protection orders or in the custody of the director-general.	*The insertion of a specific provision on case planning into the Act may result in higher standards in the development and monitoring of case plans.*
Report on implementation **9.4** That the government review, and report to the CMC on, the implementation of this report's recommendations within two years from the delivery of the report.	*Such a review and report will be necessary to enable the CMC to effectively review the level of implementation of the recommendations made in this report.*