



CHAPTER 13
OVERSIGHT, ACCOUNTABILITY AND REVIEW

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Introduction

Sound monitoring and accountability provisions are fundamental to ensure government departments and agencies, their partners and those contracted to work on their behalf, are clear about what is expected of them, that there are systems in place to hold them accountable and processes to monitor outcomes and ensure quality of services. Ultimately, this is the process by which we will know that children are receiving the assistance they require, and if they are not, identify where the stumbling blocks might be to improve the service delivered for them.

The system comprises the statutory authority, its fellow government divisions and departments and the range of agencies and individuals funded, licensed or authorised to provide child and family welfare services. With implementation of the significant reforms recommended by the Inquiry we anticipate that the system will be in a better position to assist children to reach their full potential.

When a system is overwhelmed and unable to meet the community's expectations and government accountabilities due to demand pressures, then the system breaks down. The result of this is that poor practices evolve and become standard, the workforce itself becomes overwhelmed, stressed and demoralised with high rates of departure which is symptomatic of all child protection jurisdictions. Difficulties with recruitment mean those who remain have an even greater workload and there is no time for reflection let alone to provide appropriate orientation to recruits or for professional development. Policies which look good on paper, such as those of supervision, are often not complied with. In a stressed system it is often that a culture of bullying is perceived, real or otherwise and new ideas and suggestions may appear to be ignored.

The Inquiry identified that there was lack of a clear process to review decisions which means parents or carers, disaffected by decisions, have no recourse other than to complain directly to the Minister, the opposition spokesperson, other parliamentarians, or to a complaints authority such as the Children's Commissioner, or the Ombudsman. The impact of this is that responses to ministerials which are time consuming are common and take workers away from their duties placing additional stress on an already overworked staff. The results of the system operating in this manner are described throughout this report and became evident to the Inquiry very early in deliberations.

Across all jurisdictions the capacity to provide a comprehensive, responsive and effective system for protecting children is an ongoing challenge, it is critical that the government has appropriate systems in place to monitor performance, and ensure accountability of government funding. However, in the Northern Territory there is a unique combination of circumstances that results in a high proportion of the population of children being vulnerable and indeed suffering poorer outcomes than they otherwise might. It is undeniable that children experiencing high levels of disadvantage need access to quality systems to help improve their situation in life. It is in this context that this chapter has been written.

This Inquiry has heard from over 25 percent of the approximately 500 NTFC employees either via individual submissions, hearings, phone calls or emails, via workgroup submissions, or through the official departmental response. There is consensus that the system is failing and reform is required. Submissions in the public domain on the Inquiry website highlight the particular issues relating to workforce and have the potential to be sensationalised, however, what the Inquiry often saw were examples of staff using innovative solutions to deal with complex issues. The Inquiry believes it is critical for the government to build in systems to better monitor government funded services, increase the accountability around public funding and to address complaints and allegations in a timely manner.

This chapter proposes structures to enable the system to promote child safety and wellbeing, to adopt a reflective rather than simply a procedural approach to its business, supporting evidence-based practice but where evidence is missing using appropriate evaluation tools to know that the system is responding the right way. Reflective practice if supported with appropriate mechanisms informs decision-makers about modifications to policy, practice and resources needed for improvement. Such a culture of practice will deliver a far better service to the children it serves, will build community confidence, and will be much more satisfying than the current circumstances for those working within it.

Building a culture of reflection within the system is critical and there are a number of components necessary for this to occur. These include transparency, collection of and access to appropriate data, and effective oversight to make sure it happens. It is important that oversight entities are seen as entities that can assist and promote the work of the system. Oversight entities can promote a climate of reflection that has a primary focus on children and their safety and wellbeing. Considered and appropriately obtained feedback from external stakeholders is also necessary.

Structures and mechanisms for monitoring the system

Across Australia there is a variety of structures addressing issues of monitoring, accountability and advocacy for children, young people and families. Such roles and structures include Children's Commissioners, Children's Guardians, Ombudsmen, Administrative Review Tribunals, Review Teams and Community Visitor Schemes, which may or may not be located within one of the other structures.

The roles and functions of these may include:

- Promoting and protecting the rights of all children and young people
- Monitoring and reviewing systems, policies and practices relating to children
- Monitoring the circumstances of children and young people in out of home care, promoting their best interests and ensuring their rights are protected
- Advocating for the needs of children and young people
- Strategic reporting and performance measurement which may involve the development of monitoring plans and outcome indicators as strategies for effecting change and improvement
- Investigating and resolving complaints about the provision of community services for children

- Investigating administrative complaints against funded, licensed or authorised children's services
- Regulating the employment of children and young people, promoting their welfare with employers and investigating complaints and alleged breaches of statutory provisions
- Reviewing complaint handling systems
- Reviewing circumstances relating to the death or serious injury of children in prescribed situations
- Screening people seeking employment in children's services.

In particular, the Inquiry notes one recent initiative in this area. In November 2009, the Victorian Government, in response to concerns raised by the Victorian Ombudsman regarding decision-making in the statutory child protection program and the need for greater independent scrutiny of operations, announced a program of change involving the following elements:

- [Significant funding to enable actions to] improve the monitoring, accountability and transparency of the child protection program through the development of a new regional audit and monitoring system
- Providing the Child Safety Commissioner with greater opportunity to review individual child protection case matters and raise particular concerns directly with the Minister through an annual Charter Letter
- Increasing external oversight and reporting of program performance through the establishment of a new Child Protection Standards and Compliance Committee made up of experts and an independent chair with expertise in the fields of monitoring and accountability. The committee will report to the Minister and outcomes of the committee's work are to be published
- Increasing internal monitoring of program performance through the establishment of a new area within the Department of Human Services with responsibility for monitoring child protection compliance with statutory obligations and practice.¹⁰⁸⁸

Office of the Children's Commissioner

The *Care and Protection of Children Act* provides for the Office of the Children's Commissioner which commenced in 2008. When introducing the *Care and Protection of Children Act* into Parliament in 2007, the then Minister for Child Protection, the Hon Marion Scrymgour MLA made the following statement regarding the Office of the Children's Commissioner:

This is a statutory, independent role, equipped to keep a public eye out for the interests of children who have had contact with the child protection system and to ensure that services, systems, and policies serve them well.¹⁰⁸⁹

1088 Department of Human Services (DHF), 2009, *Strengthening child protection*, Victorian Government, Melbourne, <http://www.dhs.vic.gov.au/about-the-department/news-archive/?a=434592>.

1089 The Hon Marion Scrymgour MLA, cited in Submission: Office of the Children's Commissioner Northern Territory.

The Commissioner has three main functions as outlined in the *Act*:

- To monitor the administration of the *Care and Protection of Children Act*
- To monitor the implementation of government decisions arising from the recommendations arising from the Inquiry into the Protection of Aboriginal Children from Sexual Abuse
- To receive and process complaints about services provided for protected children.

The Commissioner may also be requested to prepare reports for the Minister for Child Protection on matters pertaining to the above functions.

In addition to the above, the Commissioner has also been appointed by the Minister to be the Convenor of the Child Deaths Review and Prevention Committee (as described in the previous section).

The Children's Commissioner reports to the Legislative Assembly through the Minister for Child Protection and prepares an annual report relating to his/her functions.

The following changes to the role and functions of the Commissioner, have received support in submissions from the Ombudsman, the Opposition, and the Acting Children's Commissioner, among others:

- Own motion powers to investigate matters
- Broader investigative powers, extending to all children, not just those who are 'protected' and to receive complaints about or investigate all service providers to children, not just the statutory authority
- A more proactive advocacy role to bring about change
- Broader role in overseeing reforms
- A role pertaining to Aboriginal children in particular
- Involvement in policy and monitoring committees, ex-officio.

Own Motion Powers

The *Act* states that a central object of the office of the Northern Territory Children's Commissioner is to 'ensure the wellbeing of protected children' (Section 258). However, the means to ensure this wellbeing are very limited. Currently, the Commissioner can only investigate complaints that meet specific restrictive criteria (for example, that the complaint pertains to a service provided to a child). He/she does not have the authority to investigate a matter of concern relating to a protected child on his/her own motion. Furthermore, the Commissioner does not have the authority to investigate matters involving groups of children that come to his/her attention, for example, poor physical conditions in a residential centre.

A number of aspects to the system responsible for child safety and wellbeing are identified by this Inquiry which would warrant investigation by an office such as the Children's Commissioner, however as they do not pertain directly to protected children they are beyond the bounds of the Children's Commissioner's legislated role. An example of this would be to investigate allegations about the alleged coercion of parents into agreeing to temporary placement orders. A formal complaint investigation could not be undertaken by the Children's Commissioner because the complaint was not made about a service for an individual child.

The Northern Territory Opposition and the Ombudsman recommend that the:

Children’s Commissioner have powers commensurate with those of the Ombudsman to provide the necessary external scrutiny...¹⁰⁹⁰

As well as

to monitor and oversight the development of services, programs, and to report to the Legislative Assembly and to the public...[and] to receive and investigate complaints and to conduct self initiated audits.¹⁰⁹¹

A broader advocacy role for children

There are some calls for the Children’s Commissioner to have a broader role than the current one so as to be more proactive in advocacy. It could include an:

advocacy role that included children and young people interfaced with other areas of legislation and different service systems, such as Disability Services, Mental Health, SAAP [Supported Accommodation Assistance Program], Health and Education systems. The functions have to entail higher level investigative and reporting powers and include an adequate power base with which to lead change and require compliance from government, non government and private agencies/businesses and practitioners.¹⁰⁹²

This would include:

a proactive leadership role in helping Territorians achieve a monumental shift in how we see, treat and respond to the rights of children/young people and how we ensure their care, safety and developmental needs are met.¹⁰⁹³

The Ombudsman also recommends that the Children’s Commissioner’s powers be strengthened to:

- I. extend to all children
- II. receive complaints about, investigate and report on, public housing for children; drug and alcohol rehabilitation services for children and families with children; child care; education; truancy; domestic violence; and law enforcement involving children affecting families with children. The Commissioner’s jurisdiction should be extended to all programs and NGOs for the advancement of the wellbeing of children that receive funding or subsidy from any government and operate in the Northern Territory.¹⁰⁹⁴

Given the range of the Commissioner’s responsibilities and the over-riding focus in the *Act* on the wellbeing of protected children and child protection activities, it is

1090 Submission: Northern Territory Opposition.

1091 Submission: Ombudsman Northern Territory.

1092 Submission: Anglicare NT.

1093 *ibid.*

1094 Submission: Ombudsman Northern Territory.

probably unrealistic that he/she be responsible for advocating for and investigating complaints involving all children. However, the Commissioner's advocacy and complaint management responsibilities could well extend, as they do in some other jurisdictions, to other vulnerable children in the care of the Northern Territory Government services (or services funded by the Northern Territory Government) such as children with a disability, those in mental health facilities and those in youth justice facilities.

The Ombudsman also makes the following recommendations regarding the Children's Commissioner, among other things:

Enhancing the independence of the Children's Commissioner by,

Amending Section 262 of *Care and Protection of Children Act* by deleting the words at the beginning 'except as otherwise provided by another law of the Territory'

[The Children's Commissioner having] his/ her own budget allocation for which the Commissioner would be responsible under the *Financial Management Act*.

Monitoring the administration of the *Care and Protection of Children Act*

At present one of the Children's Commissioner's functions is to monitor the administration of the *Care and Protection of Children Act* (the *Act*). However, the *Act* provides no guidance on the meaning of 'monitoring' nor does it provide any definition of the scope of the monitoring function, or the specific powers to enable the monitoring.

A number of submissions call for a clear mechanism for monitoring the statutory agency's performance.¹⁰⁹⁵ The Northern Territory Coroner in a recent inquest finding also raised specific concerns that, under Part 4.7, there is no provision for the CEO's decision to place the children in the care of a particular carer to be reviewed:

In short, there is no external review of certain important decisions concerning the ongoing care of children. Given the systemic problems in FACS, this is disturbing. The Australian Government in consultation with all of the other states and territories is in the process of establishing national out of home care standards aimed at ensuring children in the Australian out of home care system are safe and well. One of the major factors identified in the National Out of Home Care Consultation paper is the independent monitoring of the out of home care system and reporting processes where the monitoring body is independent from the Out of Home Care service providers.¹⁰⁹⁶

With respect to the monitoring role of the Children's Commissioner he goes on to state:

there is no provision in the *Act* which guides or controls the Commissioner in how to exercise his functions. No specific powers are conferred on the commissioner to obtain documents, examine persons or carry out any type of investigations. This is in contrast to detailed provisions about the Commissioner's powers to investigate complaints. The *Act* should be amended to remedy these significant omissions.

1095 Submission: NPY Women's Council, Submission: Northern Territory Law Society, Submission: Robert Parker.

1096 G Cavanagh, 2010, *Inquest into the death of Deborah Leanne Melville-Lothian, NTMC 007*, Office of the NT Coroner, Darwin, p.81.

The Inquiry is of the view that specific powers should be provided in the *Act* to enable the Commissioner to carry out his/ her monitoring function.

A broad role in overseeing reforms

Section 260(1)(d) of the *Care and Protection of Children Act* (the *Act*) specifies that ‘the Commissioner is to monitor the implementation of any government decision from the ... Little Children are Sacred report (the Implementation Function).’ The findings of the 2007 Inquiry had a profound effect on the shaping of future Government policy towards the issue of sexual abuse towards Aboriginal Children and broader concepts of Aboriginal disadvantage and child welfare in the broader community. The findings of the report were also the impetus for the Australian Government’s intervention in the Northern Territory.

The 2007 Inquiry identified issues and indeed made crucial recommendations that had substantial effect on the most vulnerable children in our communities, those who have and are experiencing interaction with our child protection system. If it was Parliament’s intention that an independent body be put in place to monitor actions taken by Government in light of recommendations in the 2007 Inquiry, it might be relevant to extend this monitoring capacity to include subsequent Inquiries and their findings, which are somewhat similar in nature to the 2007 Inquiry. This would provide the Commissioner with the ability to not only monitor the implementation of findings in the 2007 Inquiry which are still quite relevant but also subsequently relevant inquiries which may also require the ability to be independently monitored.

The Office of the Children’s Commissioner suggests that the Implementation Function be replaced with a clause that would give effect to the following: that the Commissioner is ‘to monitor the implementation of any government decision arising from an Inquiry in relation to the Child Protection System or the wellbeing of children as constituted under the *Inquiries Act*’...This would also require consequential amendment to the objects of Part 5.1 of the *Act*.¹⁰⁹⁷

The Children’s Commissioner’s role pertaining to Aboriginal children in particular

Currently, a primary role of this statutory office is to ensure the wellbeing of protected children by investigating specific matters related to the provision of services to protected children and monitoring the administration of the *Act*, in so far as it relates to protected children.¹⁰⁹⁸ A protected child is considered to be a child who is subject to the performance of a function under Chapter 2 of the *Act*. Chapter 2 of the Inquiry’s report highlights that outcomes in the Northern Territory for Aboriginal children are poor on many metrics, and this report consistently highlights that approximately three quarters of protected children are Aboriginal.

Given that Aboriginal children are over represented in reports to NTFC and in substantiated child protection notifications and, as highlighted in Chapter 2, Aboriginal child wellbeing outcomes are poor on other measures also, there is a special need for advocacy for Aboriginal children in particular. Two submissions address this issue in very similar ways, recommending either an Aboriginal Children’s Advocate¹⁰⁹⁹ as part of the office of the

1097 Submission: Children’s Commissioner Northern Territory.

1098 *ibid.*

1099 Submission: Anglicare NT.

Children’s Commissioner or a separate Aboriginal Children’s Co-Commissioner.¹¹⁰⁰

The Children’s Commissioner’s role is largely concerned with matters pertaining to Aboriginal children, so the Inquiry does not see the need for a co-commissioner specifically and separately allocated to Aboriginal children. However the office of the Children’s Commissioner should employ an officer dedicated to issues affecting Aboriginal children in particular. This officer should be an Aboriginal person. This is especially important if the office continues to rely on complaints to perform its investigation role. The importance of this is highlighted by the fact that Aboriginal people may prefer to report matters to an Aboriginal person. An increase in reports to the office from Aboriginal people would help the Commissioner to better understand issues of importance to them, in addition of course to the principle of enhancing access to the complaints process for Aboriginal people to have problems addressed. It would help the Commissioner to identify important child safety and wellbeing issues and solutions as well as to improve community confidence in the system.

Involvement in policy and monitoring committees ex-officio

The Children’s Commissioner is in a unique position to understand child safety and wellbeing and the relevant legislation, as well as to be able to understand the functioning of parts of the statutory authority involved in child protection.

There are other meetings the Children’s Commissioner could attend which would advance the Commissioner’s understanding of the system as well as assist the functions of the meetings. Attendance of the Children’s Commissioner at the NTFC Advisory Council, described in more detail below, at the Policy Coordination and Implementation Unit — in the Department of Chief Minister — ¹¹⁰¹and other high level policy committees, such as the Interdepartmental Child Protection Policy and Practice Working Group, in an ex-officio observer capacity, would greatly enhance the functioning of these meetings and the effectiveness of the office.

1100 Submission: AMSANT.

1101 See Chapter 14.

Recommendation 13.1

That the Northern Territory Government reviews the roles and functions of the Children's Commissioner in the light of this Inquiry with a view to amending the *Act* to address the needs for:

- An 'own motion' investigation capacity
- The extension of his/ her advocacy and complaint management responsibilities to other identified groups of vulnerable children in Northern Territory Government-funded care
- Specific powers for the Children's Commissioner to obtain documents, examine persons, or carry out any type of investigations as part of his/ her monitoring functions
- A broader role in monitoring the implementation of Northern Territory Government decisions arising from any inquiries in relation to the child protection system or the wellbeing of children under the *Inquiries Act*

Urgency: Immediate to less than 6 months

Recommendation 13.2

That the Northern Territory Government ensures that the Children's Commissioner is adequately funded to carry out any additional functions

Urgency: Immediate to less than 6 months

Recommendation 13.3

That the Office of the Children's Commissioner be funded to employ an Aboriginal person dedicated to investigating issues raised by and affecting Aboriginal children in particular. This position needs to be resourced in addition to roles currently undertaken by the office.

Urgency: Within 18 months

The Ombudsman

The Ombudsman also has an important role in this field, with a broad power to investigate any complaint concerning administrative action — which includes decisions and acts and failures to decide or act — of any Agency. This power extends to the Department of Health and Families, and units of administration within that Department, including administrative action by NTFC. Conversely, the functions of the Children's Commissioner are narrower and more specific, relating to 'protected children', together with monitoring the administration of the *Care and Protection of Children Act* and certain government decisions, and reporting to the Minister.

The Ombudsman is also generally and expressly recognised in Chapter 5 of the *Care and Protection of Children Act*, which deals with complaints to the Children’s Commissioner. Section 266 of the *Act* enables complaints to the Children’s Commissioner to be referred to another person for investigation and resolution and this can include the Ombudsman. Section 266(3) also generally requires the Children’s Commissioner to refer any complaint relating to an act or omission of a police officer, to the Ombudsman. This is consistent with the broad and detailed powers which the Ombudsman holds and exercises in respect of complaints against members of Northern Territory Police.

Clear distinctions and differences exist between the respective functions of the Ombudsman and the Children’s Commissioner, however, the functions of these offices are complementary in some senses.

The Coroner

One submission to the Inquiry suggests that the Child Deaths Review and Prevention Committee (CDRPC) should review deaths of children who have had contact with NTFC within a given period of time.¹¹⁰² Across jurisdictions, various authorities have been given this function which differs from CDRPC function which is the broad review of child deaths, as described below. The Coroner generally takes a more detailed, case-based analysis of specific issues surrounding a death that seeks to draw out practice lessons for the departments involved. Following a revision of the Northern Territory *Coroner’s Act* 1993, there is an obligation to report to the Coroner the death of ‘a child who is in the CEO’s care as defined in the *Care and Protection of Children Act*’. The suggestion that a death be reportable if the child has been referred to the statutory agency in a recent period of time has merit and should be explored further.

The number of times the Inquiry, and submissions to it, cite the Coroner’s findings, demonstrates that the Coroner has an important, respected role in reviewing deaths of children in care. The key issue for the review of such deaths in the Northern Territory is the long period of time that it takes for the inquests to be conducted – sometimes in excess of two years after the death of the child. Where there are practice lessons to be learned these need to be determined and acted on more quickly than is currently the case.

External oversight

This section addresses:

- The Child Deaths Review and Prevention Committee
- The NTFC Advisory Council
- Consulting with children and young people in care, including a community visitor program, and
- Review teams

The Child Deaths Review and Prevention Committee

The *Care and Protection of Children Act* provides for a Child Deaths Review and Prevention Committee (CDRPC) with functions to maintain a register of child deaths, conduct or sponsor research into child deaths, diseases or accidents involving children; raise public awareness; make recommendations and monitor the implementation of its recommendations. The Committee must report to the Minister at the end of each financial year and its report must be tabled by the Minister in the Legislative Assembly within six days of being received.

The death of any child is tragic. In developed countries we expect life's trajectory from birth, is through childhood, adolescence and adulthood into old age before death. While we are seeing this increasingly, it has never been the reality for all. The risk factors for poor child safety and wellbeing outcomes are also the risk factors for poor child health outcomes. While one can never predict with certainty the outcome for an individual exposed to given risks, for a population we know roughly that a certain number with those risk factors will suffer adversely. This is an issue of probability, not certainty.

The question this issue raises is whether the expectation is of risk elimination or risk reduction, given the risk of child death is never zero in even the best of circumstances. Children with risk factors stand a higher likelihood of dying than those without. The best we can do for an individual is to know the risk, and reduce it as much as possible. However, the nature of risk is that it is difficult to eliminate.

The reality is that child protection systems and review entities cannot ensure the wellbeing of every child in every home, nor can it prevent every child death. The role of the system is to ensure that everything that could be reasonably done is done. Having said that, it is true that:

It is not appropriate that the broader community has to wait for a coronial inquiry to access detailed information regarding the practice standards of such a critical area as child protection.¹¹⁰³

The NTFC Advisory Council

The Northern Territory Families and Children Advisory Council is comprised of community representatives to provide:

independent advice and perspectives to the Minister, Government and the Department on key issues impacting upon children and families. The NTFC Advisory Council is primarily concerned with matters relating to child protection, domestic and family violence, sexual assault and family support services. This Council is an amalgamation of two previous advisory councils that dealt with child protection (FACSAC) and domestic and family violence (DAFVAC).¹¹⁰⁴

The role of an external Advisory Council is strongly supported. It is important that this body not be involved in case-based operational issues, with a membership prepared to

1103 Submission: Danila Dilba.

1104 Submission: NTFCAC.

consider issues from a systems perspective. Consideration should be given to whether its name reflects its role or a change is required.

While currently NTFC is overwhelmed and is perhaps unable to appear open to others' opinions, its apparently defensive position must not persist. The statutory authority must value the advisory council as an opportunity to hear ideas, or to use as a sounding board. It appears the value of an external Advisory Council could be appreciated more by NTFC and the Minister for Child Protection. Its value would be enhanced further by the following:

- Some access to department data. The Inquiry is aware of data submitted annually to the Australian Institute of Health and Welfare (AIHW) routinely. It appears that such data can appear in reports, be submitted to the AIHW and be published in their reports, all without significant analysis. The NTFCAC should be provided with such data at an early opportunity so as to provide opinion and recommendations arising from it.
- The quality of advice of the Council will be improved by access to the perspectives of the Children's Commissioner as a non-voting, ex-officio member of the council
 - The Children's Commissioner knows the system and processes well and can inform the council on matters as appropriate
 - The Children's Commissioner can play a more proactive role than does the office currently, via input to the council, and hearing the considered opinions of councillors would be helpful for the execution of the Commissioner's role.

Recommendation 13.4

That the Northern Territory Government reviews the terms of reference of the Northern Territory Families and Children Advisory Council and its access to data so as to enhance its capacity to advise the Minister.

Urgency: Within 18 months

Consulting with children and young people in care

One of the process principles followed by this Inquiry was that the voices of children and young people must be taken into account. While many adults are prepared to advocate on behalf of children, the Inquiry also attempted to listen to the opinions of young people, and attended events for children in care to hear their contributions.

CREATE is a national organisation with state affiliates whose mandate is to work with and empower children and young people in OOHC. It relies on positive cooperation from statutory authorities such as NTFC to undertake this role. CREATE has been instrumental in mobilising young people, organising activities during holiday periods, and creating a positive sense of identity and purpose. One of its key areas of focus has been highlighting the needs of young people exiting from the care system and the ways that statutory agencies and others can help them through this difficult transition. Organisations such as CREATE provide a form of accountability providing feedback on performance and highlighting areas of problematic practice.

Recommendation 13.5

That Northern Territory Families and Children establishes mechanisms for regularly listening to the voices of children and young people regarding their experiences in the care system, for determining their needs, and for implementing improvements to the standard of care and support that is provided.

Urgency: Within 18 months

Community visitor program

As described in Chapter 9, advocacy programs or community visitor schemes have been developed for children in the care system in a number of jurisdictions. In the Northern Territory there is currently a Community Visitor in Mental Health.¹¹⁰⁵

There is merit in the notion of independent advocates or community visitors going out to connect with children in their homes or foster homes. The many submissions from foster carers report little, and often no, active monitoring of a foster placement by departmental officers and no direct engagement with the child to assess the appropriateness of the placement and the happiness and wellbeing of the child or young person in that placement. There are provisions within the *Act* for this to occur, however competing demands on NTFC are such that in-person visits happen episodically at best.

Community visitor programs in other states do not perform the monitoring and checking function for every child in out-of-home care (OOHC) as is required of OOHC caseworkers in the current NTFC Manual. They can perform more of a sampling role to better understand how the system is functioning, and to hear the voices of children in care settings. South Australia's Office of the Guardian for Children and Young People recently released a report describing community visitor programs.¹¹⁰⁶ In this report, such programs for children in OOHC are described as follows:

- Queensland, where independent visitors report to the office of the Children's Guardian and Commissioner, the visitors attend:

children who are in detention, a mental health facility (known as a visitable site) or are in the care of the Chief Executive under the *Child Protection Act* and are accommodated with an approved carer or someone other than the parent of the child (known as a visitable home)... They assess the general physical and emotional wellbeing of the child and determine if the child has enough information so that they can understand their rights. As far as visitable sites are concerned a Community Visitor can assess the appropriateness of the accommodation and its service delivery (for detention centres there is a focus on services delivered to assist the child for release), staff interaction with the children and the morale of those staff. For visitable homes the accommodation and care standards are observed and assessed.¹¹⁰⁷

1105 Submission: Office of the Children's Commissioner Northern Territory.

1106 Office of the Guardian for Children and Young People, 2010, *A community visitor program for children in state care: Report*, South Australian Government, Adelaide.

1107 Submission: Office of the Children's Commissioner Northern Territory.

- NSW, where the role is more overtly one of sampling to provide advice to the Minister for Disability regarding children, young people and adults with a disability residing in residential care or boarding houses. Visitors are coordinated and report through the Office of the Ombudsman
- Victoria, where the role pertains to adults and children with a disability or mental illness. Issues not able to be resolved are escalated to the Office of the Public Advocate
- Tasmania has recently introduced a pilot scheme of sampling visits by volunteers to 20 children per month, reporting to the Commissioner for Children
- The Australian Capital Territory Public Advocate is a paid professional who visits children in hospital psychiatric care, secure care and residential services.

The report also describes models from:

- the United Kingdom, where the responsibility falls under the jurisdiction of local authorities for children in care who have limited, poor quality or no contact with their birth family. 'Independent visitors are adult volunteers who aim to establish a consistent, positive adult-child relationship. Independent visitors undertake the role for one child or young person only'
- the USA, where a court appointed special advocate performs the task to ensure abused and neglected children receive high quality, timely and sensitive representation in court hearings regarding their needs and best interests. The report describes the advocates as volunteers.¹¹⁰⁸

Three aspects which stand out to the Inquiry about a community visitor role are:

- independence from the statutory authority
- the value to the system of examining a sample of cases
- the value to the system of expressly seeking the perspectives of children in OOHC.

The above are in addition to the need for monitoring by the statutory agency to ensure individual children in OOHC are indeed receiving an adequate service. The Northern Territory Coroner has previously recommended a child under the care of the CEO be visited by a person authorised by the CEO regularly and the mechanism of community visitors must be in addition to this.

In the Northern Territory there are several reasons why this is more difficult than in other states and territories. The remoteness of many children meaning they can be dispersed over a large area with few concentrated in any one remote location would add significant logistical difficulty and cost to any centralised agency tasked with this visiting role. However, the majority of Northern Territory children in OOHC are situated in urban locations.

Should such a role be performed in the Northern Territory it would need to be performed differently in different locations, using different models, individuals, agencies and NGOs on a fulltime, part-time and pro-rata basis. An Northern Territory community visiting

1108 Office of the Guardian for Children and Young People, *A community visitor program for children in state care: Report*.

model examining OOHC would provide reports to the Children’s Commissioner. Although the importance of a community visitor role is noted, the Inquiry has not been able to explore this issue in satisfactory detail to make a recommendation about a preferred model.

Recommendation 13.6

That a community visitor model be implemented to involve a sampling of children in Out of Home Care (OOHC) with a view to informing the Children’s Commissioner about OOHC issues from the perspective of the visitor, and also from the children being visited.

Urgency: Within 18 months

Review Teams

The Inquiry notes the *Act* (part 5.2) contains a provision for review teams as a measure to ensure the operational aspects of child protection services meet the objectives and are of a high standard. The review teams have not been implemented as yet and clear guidelines would be required before they are implemented. The Inquiry notes the spirit of these teams, but suggests the reforms proposed adequately meet their proposed objectives. Having said that, there is a place for a mechanism for the ongoing review of child protection policies and procedures.

Internal NTFC quality control and review measures

This section addresses:

- the care and protection quality subcommittee
- complaints and appeals processes
- advice and support services for families involved with NTFC.

Care and Protection Quality Sub-Committee

In April 2009 Northern Territory Families and Children held a quality summit following a series of adverse reports (including the High Risk Audit) which reflected on the quality of services offered by the Department. Out of this summit, the Care and Protection Quality Sub-Committee was formed with a number of working groups focusing on specific areas of practice.

Five working groups were established and cover the work areas of:

- Training and development
- Workload and workforce
- Recruitment and retention
- Records management; and
- Systems gaps

The broad scope of the work and focus of these working groups is outlined in some detail in the DHF submission. Some of the work from these working groups, for example, 'workload and workforce', has been cited in parts of this Inquiry report.

The Inquiry strongly supports the NTFC Care and Protection Quality Sub-Committee and the work of the different working groups.

Complaints process

There must be processes 'that actively address any process[es] that jeopardise the protection of children in care or in need of care'.¹¹⁰⁹ This includes an effective complaints process within the NTFC.

A complaints process is important to enable those who feel the system has made an error to seek redress in a manner that is fair, timely and accessible. We describe in the introduction to this chapter the result of not having such a system, being complaints to higher authorities which then demand responses which occupy their time as well as the time of others which would be better spent on other activities. Currently NTFC does not appear to have an adequate system for dealing with complaints.

In the legal forums conducted by the Inquiry there was a general acceptance that the interests of children and of their families would be better served by some form of internal or external review of the many decisions taken by the Department relating to a child in out of home care. That the Department can make significant decisions such as to remove a child from one foster placement and place with another carer, or to restore a child to his or her family, without any avenue for an independent or external review of the circumstances was of concern.

Departmental representatives at the Darwin legal forum indicated support for a tiered system of internal review of administrative decisions by which parents or other parties could apply for a review of a decision in the first instance by the Operations Manager for the relevant region. If the matter was not resolved at that level, then application could be made for the decision to be reviewed by a senior officer not previously involved with the matter, such as the Executive Director or Senior Practitioner.

The Inquiry is supportive of such a proposal as potentially efficient and workable for practical and timely review of significant decisions that might not have been in the child's best interests but which might not otherwise be brought to the notice of senior management.

Following the above forum, NTFC provided the Inquiry with an undated draft NTFC Complaint Policy and Procedures which gives rise to some concerns. Firstly, one of the key principles is that the 'complainant receives an approach and perspective to their concerns, which is independent of operational management'. One of the appealing features of the basic model outlined at the forum was the early involvement of operations management who may not have previously been aware of the casework decision made (or not made) and whose experience and knowledge might allow for an immediate resolution of the matter. Given the high staff turnover, staff shortages, lack of awareness of the legislation and related policy and procedures, and the inexperience of many child protection workers then the sooner operations management is involved, the sooner the best interests of the child can be determined and the matter resolved.

1109 Submission: Northern Territory Opposition.

It is also of concern that the timeframes contained the draft policy and procedures document provide that if all the stated time periods and stages of investigation are accessed, it will take up to 200 working days or 40 weeks for the matter to either be resolved or then referred to the Children's Commissioner or Ombudsman.

In establishing a complaints process there must be a means of logging the theme of the concerns raised with the statutory agency and reporting monthly de-identified data on complaint numbers by theme to the director of the agency. There will inevitably be lessons to learn from complaints, particularly if there are consistent themes arising from them.

Appeals process

Related to the need for a complaints process, is the need for an appeals process for individuals that believe that a particular decision has been the wrong one. Access to an appeals process around professional decisions should be the right of any clients (adults or children), relatives, and carers affected by decisions and the existence of such an appeals process should help to appreciably reduce the number of complaints that are made to external authorities with the associated administrative burden they necessarily entail. Unlike most other jurisdictions, the Northern Territory does not have an Administrative Appeals Tribunal to review decisions made by professional staff members so the development of an internal NTFC appeals process is an imperative.

The appeals process should not involve the same line management structure that was responsible for making the original decision and should operate under clearly articulated and publicly available principles and procedures.

Recommendation 13.7

That Northern Territory Families and Children develops an effective complaints management process for clients of the service (and others affected by decisions) that provides for the speedy resolution of complaints. The procedural guidelines for the process should be made available on the Northern Territory Families and Children website.

Urgency: Immediate to less than 6 months

Recommendation 13.8

That Northern Territory Families and Children develops an appeals process (either as part of the internal complaints process or separately) that provides for an appeal process for professional decisions independent of the normal line management structures. The procedural guidelines for the appeal process should be made publicly available on the Northern Territory Families and Children website.

Urgency: Immediate to less than 6 months

Advice and support services for families involved with NTFC

The lack of support services for families coming into contact with NTFC is not directly a question of internal review, but it does lead to the generation of numerous complaints and raises issues of justice and procedural fairness.

Across the jurisdiction, parents who are engaged with the legal processes relating to the care and protection of their children face many challenges. They may lack a basic understanding of the nature of the Court processes and their role in these. Language and access to interpreters may further limit their ability to understand the processes and to convey their wishes to the NTFC officers or to the Court. In these circumstances genuine and informed consent is often not obtained or may be compromised by the parents cultural willingness to agree with someone from the 'welfare' or because they do not have an appreciation that they have a right not to agree.

The Family Matters jurisdiction of the Local Court only sits in limited venues and these may be far removed from the community or settlement in which the family resides and thus significant travel may be required to participate in Court hearings.

Added to all of the above are the experience and memories of past interventions and the removal of children from their families. In such circumstances, the task of establishing and maintaining meaningful engagement with parents can be a difficult one.

The submission from Danila Dilba notes the following:

The family members interviewed for this case story spoke of the lack of any support or advice on how to deal with the Department.' and advocate for an agency which provides advice to families in that 'Such a service would lessen the burden on existing mechanisms such as Ministerial offices, the Children's Commissioner and the Ombudsman that are not established for that purpose but end up fielding complaints from families.'¹¹¹⁰

A theme that arose in consultations undertaken by an Aboriginal organisation on behalf of the Inquiry with residents of town camps and the remote communities visited by the Inquiry is that, despite having contact with NTFC, there is limited understanding of and response to aspects of the child protection system. This highlights the need for a complaints process but also the need for an advice and support mechanism geared to the needs of Aboriginal people. Elsewhere the Inquiry has highlighted the case for Aboriginal Child Care Agencies, which would be able to assist with such a process.

Some jurisdictions in Australia have provided advice and support to families involved with the child protection system through mechanisms such as Family Inclusion Networks. The Inquiry strongly supports the need for the development of an advice and support service for people who come into contact with NTFC. Being served legal papers relating to the removal of children must be an overwhelming experience particularly, for example, for a young, single Aboriginal mother with a poor grasp of English.

1110 Submission: Danila Dilba.

Recommendation 13.9

That the Northern Territory Government funds the development of an advice and support program for vulnerable families who come into contact with the statutory services of Northern Territory Families and Children in both the Top End and Central Australia. This might be developed as part of the service offered by an Aboriginal Child Care Agency, family service or legal agency.

Urgency: Within 18 months

Models of accountability

A number of submissions suggest an accountability mechanism which includes measurement of performance.¹¹¹¹ A range of accountability and monitoring models are available in the field of child and family services which cover a spectrum of possible activities. Some are in-house, others completely outsourced. The Inquiry is of the view that a mix of processes along this spectrum is necessary. Internal mechanisms for responding to problems that occur closest to their site of activity allow for the most rapid solution-finding and encourage feedback for change. On the other hand, oversight mechanisms with a view from 'on high' can take a broad vision of the system (as well as a narrow one where necessary) and thereby propose broader solutions. The community is best served knowing there is a culture of reflection at all levels of the system, with the confidence that comes with having a trusted body overseeing it. Oversight entities risk contributing to a climate of blame or fear among staff, however, they can promote a climate of reflection that has a primary focus on children and their safety and wellbeing.

Performance Measures

The National Partnership for Protecting Australia's Children is working to collect and publish child protection indicators from each jurisdiction annually to assist in national monitoring and evaluation. Much of the data is collected via the Australian Institute of Health and Welfare (AIHW). Other data published by the AIHW relating to child wellbeing is highly relevant to work in the field of child safety and wellbeing and may be more indicative of the context of child safety and wellbeing work in the Northern Territory. Examples of this may include mortality at different ages and from different causes.¹¹¹²

At the state and territory level, measurement of performance as a component of evaluation is an essential element of its accountability apparatus. Implementing comprehensive structures and processes to deliver a transparent and accountable system that encourages reflective practice and professional judgment and can measure performance will restore confidence in the government's ability to provide safety and wellbeing to its most vulnerable citizens. This task is urgent.

The framework proposed for evaluation of performance is a well established one and has been adapted over the years for a variety of programmes to enable routine collection and

1111 Submission: NPY Women's Council, Submission: Danila Dilba.

1112 See Chapter 2.

analyses at four levels - inputs, processes, outcomes and impacts.¹¹¹³ Indicators within each level are used to measure different aspects of the system, and a combination of these used at work unit, program and system level. The contemporary challenge in using this framework is to develop clear parameters at each level and to integrate these within a total systems evaluation.

The following indicators are indicative only and represent a few of the measures the Inquiry considers important for the statutory authority.

Input indicators

Input indicators measure the resources needed to conduct program activities. They include an analysis of financial, human and material resources and the distribution of such resources.

Examples of input indicators may include: staff numbers and distribution, caseloads skill levels; costs allocated to the different streams of the statutory authority; grants for various outsourced programs; and time allocated within a work unit to different types of work.

Process indicators

Process indicators measure whether processes are occurring as expected or planned. For example are processes for managing out of home care operating as intended? While it is acknowledged that processes do not always result in desired outcomes, there are some processes integral to a well functioning system. Ideally, workers should contribute to the development of process indicators and at intervals be involved in the recalibration of practice process and outcomes.

Examples of processes which may be seen as important include: percent of new employees completing orientation sessions; percent of employee who have professional development plans; percent of comprehensively completed care plans as reflected by the completed domains such as education, cultural, social, medical, disability service; and percent of foster carers receiving foster care charters.

Outcomes

Knowing that appropriate processes have been followed is necessary but not sufficient in analysing complex systems. Outcomes measures quantify such issues as numbers of children helped or not helped by given interventions, and efficiencies, such as times taken for various processes. Outcome measures examine what the system does with or for children and families referred to its service, and the quality of those interventions.

Examples may include: number of children with a substantiated child protection record who are renotified and re-substantiated within a 12 month period; number of 'Incidents in care'; measures of client satisfaction; degree of involvement of children and young people in policy planning; characteristics of particular issues such as cases of malnutrition or other health problems resulting in the involvement of the statutory agency.

1113 H Ross & P Mico 1980, *Theory and Practice in Health Education*, Mayfield Publishing, San Francisco, Ca.

Impact

A thorough evaluation of a system's inputs, processes and outcomes is important but not sufficient. Evidence of impact is imperative in weighing up the value of all of the above yet traditional evaluation gives only cursory attention to impact. There is a key question that underpins impact evaluation: is the outcome better than if there had been no intervention? Whilst scholars and analysts have acknowledged the significance of measuring impact of interventions, this is one of the harder of the levels of evaluation. New methodologies are emerging.¹¹¹⁴ The Inquiry is firmly of the view that the Northern Territory system with children and families as its focus must know about its impact on children, families, communities and society in general.

Recommendation 13.10

That a framework involving performance measures in the domains of input, process, outcome and impact is adopted and appropriately resourced.

Urgency: Within 18 months

¹¹¹⁴ The Most Significant Change Technique is one that has been developed as a most useful qualitative tool to assess impact. See <http://www.mande.co.uk/docs/MSCGuide.pdf>.