TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into the handling of child abuse by religious and other organisations

Melbourne — 3 June 2013

Members

Mrs A. Coote	Mr F. McGuire
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Witnesses

Mr A. Rogers, deputy secretary, service design and implementation group, and

Ms R. Miller, acting director, office of professional practice, Department of Human Services.

The CHAIR — In accordance with the guidelines for hearings I remind members of the public gallery that they cannot participate in any way in the committee's proceedings. Only officers of the Family and Community Development Committee secretariat are to approach committee members. Members of the media are also requested to observe the media guidelines. Could you all please ensure that your mobile phones are either turned off or to silent.

I welcome everyone here this morning. The committee has heard from and sought additional information from a number of organisations and government departments during the course of its inquiry. We heard from the Secretary of the Department of Human Services, Ms Gill Callister, on 22 October 2012. To assist us with our report an area has been identified where clarification is required. Rather than having further written correspondence seeking clarification from the department, a hearing was deemed most effective. I thank you both for being before us this morning. If this committee identifies further gaps in information or receives new information that warrants it, we will not rule out holding further sessions like this.

On behalf of the committee I welcome Ms Robyn Miller, acting director, office of professional practice, and Mr Arthur Rogers, deputy secretary, service design and implementation group, from the Department of Human Services. Welcome to you both.

I remind witnesses that all evidence taken by this committee is taken under the provisions of the Parliamentary Committees Act 2003, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the precincts of the hearing are not protected by parliamentary privilege. Witnesses may be asked to return at a later date to give further evidence if required. All evidence given today is being recorded. Witnesses will be provided with a proof version of the transcript. Please note that these proceedings are not being broadcast on the Parliament website.

The hearing will commence with questions from the committee about information which we are seeking clarification on from the department. Following questions you will have an opportunity to make a brief 5-minute statement to the committee. On behalf of the committee thank you again for being with us.

I would first like to ask you questions relating to reporting. In a response that you gave to us you said that the department considers all staff-to-client assault allegations as category 1 incidents. I understand those are the most serious of incidents. Could you just explain to the committee a little bit about the categorisation and the category 1 component?

Mr ROGERS — Certainly. I will kick off. Thank you for the opportunity to be here. Robyn will add comments as required. In terms of category 1 incidents I probably need to make a distinction between some of the reports you received. You received some reports which went to our board relating to all incidents. They would include both disability incidents, which is a range of adult and children's services, and child protection, children, youth and family incidents. In relation to the children, youth and families area, or child protection and family services, all allegations of staff-to-client assault are category 1 incidents. There is no discretion for staff in DHS or in CSOs; they are all category 1s. Allegations of assault between clients will generally be category 1 incidents, but there is some discretion around that. Say, for instance, if two children, one eight and one nine, hit each other in a placement, then that would probably not be regarded as a category 1, but generally where there is a serious concern it would be categorised as a category 1 incident.

The CHAIR — In those category 1 instances, what happens in relation to the reporting of any allegations? Do they go straight to the police?

Mr ROGERS — Anything regarding a staff-to-client assault in child protection and family services, there is an MOU with police and they are required to be reported to police.

The CHAIR — Who would make the decision of reporting to the police? Would it come into the department or would it be within the organisation? How is the process undertaken?

Mr ROGERS — In relation to an incident report where that occurs there are a number of people who have sighted it. Generally the requirement would be for the CSO to report it to police. But generally the incident report is reported to the most senior person on duty. Generally a manager and the CSO would view it and so would the CEO of that agency. It also would be viewed by the senior child protection manager in the department and eventually by the executive director of that division — or region, as it was.

So a decision is usually made by the CSO agency, or it can be made by any of those people who see it. Category 1s are viewed by a number of people of ascending seniority, and decisions can be made by any of those to refer it to police, but generally the decision to report it to police is made by an executive officer or the person managing that service. But as I say, a category 1 allegation of staff-to-client, there is no discretion; it must be reported to police in child protection and family services.

The CHAIR — Thank you, Mr Rogers. Those people reporting to the police obviously have very good training in this area. They identify what is required and they would have the appropriate capacity to do so; is that your understanding?

Mr ROGERS — Child protection workers have mandatory training. It is a bit more variable, I think, in community service organisations, but Robyn might want to just comment on the training and qualifications of workers in that sector and in the field.

Ms MILLER — Generally in child protection there is a social work qualification, a psychology qualification or welfare studies, so we have tightened up considerably in that area over the past two years.

The CHAIR — What do you mean by 'tightened up' in that area?

Ms MILLER — Sometimes people will have completed a four-year psychology degree but they may not have had any experience in child development or in case management. We have now said if we are taking in psychology graduates who have not done their postgrad training — they have done their undergraduate psychology degree — that they need to have a component that includes child development and case management, because those skills are basic to the work we do.

The CHAIR — Thank you for that clarification.

Ms HALFPENNY — You say that all category 1 allegations are reported to the police. Does the organisation report it to the police or does DHS report to the police?

Mr ROGERS — It could be either, but generally if it is a community service organisation they would report it to the police. That is in the children's area and child protection and family services. There is some more discretion in disability services, and some of the reports you have seen have combined both those areas. So there are differences between both in relation to the instructions.

Ms HALFPENNY — I understand that, but we are asking questions about monitoring and overseeing organisations and how the Department of Human Services does that. I wanted to raise a June 2012 incident in the July 2012 report, 'Client incident management and reporting'. In that report there is a reference to an allegation of rape within DHS — within disability services.

Mr ROGERS — Yes.

Ms HALFPENNY — Was that reported to the police?

Mr ROGERS — The actual report that I think the committee received, which was a copy of the report that the board received, said it had not been reported to police.

Ms HALFPENNY — That is right, yes.

Mr ROGERS — We followed it up with an incident report again, and that was incorrectly shown on that report that you have. In fact the incident report does show that it was followed up with the police. The police were notified. It refers to a particular policeman's name. The follow-up to that actually talks about a discussion with the Knox sexual offences and child abuse unit around that. This refers to an adult, a 57-year-old person, but the incident report does show it was actually reported to police with a follow-up to that unit to ask a bit about how it actually should be reported. So whilst it does not show that, it does actually show on the incident report that police were notified.

The CHAIR — Just for clarification, that was misinformation that the committee received in relation to that particular incident?

Mr ROGERS — In the time we have had available, I am not sure where they sourced that in terms of that analysis that you received. It may not have been on one of the documents they have seen, but we have had time now to actually follow that up. Certainly the client incident report clearly shows a tick that it was reported to police with a policeman's name on it, and the follow-up does show a discussion with the sexual abuse unit and the policeman.

Ms HALFPENNY — And that would have been done within the 24-hour requirement?

Mr ROGERS — It shows that it was reported to the police on 20 June, and the incident report was dated 20 June. Yes, I think it was actually on the 20th.

The CHAIR — On the same day? On 20 June the incident occurred and it was reported to the police on 20 June, so the same day.

Mr ROGERS — I am just checking on my incident report. The time and date of the incident was 20 June at 11.00 a.m., and the incident report shows that it was reported to the police on 20 June. It does not say what time, but it says the date.

The CHAIR — But within the 24-hour time frame?

Mr ROGERS — Certainly on that same day.

The CHAIR — Yes, thank you.

Ms HALFPENNY — Okay, thanks. The questions I will go through now are related to the various incident reports and some of the things that seem to be coming out of that. For example, the information that was provided to the committee indicates that of organisations that care for children in out-of-home care settings 44.41 per cent of all allegations of child abuse between 2008 and 2012 were from religious organisations; that is in comparison to 37.93 per cent from the non-church-based organisations. Then you have 16.89 per cent of allegations coming from institutions under the Department of Human Services. Is that correct? Do you acknowledge that?

Mr ROGERS — Could you perhaps provide the source of where that came from?

Ms HALFPENNY — This is the document that was provided by Department of Human Services. It does not have page numbers.

The CHAIR — Which report are you referring to, Ms Halfpenny?

Ms HALFPENNY — The department's report.

The CHAIR — No, which one?

Ms HALFPENNY — The front; the summary.

Mr ROGERS — It is the March 2013 document?

Ms HALFPENNY — No, this is the Department of Human Services letter to Janine Bush dated 10 December.

Mrs COOTE — It was received on 10 December.

Ms HALFPENNY — Yes, sorry. It was received on 10 December, but it does not have a date.

The CHAIR — I think that is in relation to the questions we were seeking clarification on from the department?

Ms HALFPENNY — Yes.

The CHAIR — So, in that, could you just highlight the question that was asked and what you are referring to in relation to your question? That might assist Mr Rogers and Ms Miller.

Ms HALFPENNY — Okay. The Department of Human Services has written to the committee and provided a table called 'Number of identified allegations of child abuse by agency/facility type over the period 1 July 2008 to 30 June 2012'.

The CHAIR — We will just show you what Ms Halfpenny is referring to. I think that will be easier.

Mr ROGERS — I have that now.

Ms HALFPENNY — I just wanted to confirm that according to this information provided by the Department of Human Services of the total number of child abuse allegations between 1 July 2008 and 30 June 2012, 44.41 per cent were from church-based organisations, 37.93 per cent arose from non-church-based organisations and 16.69 per cent arose from Department of Human Services-run organisations.

Mr ROGERS — Certainly that is the information that was provided to this group. I have not seen anything that would contradict that. The thing that I guess it does not tell me relates to the percentage of the number of clients or the site — the share group.

Ms HALFPENNY — That was the second question I was going to ask: the ratio in terms of the size of an organisation versus the number of complaints.

Mr ROGERS — I think it would be an important thing to compare that to the size of the organisation and the types of services. I do not have that information, but I can certainly get that provided for you if you wish it. I can follow up and I can find out for you.

Ms HALFPENNY — Okay. Are you familiar with any of these reports, because a lot of the questions I have got are about compliance issues? Can you answer them, or are you not the right person?

Mr ROGERS — If you ask the questions, I will endeavour to answer them.

The CHAIR — Yes. Ms Halfpenny, can you go to the next question and then give Mr Rogers and Ms Miller an opportunity to answer them.

Ms HALFPENNY — In the three months of the reports that were provided, it seems that about 50 per cent of allegations of child assault and abuse are attributed to six organisations only. Which organisations were they?

Mr ROGERS — The six organisations that that refers to range in funding quite a bit, but they were Anglicare Victoria, Berry Street child and family services, MacKillop Family Services, Wimmera UnitingCare and the Salvation Army.

Ms HALFPENNY — How many organisations are there in total that run out-of-home care — non-government organisations?

Mr ROGERS — In terms of the response we gave you, I think we reviewed 78 agencies. I do not know if that is the exact number; Robyn might know the exact number.

Ms MILLER — I believe there are 22 agencies — I have got it somewhere — that provide residential care and there are more that provide foster care.

The CHAIR — So those remaining of the 78 are foster care? Is that right? Is that what you are saying — 22 out-of-home care and the remainder are foster care?

Ms MILLER — Yes. I would need to check that, if I may.

Mr ROGERS — If we have not got it here, we will actually check that and provide that to you.

Ms MILLER — Yes.

Mr ROGERS — Those six agencies vary in funding from $4 million up to about $46 million, so they are quite a sizeable chunk of that sector.

Ms HALFPENNY — Okay. So of the reports again in June 2012 there were 16 allegations of child abuse and in 3 cases the organisations concerned did not undertake the mandatory quality-of-care review. That is our understanding. Would that be right, if you look at the reports?

Mr ROGERS — Could you perhaps again just refer me to the pages of the report?

Ms HALFPENNY — Yes, it is the report for June, which is titled 'July 2012'. Now I cannot find the page.

The CHAIR — Would you like to come back to that question and go onto another one?

Ms HALFPENNY — There are also, in the October report, 35 allegations of child abuse within the out-of-home care organisations that were not reported within the 24-hour mandatory requirement. That is my understanding from these reports. I guess what this seems to highlight is there is — —

The CHAIR — Could you reference that report, because we all have that report? Could you reference where you are referring to?

Ms HALFPENNY — Yes. I am now going to the October 2012 report.

The CHAIR — The pages are numbered.

Ms HALFPENNY — I just put my notes down. I assumed that they would have them.

The CHAIR — They have the report, but it is very hard for them. You need to reference it.

Mr ROGERS — I am aware of the history.

Ms HALFPENNY — I will just go through the issues. Page 4.

The CHAIR — Could you repeat the question, Ms Halfpenny?

Ms HALFPENNY — What I am trying to go to are the compliance issues. For example, of the reports in June 2012 there are 16 allegations of child abuse where in 3 cases there was not the mandatory reporting. Then in the October report we have 35 allegations of child abuse within out-of-home care where 17 agencies have not reported those allegations within the 24-hour mandatory period. What I wanted to ask you was: do the service agreements that DHS has with these organisations require these obligations to be met?

Mr ROGERS — Thank you. The 35 late reports you are referring to are actually in the November report, which is about October. I found it; it is on page 4 of the November report.

Ms HALFPENNY — Sorry. Yes.

Mr ROGERS — That indicates that there were 35 allegations where agencies did not comply with the time lines. The time lines are within 24 working hours. It also shows that of those I think a number were followed up at the time of the incident report. We would have expected that the staff who manage the service agreements would follow it up with the agencies when they are late. If they are late, it does not mean there is nothing happening. In fact I think it mentions three from MacKillop Family Services, and we had a look at those and I can go through them if you wish. But it did show that some action was taken and the department was aware of those before the incident report was formally received.

But we actually do expect that the agencies will put them in on time. We expect that they will follow them up. If it is a day or two late, it is a breach and it is not satisfactory. If there has been some discussion and some action happening, it is probably not a major breach, but it is still not satisfactory.

Ms HALFPENNY — But I think the idea is that if there are certain obligations within a service agreement, they ought be followed. What happens if an agency does not comply with the service agreement and the requirements in it?

Mr ROGERS — The service agreement is managed through the divisions, and it used to be the regions when this report was written, so just in terms of the terminology they were regions then and they are divisions now. Each service agreement will have a person who manages that service agreement. They would be

managing the service agreement on a daily basis, but there is also an annual review. If there are instances where the agency does not comply with the requirements, then we would expect that that agency would be contacted to remind them that they do not comply with the requirements.

Ms HALFPENNY — And if they repeatedly do not comply, as in the case for example with MacKillop Family Services?

Mr ROGERS — This one was three instances in four months. I do not have information to know the response on that, and certainly in the time we had we could not check that up. In that case we would be talking to the agency and reminding them of their obligations. I do not have the information to know whether there has been a recurrence of that situation.

Ms HALFPENNY — Are there any penalties or any consequences if they do not comply?

Mr ROGERS — The department has a few available means at its disposal. At the most extreme, it can actually cease the service agreement.

Ms HALFPENNY — Has that happened in the past?

Mr ROGERS — It has happened. We do not have one record that shows all of that, but certainly in this space we have had a look, and over the last 10 years or so there have been about five agencies where either their funding has ceased totally or parts of their funding has ceased for certain programs. We do have that available to us.

Ms HALFPENNY — But you do not have the details of why?

Mr ROGERS — We do not have a single record that says, 'This agency was defunded for this reason'. We have actually spoken to staff, and we do have some details. We do not actually have one database that shows that. But we do know from speaking to staff in some of those instances why they were ceased, and Robyn knows a couple.

Ms HALFPENNY — So does that mean that they could enter into another agreement later even though the agreement was previously terminated for what may have been allegations of abuse that were not monitored or complied with?

Mr ROGERS — No, it does not mean that. The division and the region would be aware of that; they are certainly aware of it. I am just saying that we do not hold one single database to get that information. But we checked with divisions and with staff in the former children, youth and families division, and we are aware of at least five in the last decade that have been either partly or wholly defunded and the services reallocated to someone else, and they have not had the services reinstated with them since that time.

Ms HALFPENNY — Okay. Just a couple of final questions. Rather than just individual complaints or non-compliance issues, do you do a systemic or overall investigation of the non-government organisations providing care to children in respect of this area of child abuse to see what is going on, whether it is what type of organisations, repeat offenders and that sort of thing?

Mr ROGERS — We investigate each individual allegation, and there is a formal process to do that, set through divisions, which includes quite a formal process which I can go through. Where there are repeated incidents or trends emerging, then the matter will be referred to Robyn's area for more systemic review, and Robyn can talk a little bit about the work that the office of professional practice does around that.

The CHAIR — Would you like to comment, Ms Miller?

Ms MILLER — Yes. I think there are two issues here. One is that I am wondering whether you are meaning the registration of agencies and the reviews of that funding agreement and their performance, and that occurs regularly every three years.

Ms HALFPENNY — Not specifically. If you look at the reports you provided, there seem to be more allegations for example in particular organisations with a religious affiliation. There seem to be particular organisations that may not comply more regularly than others. These are things we have been asking all

non-government organisations internally as to not just whether they look at individual complaints but also whether they take a systemic approach to look at the lot to try to explain why these things are happening in order to put policies in place to better protect children in the future.

Ms MILLER — Yes. We would certainly have that systemic analysis. Particularly if you see a cluster of reports coming from one particular agency or one particular unit, that would be a trigger for a more systemic analysis of what is really going on. I note in the report that you received that in 6 of 17 incident reports or alerts it was noted that a review or similar follow-up assessment was to be conducted in relation to the reporting delays, for example. So that absolutely happens, and yes, I have been involved in some of those.

Ms HALFPENNY — Just a final question: in terms of one child abusing another child — because we have heard during this inquiry about institutions where in the past there has actually been an encouragement of that sort of thing and also that it has happened — how do you report that? It is not in any of these reports. Do you provide a separate report to the boards on that sort of behaviour, or how do you sort of monitor that?

Ms MILLER — That would be an incident report as well, a category 1 or category 2 incident report, and we take that very seriously.

Ms HALFPENNY — But it is not in the reports that we have been given. We have only got the client allegations against staff. Is there separate information about client against client?

Mr ROGERS — So do we have a record of incident reports of client-and-client assault? If it is not in what you have, we will have that. We could follow that up if you want us to get something on that.

Ms HALFPENNY — Okay, because it still sort of paints a picture of what is going on in these organisations.

Mr ROGERS — Yes, sure.

Ms MILLER — Absolutely.

Mr ROGERS — I wonder if I could just clarify the overview of the department, because we have talked a little bit about it in different places. As Robyn mentioned, there is a three-year independent review of agencies that they meet standards. If there are concerns, it is done by an external body. If there are continued breaches of standards, then we would look at ceasing their funding or their registration. If there are standards that we find they do not meet, we can do a number of things. We can actually ask them to do an action plan and monitor that they are improving their areas; we can put conditions on their registration; we can actually remove their funding; we can revoke their registration; we can appoint an administrator under both the Disability Act and the children's act, where we replace the board; and we can defund the agency. So the fact that we have taken the major actions against five that we know of does not mean that other actions have not been taken on a continual basis against those agencies. As I mentioned before, the office of professional practice is also asked to look at these things on a more systemic basis.

Ms HALFPENNY — Just going back to the client-on-client allegations, are there cases where children are taken out of the family setting and put into care, because of problems with funding or numbers of places, and they could actually be put in a situation of risk? I have heard of cases where, for example, a young girl may be put into residential care with, say, six adolescent boys because there has not been room available somewhere else. Are you aware of those sorts of situations occurring, and what do you do in those circumstances?

Mr ROGERS — When we are looking at a placement we do obviously bear in mind the safety of the person and the compatibility. I would concede that there may have been occasions when someone has been in an incorrect placement. You would review that and try to make sure that you can move them when you have a chance to. Robyn might want to comment on that some more.

Ms MILLER — Every effort is made to match correctly — so the circumstances of the young person, their history, the particular group in the unit. Generally they are four-bed, so there would not be six. There are none that I know of except for one, which is Hurstbridge Farm, which is eight-bed, and that is a special therapeutic placement. Normally residential units are four-bed or two-bed.

Ms HALFPENNY — But could there be a lack of places; do you know? Has that occurred, that because of the lack of places perhaps people are put in the wrong or an inappropriate place?

Ms MILLER — There is every effort made. At times we will set up contingency placements because there actually is not a bed available that we would think is suitable. Sometimes where we are aware that there is a match of young people that could be difficult or increase risk, there will be extra staff that will be put on. So every effort is made to ensure the safety of those young people.

Ms HALFPENNY — Is that within the non-government organisations as well, or are you talking about within the Department of Human Services-run programs?

Ms MILLER — In Victoria, all — bar eight beds of the out-of-home care is run by non-government agencies.

Ms HALFPENNY — Okay; sorry.

Ms MILLER — Yes. We work very closely with them though, and the placement coordination unit that actually takes the referral from child protection is within the Department of Human Services and they then liaise with all the agencies in that area to see who has a bed, who has a space, where is the best place. We try wherever possible to have a home-based placement.

Ms HALFPENNY — Can I just understand that then: in this scenario you look for the most appropriate place to put the person?

Ms MILLER — Yes.

Ms HALFPENNY — If that is not possible and it is an inappropriate placement, then additional measures are put in place to protect the child? Is that what you are saying?

Ms MILLER — Yes, or we will set up what we call a contingency placement. So it is one that is not formally funded, but because the child's best interests are paramount we would say 'This child needs a special arrangement' because of complex situations or where we have become aware that the mix in that particular house is not good. So we are monitoring that very closely and speaking and running forums and training and working very intensively with agencies to make sure that we mitigate that risk.

Ms HALFPENNY — And they report that to you? Those organisations obviously must report those issues to DHS? When you say 'We work' and 'We do things', that is because other people are telling you about them?

Ms MILLER — We work very closely, so child protection would have case management and the agency would be providing the care, so there is a care team around that young person. There is very close communication — and so there should be — around any issues that are emerging within the placement.

Ms HALFPENNY — Good. Thank you.

Mr ROGERS — Just in terms of contingency I might just add that at any time we have got a fixed number of recurrently funded beds in out-of-home care for the sector. As Robyn has mentioned, it is not at all uncommon for us to set up contingency places for individuals. At any given time we have a large number of those places where people are generally placed in one-to-one situations in the most appropriate way. We are not just restricted to this number of recurrently funded beds; as a matter of course we do fund contingencies, and there is oversight of those through the placement in the department but also the child protection worker will actually have oversight as the case manager.

Ms HALFPENNY — Thank you.

Mr O'BRIEN — Thank you for coming. Just as a follow-up, if there are any of those systemic-type investigations that could provide a good precedent in terms of format or in the setting out of a report or the manner in which it is conducted, we would obviously appreciate it if you could provide those to us, if that is possible. It may be that there are confidentiality issues and difficulties, and we will do our best without it.

Mr ROGERS — We will probably need to take that on notice and see what we can provide, but there will be records of actions that we have taken against agencies.

The CHAIR — Thank you for doing so.

Mr O'BRIEN — I just had a query in relation to mandatory reporting, particularly in relation to reporting to DHS as opposed to or in addition to reporting to police. Are your procedures clear about where individuals need to go in relation to reporting?

Mr ROGERS — For agencies reporting to the department there is a clear process where they clearly know how they do it and when they have to do it.

Mr O'BRIEN — And when they have to go to police with the category 1 et cetera?

Mr ROGERS — Yes. On the incident report — sorry, if I could just say this — it actually has a category where they have to show the follow-up action, which is that the client is safe and so on and the police have been notified and other support provided. The format of the incident report is quite clear about what has to happen. There is not a lot of discretion for people in that; they have to follow that through. We can leave you a copy of the incident report if you would like that.

Mr O'BRIEN — One example might be useful for our records, thank you. On page 5 of the November 2012 report, in terms of follow-up once a report is made, or an investigation of a report — and you were on this page before, Mr Rogers, I believe — under 'Sexual assault — rape' it states:

> There are questions as to the veracity of the two incidents of rape reported in October 2012. However, all appropriate follow-up actions have still been taken.

Are you able to advise us who determines, in relation to veracity, if an allegation is not substantiated? Is that the department, the police or the agency?

Mr ROGERS — There are two processes I guess. If the agency or a person reports to the police, the police will make a decision on their follow-up; that is a matter for them. In terms of the department's processes, we have a screening process when this report comes to the department. There is a reasonable quality-of-care screening process which involves child protection, the CSO and the quality of care coordinator, who is a departmental person. They will screen the process to determine what follow-up action is required. They might determine no further action, that supervision and support is required for the staff member or a formal care review or quality-of-care investigation is required. That is determined by that panel; they do that. That is in relation to all the incident reports that come through the department. It is led by the quality of care coordinator — which used to be a regional appointment but is now a divisional appointment. That person has similar qualifications to a child protection worker.

The CHAIR — Is that a similar process for an internal investigation, or is it a little different?

Mr ROGERS — It is a similar process in the children's and family services space. There is a standard process that is gone through. It can also then be referred to an authorised investigator, who would look at whether the carer should be disqualified. Depending on the severity they would make some decisions around those things. But it is not made by a single person; it is made by that group, and that is the process that applies to all quality-of-care allegations.

The CHAIR — Thank you.

Mr O'BRIEN — I know both of those allegations mention the police, so that is fine.

Mr ROGERS — I just might add, if I could, that in relation to when those things happen, we are also guided by the police. We actually do talk to the police. If they require us not to commence something, we will not commence it until they are ready for us to do so. They are sometimes in parallel and sometimes they are not in parallel.

Mr O'BRIEN — Just to follow up on your experience, do you support — this might sound obvious — the involvement of the police at the earliest stage, even for that guidance?

Mr ROGERS — We would notify the police and we would talk to them around our process to make sure that we do not obstruct any investigation that they are making. We would do that as a matter of course.

Mr O'BRIEN — So it might not look like there is a police investigation but they are very much aware of what is happening?

Ms MILLER — Absolutely. What we do is notify the police. They might say, 'Look, we don't think there is enough for us to become involved now, but let us know and come back to us'. The protocol is very clear — that we must go to the police. If they do start an investigation, then our investigation respects theirs as a priority, so the police will lead interviews and we will make sure not to contaminate any evidence. We have very clear protocols around who has precedence.

Initially an investigation planning group is set up — an IPG, as it is known. That planning group thinks through these issues. That happens very quickly, and then decisions are made as to how the quality of care investigation will proceed. If the police are interviewing the alleged perpetrator, then we will make sure that we do not do that. But we will certainly act around the needs of the child at that time and also support the family, the carers, ethically, as is our duty of care.

The CHAIR — In the reports you provided to us, which we requested, roughly 20 per cent of those incidents were not reported to the police. That would be in the context of what you have just described; is that correct?

Ms MILLER — They would be reported. Whether the police investigate is a police decision, yes.

The CHAIR — So they would do that? Does it go back to that management decision that you described earlier about whether it needs to be followed through? The management would actually determine whether it needs to go further.

Mr ROGERS — Yes. We have not had time yet to finally analyse the 20 per cent, but that includes both disability adult cases as well as children's and child protection cases. In the disability space there is a different protocol. There is some discretion around what is reported to police, particularly where the person with a disability acts in a way that they may not know the consequence of their action and it is not regarded as a serious matter. And there is a small amount of discretion in the children's space where, as I mentioned before, two young people might push and shove each other. Where there is no apparent criminal activity in the disability space it is not reported, so that 20 per cent may well refer to that. We have not had time to complete that analysis.

The CHAIR — Thank you.

Mr McGUIRE — Thank you very much for being here. For the record, can you explain why the secretary is not here today?

Mr ROGERS — Certainly. The secretary is on annual leave and overseas.

Mr McGUIRE — The testimony we now have is that the secretary testified before this inquiry that compliance was being upheld, in answer to that line of questioning. Then you have said in the follow-up material that the department has provided a statement regarding an alleged rape and the non-compliance of that reporting. It was provided to us that that was not complied with. Now today you are testifying that in fact that report was wrong. Is that the fact of the matter?

Mr ROGERS — The report that you were given a copy of referred to an alleged rape, and I am happy to go to the detail. It said on that report that the police were not notified. We have looked at the incident report, and it clearly shows that the police were notified. It contains the name of the policeman who was contacted. The follow-up document to the incident report shows that there was a further discussion with police around the nature of the alleged offence. The police had indicated that they were not going to be following that matter up. The actual incident was regarding a 57-year-old lady, and it was regarding an inappropriate action by a staff member, which I am happy to go into. That person was stood down, an investigation occurred and that person resigned from the service, but the police were notified and did not follow it up. The report that you received was incorrect.

Mr McGUIRE — The police were notified but — —

Mr ROGERS — But did not investigate the matter.

The CHAIR — The victim was 57 years old, so it really does not fit within our terms of reference, but nevertheless thanks for that clarification.

Mr McGUIRE — But the bigger point, the issue here, is about compliance. Do you agree that compliance is critical?

Mr ROGERS — I do agree, yes.

Mr McGUIRE — You understand what we are doing. It does not matter in some ways how forensic our investigation is, how strong the findings are and what the recommendations to the Parliament are; whatever action that government takes, if it is not complied with, the system still fails and people can be assaulted.

Mr ROGERS — We take compliance very seriously. In this case you received, unfortunately, a piece of information that we have looked at subsequently and that turned out to be not correct — that the police in fact were notified of that occasion on the day that it occurred, with follow-up discussions with the police. We did comply with the process; unfortunately you received a piece of information that was incorrect.

Mr McGUIRE — How did that happen?

Mr ROGERS — We have not had the chance to go back to the person who compiled that report. They may have seen an earlier document that did not show that. They may have misconstrued the fact that the police did not follow it up with the fact that they were not notified. I cannot give you a definitive answer to that today. We have spent some time checking whether we did comply, and as I say, the report does show that we did.

Mr McGUIRE — Do you have a credibility issue with your record keeping?

Mr ROGERS — We will need to look at the circumstances of why that report was shown like that. I cannot give you an answer to that at the moment. We will need to follow that up. We spent the time looking to make sure whether we complied or not, and we are satisfied that we did, according to the information.

Mr McGUIRE — By deduction, I put it to you that you do have a credibility issue with your record keeping.

Ms MILLER — I think the analysis of the incident report is the problem. The record keeping of the actual incident and the follow-up on the day and the system internally in the service were accurate. I think what happened then is that those incident reports were analysed by a different part of the department that made an error, and that was given to you in this report.

Mr McGUIRE — Do you understand the issue?

Ms MILLER — Yes.

Mr McGUIRE — We are trying to work out what recommendations we need to make to change the system to try to avoid these issues happening in the future. We are looking at compliance as being a critical point. Now, by your own admission, there has been an error in interpretation of the reporting, so what does that say to the public?

Mr ROGERS — Can I just say — —

Mr McGUIRE — No. Ms Miller, please. I was asking Ms Miller.

The CHAIR — Just a moment. Ms Miller and then Mr Rogers.

Ms MILLER — I think that is something we need to take very seriously and address with the area of the department that analysed those reports and make sure that does not happen. It needs to be accurate, it needs to be clear and we need to have credibility.

Mr McGUIRE — Correct.

The CHAIR — Mr Rogers, would you like to make a comment?

Mr ROGERS — Your comment was in regard to compliance. My answer to that would be that we did comply. The error was in a post-incident analysis, which you received a copy of. I agree with Robyn that we need to follow that up; it is a serious matter. The essential point is that, with the incident, we did actually comply with the requirements of that incident and report it to the police that day.

Mr McGUIRE — If I can go back to Ms Miller. What initiatives do you think need to be introduced to improve the system so that we actually have certainty of compliance and reporting and information flow so that we actually are on top of this?

Ms MILLER — I think constant vigilance and rigour, and that goes to people's commitment and training. I think we have a very committed workforce, and we have had a huge consciousness raising around the importance of incident reporting and training across the state. It is also that a fundamental respect for human rights needs to be embedded in everything we do. It is a multifaceted response. The particular issue that has confused the matter today I think is probably the easiest thing to address in terms of the analysis. If there was a mistake to be made, I am pleased that it was at that level, post the incident — at the level of compiling a report months down the track. I am pleased that there was compliance and that this poor woman's situation was responded to appropriately on the day. The police were notified, and that is the most important thing in my mind.

Mr McGUIRE — I agree with that, but I am asking, 'How do we get a better model and better compliance?'. What has been initiated since this incident to make sure that we get better, more accurate, credible information flow?

Ms MILLER — The conversations that will be happening and are happening now in terms of the performance analysis are an issue that I think will become more rigorous. I think that there is important information around understanding the themes that emerge and responding quickly to any incident report, and not just to the individual incident but to the themes emerging. That is something we are looking at very closely in the office that I am acting head of at the moment, and looking at how we learn from overseas. We look at other jurisdictions. That partnership with agencies and that rigour around performance are things that are being stressed.

Mr McGUIRE — Has any action been taken at this stage?

Ms MILLER — Around this particular — —

Mr McGUIRE — Yes, to fix it, so that we do not get this again — —

The CHAIR — Hang on, Mr McGuire. Obviously this particular incident is outside our terms of reference. We are looking at child abuse, and I understand that this happened to a woman. What we need to be satisfied with is in relation to our terms of reference and compliance across the board pertaining to child abuse. Without going into the detail of this particular case — I do not think we need to be bogged down in it — we really want to be reassured that we have compliance in relation to the reporting of any abuse that happens with children.

Mr McGUIRE — Can you understand that this looked like a red light flashing to this inquiry? After all that has been said, after the focus on these issues, we then get information back that this has not been complied with. It is also in the context — I do not know if you are following what is happening interstate as well — of the Anglican bishop of Grafton having to resign for a failure of compliance. What I am saying is that right now this is incredibly critical. We are trying to find a better way of doing it. Can you say what action has been taken to make sure of the accuracy of these reports?

The CHAIR — Ms Miller and then Mr Rogers, would you like to add anything further to what you have already said in response to Mr McGuire? I think it is a similar question to the last one.

Mr McGUIRE — What action has been taken?

Ms MILLER — My personal knowledge of this area in the report that you received has only been over the last few days, and there have been discussions at executive level.

Mr McGUIRE — So, just to understand, no action has been taken at this stage?

Ms MILLER — There have been meetings. In terms of concrete action, this was a report about which I think there will be training, and there has been feedback. Clearly this should not happen. Mr Rogers might be able to assist.

The CHAIR — Mr Rogers, would you like to comment?

Mr ROGERS — In terms of the individual incidents, there has been no breach of duty of care, because each of the incidents has been followed up, as this one was. In terms of the error of reporting, this came to light last week. In terms of where this report was done, it was done under the former department structure, which was a small group within the service delivery and performance group. The new structure of the department, which came into being in December last year, has all the performance reporting in one area, managed by a senior executive officer. We have upgraded our performance reporting to be in one place. The people around that are receiving training and we are recruiting to that area. I met with the director of that area last week to go through the report, and we will follow up what happened in this instance. What the department has done, I think, is recognised in its new structure that we needed to improve the focus and concentrate our performance analysis. That has happened in the new structure. As I said, a senior person has been appointed to that. We have put people into that area and we are recruiting more people to make sure that our reporting to the board, and the board's understanding of what is going on, is as accurate as it can be.

I regret that there was one error in the report you received. We will look to see whether there is any systemic issue with that. There does not appear to be on the first look in that direction, but we will follow that up. We would just like to reiterate that it is not a failure of compliance, it is a failure of post-incident reporting that we need to look at here.

The CHAIR — Thank you, Mr Rogers.

Mr McGUIRE — Just on that to follow through, since we have raised it with the department, the department has taken action. Is that what you are testifying today?

Mr ROGERS — When we became of that error last week I met with the director of that area to discuss that. There will be a further follow-up. We have not had time to actually go back to look at the reasons why that one particular thing was in error, but we are doing that. More broadly, we have actually reorganised and refocused our performance reporting to make sure that it is as accurate as it can be.

Mr McGUIRE — So you are trying to change from the silo issue that you have described? Ms Miller, you were describing that there were problems with the silos, and this happens in all bureaucracies. This is what we are trying to get to: how do we improve the system? You are saying you are changing from a silo system to a key person with direct authority and responsibility; is that what it is?

Mr ROGERS — Yes. The new structure of the department moves away from the program structures to a more functional basis, and we have a dedicated group of people who just do performance reporting and analysis. That is their job; they are the holders of the information. We will have a highly skilled group of people — we have some good skilled people now — and a greater group of skilled group of people doing that on behalf of the whole department across all areas of the department.

Mr McGUIRE — Do you need more resources?

Mr ROGERS — We have resources that are adequate to the task that we have in front of us.

The CHAIR — Thank you. Do you have one more question, Mr McGuire?

Mr McGUIRE — Yes, I have more questions. Just so I understand, who interprets the context of incidents and makes the decision regarding whether or not to report them to the police?

The CHAIR — That was basically my question in relation to — —

Mr McGUIRE — Yes, but I just wanted a little bit more.

Mr ROGERS — In terms of the children and families space, any allegation of staff-to-client assault is mandatorily reported to police. There is no discretion. For client-to-client assault there is some discretion in the children's space where it might be that the younger people are just pushing and shoving each other, but they are generally reported to police as well. In the disability space, there is some discretion of the manager. However, there are a number of people who see all incident reports. They can all make that decision if they think something should be reported to the police. It goes from the local manager through to the child protection manager, the area manager, the executive director of the division — any of those people can make those decisions. But generally they are all reported to police where it is an allegation of staff-to-client assault.

Mr McGUIRE — Just a final question I will put to both of you, Ms Miller first. What recommendations or insights would you provide to this inquiry as to how we can make compliance more bulletproof, for want of a better description? What proposals would you put to us that could actually help improve the system?

Ms MILLER — Is your question particularly to children in out-of-home care or across adult disability as well?

Mr McGUIRE — Across both. What do you think we should do? What would be a really good initiative that would help with the compliance issue, because that is critical?

Ms MILLER — Again, I think the quality of the supervision and the culture within each individual unit and each individual program is critical. It is also critical to have an expectation that the senior people running agencies and community service organisations are on the floor and that we have a culture of openness and transparency, and that we have very clear guidelines and people know what they need to do. That training of staff in the houses of foster carers, their home base, but also particularly residential care staff is critical. But it is not just training; it is that culture, it is that ongoing supervision and deep respect for people and their rights, and that is embedded not just through training but also in supervision. That word 'culture' means many things, but I am trying to get across that sense of deep respect and that compassion that should be in every out-of-home care facility.

Mr McGUIRE — Do we need greater penalties?

Ms MILLER — I am not sure what you mean by penalties.

Mr McGUIRE — Just for enforcement. You were saying, and I agree with you, that it is right across the culture. How do you improve that? I am just taking it to the next step: would greater penalties be of value or not? It is an open question to you.

Ms MILLER — I think rigour around performance and being accountable, and that is in place now more than it ever has been through registration, the three-year reviews, individual cases being followed up more rigorously, investigations being put in place and external people coming in and investigating. In fact there are two ultimate penalties. One is systemic, and that is being defunded, and we have done that and that is important, because for me these issues are not negotiable. The other issue is around individual cases, and the penalty — and there is clarity around this — is being reported to the police. This is an arena of safety here. Whether the police pursue it, we will be reporting to the police. I am not sure whether other penalties would make a difference.

The CHAIR — Thank you. Mr Rogers, would you like to briefly comment?

Mr ROGERS — Just in relation to penalties, I am not sure there is anything you can do on an agency basis beyond defunding them. In terms of an individual carer, it would be their being disqualified. I am not sure you can do much more than that outside the criminal activity, which the police look at of course.

Mrs COOTE — Thank you, Mr Rogers and Ms Miller, for being here today. I would like to direct my question to Mr Rogers. It was a Liberal government that brought in mandatory reporting in 1996. I know you have been in the department since that time. Could you give us a very brief overview of what your understanding has been in the development of mandatory reporting since its introduction in 1996? I am

particularly keen to know what changes have happened in the last two and a half years and what changes have happened as a consequence of them?

Mr ROGERS — I think in relation to mandatory reporting it has certainly brought a greater focus to the professions that are subject to mandatory reporting about the importance of this area — not just about reporting but also the importance of child welfare and safety. We have obviously seen an increase in the number of reports since mandatory reporting increased, and each time a new group comes in we expect to see a spike and then an increase in the reporting as well. In terms of that I think there has obviously been a greater rate of reporting and a greater appreciation of the issues in those mandatory reporting professions. Certainly with the police we have a much greater understanding of some of those relationships and their reporting around family violence as well. I think it has led to both an increase in reports but also an increase in the focus and awareness of this as an issue in the community. Does that answer your question?

Mrs COOTE — I am particularly keen to know what systemic issues were identified in the department as a result of the introduction of mandatory reporting and what in fact was systemic, probably in that period 1999 to 2010?

Mr ROGERS — Within the department?

Mrs COOTE — Yes.

Mr ROGERS — In terms of the systemic issues, it has certainly led to a greater level of working with other groups, such as the police and teachers, and certainly more formal connections around that and the understanding of how they report and how we work with them. It is not just about taking the reports; it is about how we work with them to resolve the matter and for the safety of the child. It has led to a greater focus on screening in the department in terms of the intake process and trying to make sure that we have got senior staff at that screening and intake process, because not all reports obviously go on to investigation.

It has also led to a greater development of what happens to those reports that do not go on to investigation, where there are some issues in terms of working with community groups and working with children's services to make sure that referrals are made to assist families, even though they do not go on to an investigation stage. I think it has led generally to a much greater appreciation about the issues in the community and also about how we can work with others formally, and less formally, to make sure the safety of the child and the family welfare is attended to.

Mrs COOTE — You have spoken on several occasions today about the changes to DHS and its structure, and that it is to be more pertinent to the local regions and divisions. Ms Miller spoke before about the training programs and regimes that are in place. Do you believe those changes are going to make a difference in scrutiny and transparency into the future?

Mr ROGERS — I might just perhaps answer on the basis of the structure and then get Robyn to talk a little bit about the training. So the new structure of the department actually has a much greater focus on local area services and local connections. We do have child protection teams that are managed divisionally but are locally based, and they are working much more closely in the new structure in terms of local areas and working across services. There is also a new service delivery offering called Services Connect being provided within the department, which is a much more integrated service where people will come to a worker and have one case worker — who is not the statutory worker, but they have one case worker — so they will not need to go to the disability worker, to the housing worker and to the children's worker; they will have one worker for a much more integrated response. That Services Connect approach is being trialled, as is the relationship of that to the statutory services.

Mrs COOTE — So that is to break down the silo approach?

Mr ROGERS — Yes. So the client does not actually have to navigate the maze of services and can actually go to one intake point, one phone number, one worker. And there does need to be a good strong relationship and referral point between that and statutory services, which we are working on in Services Connect as well. So we are aiming for a much more integrated response to people but not losing the focus where we need it on specialisation around, say, child protection and statutory services. That is being trialled and being rolled out across the state, with the last state budget announcement.

Mrs COOTE — Yes. So Services Connect — could you just remind me — when was it initiated?

Mr ROGERS — It has been initiated in the last couple of years. It was trialled last year. It was the result of, I think, the policy of the incoming government around much better case management. It has developed into Services Connect as a result of that. It was trialled last year in three locations: the south-west, Geelong and Dandenong. It is now being rolled out to further locations. It has been trialled in managed care, but we are also looking at a more integrated front end and just one case worker, one case plan for each person and a good strong relationship to statutory and more specialist services.

Mrs COOTE — Can I ask one final question? Having watched mandatory reporting and its introduction and watched it being rolled out for the length of time it has, if it was to be broadened — it has been suggested here by a couple of organisations, and certainly in the Cummins report, about criminal mandatory reporting being expanded — what would your attitude to that be?

Mr ROGERS — Any measure that actually protects young people and children in the community is to be supported. You want to just have a look at the particular groups. I am not sure which groups you have in mind, but it might have an impact on different groups. It would have some impact on the department's workload, of course, because you have more reports. But generally anything that protects people's safety, children's safety, is a matter that should be supported. Robyn might want to add to that. I did mention that Robyn might want to talk about the training. Did you want to follow that up, around the training of the staff?

Mrs COOTE — I think it is imperative, if there is going to be increased mandatory reporting or if it is going to be a consideration, that there is training. I would be very keen to hear what you have done with training in the past couple of years.

Ms MILLER — Yes. We have been very clear that we have a practice model that has the best interests of the child. So section 10 of the act is the best interest principles, and it talks about giving the widest possible assistance to the family and the needs of the child and safety of the child being paramount. So the area we work in is complex, because the way we have directed the policy in Victoria has been actually to support children, to prevent children needing to come into out-of-home care and to work to safeguard them at home. So there has been some very good training, joining up across sectors — family services, early childhood, child protection and out-of-home care services, together with family violence and maternal and child health.

So we have worked in an area-based sort of model doing lots of training in local areas, and we have developed manuals and practice resources that are applicable across sectors, and we have one language across sectors rather than having different ways of speaking about children and their needs. We have Child FIRST and integrated family services that can take reports on children with wellbeing issues. What we make sure is that we train across in a consistent way and that we have one case practice model. That, I think, has been something that has made a difference. We have done some evaluation of that, and the sectors are very clearly saying that having that shared language and that shared understanding about risk, but also a strength-based approach but forensically astute, is enabling them to actually work to support children and prevent vulnerable children needing to come into care in the first place, but if they are, to do everything possible.

So in relation to the particular awareness of children with problem sexual behaviours and young people with sexually abusive behaviours, we have set up treatment services across Victoria to deal with those. We did not used to have those. We do have the lowest rate of children going into out-of-home care in the country. Some states are double or more than double our rate per thousand in the population of children.

So that approach, I think, which is about prevention and earlier intervention, is based on the evidence that if we can intervene then, it is so much better for the child and their development. So there is a wealth of information we have now around neurological development of children and the impact of family violence, the impact of neglect and cumulative harm. We have been working very hard to make sure that that information is out there so literally thousands — they are on the internet of course, but — —

The CHAIR — Those manuals are on the internet, are they?

Ms MILLER — Absolutely, and other states are using our resources now, and organisations overseas are using some of our resources as well. We have developed them in conjunction with the Australian Institute of Family Studies, and they are cutting edge in terms of current best practice and research and evidence-informed

practice. So that has been really important, but as I said it is not just the training, it is the quality of the supervision and the quality of the staff we have.

Mrs COOTE — So you work very closely with other organisations? It has come to our notice that AusAID has a very good program. Are you aware of that program? Have you been working with them?

Ms MILLER — I am aware of them in general terms; I have not been working closely with AusAID. OzChild, yes, but not AusAID.

Mrs COOTE — Thank you both very much indeed.

Ms HALFPENNY — Just in terms of the training, that all sounds really great, but because we are dealing specifically with abuse within non-government organisations, a lot of the information we have received in evidence is about people who go into organisations where children are with a specific paedophile intention, so in terms of the training is it also about trying to ensure that people are monitored and that people know the signs to look out for to ensure that children are protected within the organisations?

Ms MILLER — Absolutely, and I have someone in my team co-located down at the sex offender registry. We have a very close relationship with the police. We are co-training with the sex crime squad and the SOCIT program. So the three of us have 10 sessions coming up in the next six months before Christmas that we are delivering at different locations. We had 170 people on Friday in at Melbourne, we had 300 resi carers two weeks ago at the annual resi carers day, and that was all about the issue of how we understand trauma, how we understand the impact of that on children, how we need to respond as adults and absolutely that arena of safety.

The CHAIR — Thank you for that clarification, and on behalf of the committee I thank you both for being here before us on behalf of Ms Callister, who is away. So again, your evidence has been most helpful. We do appreciate your time. Thank you.

Ms MILLER — Thank you.

Mr ROGERS — Thank you.

Committee adjourned.