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## THE STATE OF VICTORIA'S CHILD PROTECTION

As I finished this piece for *Children Australia*, a man was sentenced to more than 22 years gaol in Victoria's County Court. He had pleaded guilty to ten counts of incest, two of indecent assault and one of assault on his daughter. According to the *Herald Sun*, the man had sexually abused his daughter for 28 years, and she bore him four children. The Crown Prosecutor described the case as in 'the worst category of cases of abuse of a natural child' (Murphy 2010).

A single, extreme case, we are told, can provide an inaccurate picture of child protection. This case was extreme by anyone's measure. As I sat through the judgement and discussions of suppression orders, it was hard to believe that so much damage could be done to so many for so long, hard to understand how so many people knew and apparently did so little.

Unfortunately, there are many more disturbing cases in Victoria. In November 2009, the Victorian Ombudsman published a damning report on Victoria's child protection system (Ombudsman Victoria 2009).

It had been clear for many weeks that the Department of Human Services was concerned about the publicity the report would receive. There were many activities, some involving the Centre for Excellence in Child and Family Welfare. It was interesting to observe roles played, messages developed.

One of the results was an 'Age Round Table on Child Protection' (*The Age* 2009). Inevitably, nothing could reduce the large headlines, like these in *The Australian*: 'Children at risk failed by system' (Wallace & Rout 2009) and 'It's shameful, and there are more cases we don't know about' (Wallace 2009). Other newspapers were equally forthright (see, for example, McMahon & Murphy [2009]).

The Ombudsman paid tribute to Victoria as a 'leader in terms of its policy framework' and noted that most child protection staff are 'highly committed'. He found, however, that the system is not meeting its 'operational responsibilities' (2009: 8-9). The Ombudsman concentrated on more than a dozen areas. In 'Responding to reports of abuse' he found, *inter alia*, 'statistical evidence, case examples and sworn

statements' demonstrating that many reports of suspected child abuse and neglect 'do not receive a timely response' (2009:9).

The findings are extraordinary:

... I received sworn statements from witnesses that the immediate response indicator is at times manipulated ... Senior departmental staff said this performance measure was often recorded as met despite the child not being sighted (2009:9).

The report goes on to state that:

Evidence was received that at times they had telephoned families and recorded this measure as having been met, *despite the child not having been sighted or visited as required to meet the standard* (2009: 9, emphases added).

This is an astounding finding that places bureaucratic requirements before child safety: children are recorded as having been seen when no child protection worker had visited.

The Ombudsman reported that, in reviewing files, his staff 'rarely located evidence of thoroughly planned and comprehensive investigations ... beyond the initial visit' (2009:9). This is not surprising given that almost 2,200 child protection cases (or 22.6% of all cases) were unallocated in June 2009. The Ombudsman's distrust of the data is obvious in the following sentence:

This figure is also subject to a number of exclusions and I consider it likely that this data under represents the true number of children without a child protection worker (2009:9).

The criticism of management continues:

I am concerned about the high proportion of unallocated cases in some regions ... some regions have a level of demand for child protection services they could not meet even if fully staffed (2009:10).

Even as the Ombudsman investigated, matters got worse: in April 2009, Gippsland had 52% of cases unallocated, and by early June this rose to more than 59%.

There are many other equally damning findings. The Ombudsman found that:

... the degree of tolerance of risk to children, referred to as the 'threshold', varies across the State according to the local department's ability to respond. I located many examples of cases where I consider that the risk of harm to children was unacceptable ... (2009: 10).

The Department's staff reported that they were 'directed to close cases' even when they believed action was required (2009:10). As Joe Tucci and I wrote in *The Australian*, it appears that Victorian policy has created the extraordinary situation where the 'severity of bruising depended on the location of the child rather than the location of the bruises' (Goddard & Tucci 2009: 12).

The Ombudsman also found that the Department is unable to give cumulative harm sufficient priority; that information technology is inadequate; that the legal system required review; and, that staff supervision is inadequate.

There are many other deficits. The Department has, in certain cases, a statutory obligation in accordance with the legislation to develop a 'Best Interests Plan' for children. The Ombudsman found 'numerous instances' where this was not done (2009: 76-77). Comments from senior staff suggest that compliance is poor. One said only '... about 50 per cent are done ...' (2009:77).

The central finding again concerns the lack of transparency and accountability:

Despite ... media attention, it is clear that most child protection cases receive limited if any external scrutiny. My investigation revealed instances where children have died, been seriously injured or allegedly assaulted by their carers ... Yet, these cases have attracted little or no external scrutiny (2009: 14).

As the report was released, this lack of accountability continued. The Ombudsman started the section on accountability and transparency with reference to the case of 'Hayley', who sustained fatal injuries in spite of being reported to the Department. On the same day as the report was made public, Victoria's 'Child Safety Commissioner' announced he had completed his report into her death:

Barely three pages long, the announcement makes no mention of her age, or how she died, because he was merely asked to provide a 'systems report'. Nevertheless, a '\$77 million government funding boost' is mentioned five times (Goddard & Tucci 2009:12).

The next day, the Minister herself released at least eight media releases, all mentioning '\$77.2 million child protection workforce plan'. As Joe Tucci and I wrote:

It is difficult to imagine a clearer demonstration of the inadequacy of the reviews of child deaths and the limited role of the commissioner. The Ombudsman's report stresses that

additional resources alone will never be sufficient (Goddard & Tucci 2009:12).

It is not surprising that the Ombudsman reported that 'many witnesses' spoke of the 'limitations' of both the commissioner and the child death reviews (2009:110).

The cost of child abuse in Australia is enormous (Taylor et al. 2008). Protective services have also been found to be 'fatally flawed' in New South Wales (Sammut with O'Brien 2009). Yet the transparency and accountability failures continue:

A State government investigation into mandatory reporting breaches at a school linked to one of Victoria's most gruesome murders did not interview a crucial witness ... The investigation came after an horrific sex-abuse case that led to the murder and dismemberment of a man who photographed himself abusing his teenage step-daughter (Johnston 2010:8).

The investigation was carried out by Worklogic Consulting, according to Johnston (2010; see also, Stephens 2009).

It will come as no surprise to learn that the case of the man who abused his daughter for 28 years will also only merit another so-called 'inquiry' by the 'Child Safety Commissioner'. Yet another failure of accountability and transparency in Victoria's child protection, so soon after the Ombudsman's grim warnings. Surely this case deserves a fully independent inquiry, if nothing else.

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