Commissioner for
Children and Young People
Western Australia

Oversight of services for children and young people in Western Australia

Commissioner for Children and Young People WA

November 2017

Recognising Aboriginal and Torres Strait Islander People

The Commissioner for Children and Young People WA acknowledges the unique contribution of Aboriginal people's culture and heritage to Western Australian society. For the purposes of this report, the term 'Aboriginal' encompasses Western Australia's diverse language groups and also recognises those of Torres Strait Islander descent. The use of the term 'Aboriginal' in this way is not intended to imply equivalence between Aboriginal and Torres Strait Islander cultures, though similarities do exist.

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Message from the Commissioner

Every day children and young people across Western Australia engage with organisations and participate in activities outside their home. In addition to the diverse government agencies and institutions that deliver services in most areas of a child or young person's life, there are many private and non-government organisations that have routine contact with, or are involved with the daily care and management of children and young people.

While for most children and young people, interaction with these service providers is a positive experience, the report of the *Special Inquiry into St Andrew's Hostel Katanning*, the ongoing Royal Commission into Institutional Responses to Child Sexual Abuse, and other similar inquiries, have highlighted the vulnerability of children and young people to abuse and harm in institutional settings and the unique barriers they face in speaking up and seeking help.

Monitoring the care, safety and outcomes of services for children and young people is critical to ensuring their wellbeing. Internal review and monitoring processes, regulatory agencies such as the Working with Children Screening Unit, and non-government advocacy agencies such as Developmental Disability WA, all have an important role to play in monitoring service standards and the quality of care. However, previous inquiries have shown that independent oversight bodies are the most effective means of preventing abuse and maintaining high standards of care. It is for this reason that these bodies are the focus of this report.

In June 2016, the Joint Standing Committee on the Commissioner for Children and Young People[1] recommended that my office undertake a project to map the oversight of services for children and young people in Western Australia. This report provides an overview of best practice principles of oversight of these services and assesses WA's current arrangements against these principles in order to identify areas of improvement.

While it is critical that all organisations that provide services to children and young people are subject to oversight and monitoring, this report focuses on six priority service areas: child protection, disability services, youth justice, mental health services, police custody and the education system.

It is clear that while Western Australia's network of independent oversight bodies does important work in a range of areas, further work needs to be done to ensure mechanisms are comprehensive and robust, the rights and wellbeing of children and young people are protected, and services are safe and fit-for-purpose.

This report provides a snapshot of the oversight landscape in Western Australia. It is my hope that it be used as a tool of review and that government, service providers and oversight bodies reflect critically on the appropriateness of current

arrangements as they relate to the unique needs and vulnerabilities of children and young people.

Colin Pettit

Commissioner for Children and Young People

Summary of Recommendations

Mapping the current framework of independent oversight against services provided to children and young people has revealed that while there are key strengths in important areas there also significant gaps and areas for improvement.

Extension of oversight to cover services provided by non-government organisations is required to ensure all children young people have the necessary protections, wherever they are.

The vulnerability of children and young people and the challenges they face in raising issues, navigating systems and understanding their rights requires a strong proactive and supportive approach to oversight.

Particular groups of children and young people are also more likely to need a higher level of oversight and it is of concern that disability services, child protection and police services, who engage with some of our most vulnerable children and young people, have such limited independent external oversight.

Similarly, the use of certain behaviour management practices, such as restraint and seclusion, can have a serious detrimental effect on the mental health and wellbeing of children and young people and should have a level of independent oversight wherever they occur in the service delivery landscape.

The following recommendations, although identifying the specific areas for development, are intentionally broad as further work needs to be done to establish the most efficient and effective mechanisms for oversight. While there is scope to develop the means of achieving oversight, appropriate levels of resourcing and a commitment to engaging proactively with children and young people, particularly those who are more vulnerable, is essential.

Recommendation 1

That a robust, comprehensive system of independent oversight for all children and young people in out-of-home care be established. This should include:

- access to an independent advocate to support children and young people to raise concerns about their care
- monitoring of the application of policy and practice
- Monitoring of the outcomes for children and young people in care.

Recommendation 2

That strategies to further strengthen the independent oversight for children and young people in relation to mental health services are considered including:

- inspection of facilities and review of practices such as restraint and seclusion be improved through increased regular, systematic, independent oversight
- proactive engagement of independent advocacy with voluntary patients
- independent monitoring of the outcomes for children and young people's mental health and the adequacy of treatment provision broadly across WA.

Recommendation 3

That a robust, comprehensive system of independent oversight for vulnerable children and young people in the education system be established. This should include:

- systematic inspection and investigation of facilities and the implementation of policy and practice in relation to the use of suspensions, exclusions, and behaviour management, particularly the use of seclusion and restraint
- monitoring of outcomes for vulnerable groups of children and young people including Aboriginal and Torres Strait Islander children, children with disability, children in the youth justice and/or out-of-home care systems.

Recommendation 4

That a system of comprehensive independent oversight of the detention of children and young people in police custody be introduced in WA.

Recommendation 5

That a robust, comprehensive system of oversight for all children and young people in the youth justice system be established. This should include:

- access to an independent advocate to support children and young people to raise concerns about their treatment and support
- monitoring of the application of policy and practice
- monitoring of the outcomes for children and young people under the care and supervision of the youth justice system.

Recommendation 6

That a robust, comprehensive system of oversight for all children and young people with disability be established. This should include:

- access to an independent advocate to support children and young people to raise concerns about their treatment and support
- monitoring of the application of policy and practice
- monitoring of the outcomes for children and young people with disability.

Introduction

International human rights instruments have long recognised the need for special safeguards and care for children and young people due to their particular vulnerability. Recent inquiries, in Australia and internationally, have drawn attention to this vulnerability, documenting a litany of examples of the abuse and neglect children and young people can experience in a variety of settings.

Children and young people also have specific needs and face unique barriers to accessing services and supports, raising concerns or making complaints. Ordinarily, children and young people rely on a competent adult, usually a parent, to assist them to identify and raise concerns.

Many organisations provide services to children and young people on a daily basis, for a variety of purposes including education, health care, and recreation. Some organisations focus on children and young people who have specific needs such as safety and protection, disability, or housing.

Monitoring of these organisations can improve the transparency of practice and procedure and provide parliament, government and the public with important information about service standards and performance. While ultimately seeking to ensure that service provision is safe and fit-for-purpose, oversight can also support efforts to direct services more appropriately and foster broad improvements in sector practice.

There are a range of strategies that work to monitor the safety and wellbeing of children and young people in diverse settings. These strategies can differ in their mechanisms, jurisdiction, scope, and powers. They can be internal to the organisation being monitored, independent of the direct service provider yet internal to the service procurer (where direct service provision is devolved to another provider), or entirely independent and external.

Independent, external monitoring is a complex picture of a variety of organisations with different levels of independence and varying legal statuses. Regulatory bodies such as the Australian Children's Education and Care Quality Authority (ACECQA) and the Teachers Registration Board (WA), or non-government organisations, such as Amnesty International, the CREATE Foundation or Developmental Disability WA, all provide an important level of monitoring that influences quality of service delivery at both an individual and systemic level.

This resource seeks to map only independent statutory bodies that oversee the provision of services to children and young people. While this report endeavours to provide a snapshot of independent oversight mechanisms working to ensure the safety and wellbeing of all Western Australian children and young people, special attention will be paid to the State's most vulnerable. This report:

- reviews and outlines the principles and components of a comprehensive, best-practice framework of independent oversight
- describes the existing structures, powers and functions of the independent oversight mechanisms relevant to children and young people in Western Australia, and
- identifies gaps and makes recommendations to improve the operation of Western Australia's system of independent oversight of services provided to children and young people.

Independent oversight

Recent inquiries in a range of jurisdictions have revealed that an effective and holistic system of independent oversight should ensure that coverage is comprehensive in terms of target group, aspects of measurement and the robustness of methods used. Such a framework should examine both systemic and individual issues through integrated mechanisms capable of operating collaboratively. Ultimately, these mechanisms should seek to ensure the safety and wellbeing of individual children and young people while endeavouring to improve the overall quality of service provision.

A number of agencies are responsible for the oversight of services provided to children and young people in Western Australia. These agencies carry out a range of functions, are invested with diverse powers and have distinct mandates. Mapping not only their functions and jurisdictions but also their powers, and the extent to which such powers are exercised, is essential to understanding their place within Western Australia's independent oversight framework.

Example

Oversight of youth detention

The varying bodies with oversight of Western Australia's juvenile detention system demonstrate the complexity of this mapping exercise: The Office of the Inspector of Custodial Services assesses detention centre conditions and all services delivered to young people in custody (including education, health and transport); the Health and Disability Services Complaints Office can investigate systemic issues and receive complaints related to the centre's medical regime; the Auditor General has a specific role with respect to efficiency, effectiveness, legislative compliance and financial management; the Ombudsman investigates individual complaints related to facility administration and decision-making and can undertake own-motion investigations; the Public Sector Commission and Corruption and Crime Commission monitor and investigate allegations of employee misconduct; and the Commissioner for Children and Young People advocates broadly for changes and improvements to centre policies and regimes affecting the rights and wellbeing of the detained young people. In order to identify gaps in oversight and any weaknesses in the overall framework, it is essential to understand the nature of each agency's functions, mandate and supporting powers.

What is independent oversight?

Independent oversight refers to mechanisms that seek to strengthen the integrity of government agencies, public officials and funded services by reviewing decisions made and services delivered in the performance of their duties. In this sense, independent oversight agencies serve to enhance public confidence in government

agencies and the services they fund and seek to ensure organisations are responsive to the interests of clients and the general public.[2]

Typical mechanisms of oversight include monitoring and review functions, complaints handling and resolution, and individual and systemic advocacy. Independent oversight agencies can operate a specific mechanism or a combination of mechanisms. Monitoring and review agencies are typically those responsible for the examination of issues at a systemic level. These agencies are ordinarily invested with proactive accountability functions, such as audit, evaluation, investigation, inquiry and inspection. It is this focus on systemic issues in institutional and administrative practice that distinguishes these bodies from complaints handling and individual advocacy mechanisms. While dedicated complaints handling bodies focus largely on investigating individual grievances they can also serve to complement proactive monitoring by undertaking thematic reviews of trends in complaints received in order to identify systemic issues in process, practice and procedure.

Independent oversight agencies can have generic or specific mandates, different legal status, varying levels of power, and may be complaints or compliance-focused. While these bodies can be classed, in at least a cursory fashion, by thematically similar governance structures, there is no uniform set of criteria that guides the substantive exercise of their functions. In practical terms, this means that agencies may be guided by human rights standards, good governance criteria, sector specific guidelines or standards, 'best interests' determinations or a combination thereof.[3]

Effective oversight

There are a broad range of factors that influence the effectiveness of oversight mechanisms. At a rudimentary level, all such bodies should be independent, invested with powers that accord with the satisfactory fulfilment of their purpose, and adequately resourced. Practically, there is also a need for systematic communication between oversight agencies, an ability to report publicly on findings and recourse to specialist knowledge in relevant fields.[4]

Specialist knowledge is particularly important for vulnerable groups of children and young people. As the indispensable elements of an effective system of oversight will vary according to the nature of the service and the vulnerabilities of the individuals to whom the service is provided, an independent oversight agency invested with broad powers and a comprehensive mandate may be objectively effective for some groups of young people but not others. The United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment notes that "[i]ndependent monitoring mechanisms should draw on professional knowledge in a number of fields, including social work, children's rights, child psychology and psychiatry" and that effectively tailoring oversight to the specific vulnerabilities of relevant children and young people requires agencies "to understand the specific

normative framework and overall system of child protection".[5] In practical terms, this means that a comprehensive system of oversight with a network of complementary agencies, broad jurisdiction and robust powers, must also be able to modify its operations to the specific needs and vulnerabilities of children and young people. This includes such things as adopting child-friendly complaints systems, undertaking regular, age-appropriate outreach and making use of specialist knowledge of the often complex and diverse challenges faced by children and young people.

Independence

Independence is a critical component of effective oversight. A lack of independence, or merely the perception thereof, can undermine confidence in an oversight agency's ability to engage in robust and critical review. Independence is, however, a nuanced concept. An oversight agency's level of independence is largely shaped by its physical, legal and practical independence from the agency or services it oversees. Independent oversight bodies should have the capacity to direct their own work within the broad frame of their jurisdiction and report publically on their findings. This independence provides the foundation upon which public confidence in these organisations' impartiality and objectivity is built.

In practical terms, comprehensive independence is achieved through independence of funding, independence of location, and independence with respect to powers, resources and expenditure.[6] Reliable funding is particularly crucial to independence and, as a result, effectiveness. Naylor observes that "[a] government's commitment to human rights compliance is most readily undermined by under-resourcing".[7]

It is important to note that the absence of one or a number of these criteria does not abrogate an agency's claim to independence, it rather has the potential to diminish its effectiveness and moderate the robustness of its oversight.

Adequate powers

Effective oversight depends to a large extent on the powers conferred on the agency and the complexity of the standards against which monitoring is undertaken. An agency invested with broad powers and guided by sophisticated guidelines is significantly more capable of fulfilling a robust accountability role.[8] Broadly speaking, powers can be divided into two classes of function: the capacity to gather information and the power to report on findings.[9]

Information gathering

Information gathering functions involve an oversight agency informing itself on issues related to how services are being delivered and the safety and wellbeing of clients, users or detainees. These functions allow oversight bodies to undertake systemic review of service delivery through the receipt and handling of complaints or

the conduct of investigations and inquiries. Review and complaints handling functions are typically supported by powers to visit and inspect facilities, interview residents, clients, detainees and staff, and require access to relevant documents.[10]

Information gathering is generally carried out through:

- complaints handling
- individual advocacy
- inspections and visits
- investigations and reviews.

Complaints handling

Complaints handling is the primary role of many oversight agencies. Broadly speaking, receiving and addressing complaints serves two primary purposes. Firstly, it allows individuals to express concerns about the provision of a particular service to an agency external to the service provider – this provides individuals with an opportunity to obtain redress or effect a change in practice or policy. Secondly, it provides oversight agencies with an opportunity to collect information from users, clients, patients and detainees in order to identify systemic issues in service delivery.

As an information gathering exercise the utility of complaints handling is limited to the content and frequency of complaints.[11] Its effectiveness depends, in large part, upon informed service users being aware of their right to minimum standards of treatment and having the capacity and desire to enforce those rights. To the extent that complaints-based systems do not regularly receive thematically similar complaints, they are ill-equipped to identify systemic issues in service delivery, isolate trends in reporting and monitor health and wellbeing outcomes.[12]

Further, if individuals do not raise abuse, mistreatment, inadequate healthcare or poor facility maintenance, it is not possible to infer that such problems do not exist. For example, if a child isn't aware of their right to a particular standard of treatment they cannot be expected to proactively assert that right when that standard is not met. Complaints handling bodies should actively support children and young people to make complaints via outreach, awareness raising, rights education and, perhaps most importantly, individual advocacy.

A best-practice system of complaints handling for children and young people should:

- be independent of government agencies and service providers
- proactively seek to elicit information from children and young people about their treatment or care
- employ a range of strategies, aimed at children and young people, to promote the existence of the mechanism and of children and young people's right to make a complaint

- have a variety of ways for children and young people to lodge complaints in order to increase accessibility
- be flexible and sensitive to the specific needs of children and young people, particularly those with a disability and those who may have trouble making a complaint on their own behalf for any reason
- be complemented by individual advocacy that supports children and young people to make complaints and raise concerns.

Individual advocacy

Individual advocacy can serve to ensure children and young people are aware of their right to complain and are supported should they choose to do so. Ordinarily, children and young people rely on trusted adults, usually their parents, to assist them to raise concerns about their welfare or complain about their treatment. However, for some children, particularly in the out-of-home care and youth justice systems, parental advocacy is either unavailable or inappropriate, or the complexity of the system or issues involved necessitates specialist support. As a result, and owing to children and young people's documented reluctance to complain about their treatment, independent external individual advocacy is indispensable in ensuring children and young people are able to access complaints mechanisms.[13]

Access to individual advocacy, particularly with respect to navigating complex bureaucracy and understanding complaints processes, is as important as the establishment of agencies with complaints, compliance and inspection-focused mandates. Children have a right to participate in the making of decisions that affect their lives and to the extent that their participation is not supported by individual advocacy mechanisms, this right is seriously undermined.[14]

Individual advocates can complement complaints handling by working to ensure complaints are directed to the most appropriate grievance mechanism.[15] Most service providers are subject to the jurisdiction of more than one oversight body whose ability to deal with a particular complaint may depend on the nature of the complaint, the nature of the young person, the nature of the service or the extent to which the complaint has been addressed internally. Individual advocates can help children and young people navigate these complexities, which in turn streamlines grievance processes.

Individual advocacy can also serve to mitigate institutional power imbalances. These imbalances, exacerbated by compound vulnerabilities, render children and young people less likely to complain about their treatment, particularly through internal processes. In 2009, the Commissioner for Children and Young People held consultations to understand the issues and challenges children and young people face when making complaints. A significant number of the children and young people consulted expressed a preference to complain through an advocate.[16] This

was particularly important for children and young people who were vulnerable or disadvantaged for any reason. The Commissioner ultimately found that:

> *It is important for agencies to raise awareness of the complaints systems available so advocates and peers can help with this information when needed. Agencies can support advocates to lodge complaints on behalf of children and young people.*[17]

A best-practice system of individual advocacy should:

- include an appropriate number of trained independent advocates with the expertise to engage with children and young people, particularly those who are vulnerable or disadvantaged for any reason
- have broad powers to contact, investigate and follow-up concerns and complaints of children and young people
- have the financial and operational capacity to be able to exercise all powers when appropriate
- actively facilitate the participation of children and young people in its work
- proactively engage with children and young people as well as respond to requests for support
- collaborate, when necessary, with other oversight bodies to raise systemic issues in service delivery
- have statutory powers to enter facilities or services and meet privately with service users.

Individual advocacy should be complemented by systemic, broad-based advocacy that serves to promote the best interests of children and young people and encourage their involvement in decision-making that affects their lives. This type of advocacy includes functions ranging from promoting the best interests of children and young people generally and monitoring legislative and policy compliance with international obligations, to conducting research on issues related to the rights and wellbeing of children and young people and encouraging the development of structures and systems that support child and youth participation.[18] Systemic advocacy can be informed by a range of information gathering functions, including inspections, inquiries, and reviews as well as research and review and monitoring activities.

Advocacy is an important component of a comprehensive system of oversight and accountability. Children and young people, as a group, are largely disenfranchised. They have very little political power and, in many cases, a limited say in decisions that affect their lives and best interests.[19]

Inspections and visits

Visits and inspections are important tools for oversight and monitoring. Visits, which involve attending facilities or organisations to meet with service users, and inspections, which involve a systemic and more rigorous examination of facility administration, standards and treatment, grant oversight bodies a unique understanding of, and insight into, safety and wellbeing. These functions are particularly important in closed environments. Unrestricted access to closed facilities, including opportunities to speak privately with service users and staff, is indispensable for effective independent oversight.

A best-practice system of inspection should include:

- an appropriate number of trained, independent inspectors with the capacity to understand and engage with children and young people
- adequate powers to access facilities, records and information, and to speak privately with service users and staff
- the capacity to undertake a regular program of inspections and visits
- objective, sophisticated sector standards for inspection of all services and facilities
- the capacity to undertake unannounced inspections
- a system of complaints receipt, referral and follow-up
- the power to ensure that inadequate standards and gaps in service delivery are addressed and followed up.[20]

Engaging with children and young people as service users is particularly important to understand the practical application of policy and procedure.

Visits and inspections can be either announced or unannounced, with both offering distinct benefits. Announced inspections can serve to incorporate facility administration more inclusively and collegiately into the oversight process and, rather than seeking to shame organisations into action, can encourage them to reflect critically on their own service delivery. Announced visits are also more likely to foster positive relations between the oversight body and the agency being inspected. Conversely, unannounced visits can serve to ensure facility standards are consistently maintained over an extended period.

Investigations and reviews

Investigative and review functions allow oversight agencies to conduct broad-based, systemic inquiries into particular aspects of an organisation's service delivery. Typically, oversight bodies with investigative powers undertake thematic or targeted reviews. Thematic reviews examine a particular area of service provision that might exist across a sector or facility and can include an examination of a sector as a

whole. Targeted reviews ordinarily examine an individual or group's particular experience of an agency's service provision.

Oversight agencies with investigative functions are ordinarily invested with a broad range of powers to facilitate access to relevant information in the course of an investigation, these include powers to:

- visit or inspect any part of a particular facility
- interview any relevant person, including staff, patients or detainees
- require staff to provide assistance to investigators
- inspect, or take copies of, any relevant document
- audit files to understand the application of policy and procedure.

In addition to having adequate investigative powers, a best practice system of investigations and reviews should:

- have the capacity and required expertise to engage with and seek the views of children and young people during the course of an investigation
- have the financial and operational capacity to initiate reviews when required, to exercise all appropriate powers in the course of such a review, and to monitor compliance with recommendations or findings.

Reporting

An agency's reporting function is the natural consequence of its information gathering function. Reporting allows oversight bodies to make recommendations in relation to issues identified through information gathering and to use those findings to advocate for systemic changes. Oversight agencies must also be able to exercise reporting functions independently and publicly. While seeking comment from agencies and providers under review is commonly carried out in the course of an investigation, independent oversight agencies should be able to report freely and publicly on findings.

An oversight body's ability to make recommendations depends largely on its object and purpose and the powers with which it is invested under its constituent legislative or policy document. The recommendations made by oversight bodies typically range from specific findings about discrete clients, detainees or patients to general comments about system administration, sector failings or institutional structure.

A key measure of an oversight bodies' effectiveness is the extent to which its recommendations are complied with and findings acted upon. Monitoring bodies are not, as a general rule, invested with the power to enforce departmental compliance with their recommendations. This is an unavoidable consequence of such bodies' independence from government and the importance in a democratic system for the government to retain the ultimate decision making power with respect to

expenditure and service delivery. Notwithstanding the absence of enforcement powers, oversight agencies consistently identify the inability to attach consequences to the failure to implement recommendations as a significant gap in their powers.[21] This inability results in oversight agencies investing considerable time and resources in follow-up work that seeks to monitor department or facility progress on recommendations as well as effort spent trying to encourage compliance.[22]

Post-report monitoring ordinarily includes site visits, audits, departmental progress reports, independent progress assessments and, importantly, behind-the-scenes dialogue with administrators and departments. Strengthening the accountability of government through the requirement to respond formally, either accepting or rejecting the recommendations of oversight agencies would improve the efficiency and effectiveness of the investment in oversight.

Example

Persistent noncompliance – 'show cause' notices

While the Inspector of Custodial Services is statutorily empowered to report on and make recommendations concerning performance standards, he is unable to compel compliance. The consequences of noncompliance were demonstrated in 2008 when, after repeated warnings from the Office of the Inspector of Custodial Services about prisoner transport services, an Aboriginal Elder died from heatstroke in a prison van. The incident precipitated changes to the *Inspector of Custodial Services Act* investing the Inspector with the power to issue the Department with show cause notices "if the Inspector suspects on reasonable grounds that there is, or has been, a serious risk to the security, control, safety, care or welfare of a prisoner, detainee or person in custody, [or] that a prisoner, detainee or person in custody is being, or has been, subjected to cruel, inhuman or degrading treatment".[23] After having received a notice, the Department has three days to make submissions to the Inspector with respect to its contents. If the Inspector is satisfied, pursuant to departmental submissions, that the circumstances giving rise to the notice have been, or are being addressed, they may decide to take no further action. Alternatively, the Inspector may choose to refer the matter specified in the notice to the Minister with recommendations for improvement. These additional powers were borne out of recognition of the fact that "process failures of different agencies and organisations are not always readily apparent from static inspections of facilities or equipment".[24]

Collaboration

In lieu of a single, overarching external agency, an oversight system that endeavours to ensure comprehensive monitoring of children and young people's services must foster coordination and collaboration between oversight bodies. High-

quality, systematic collaboration between agencies can serve to ensure that the intersections, overlaps and differences between these bodies are capitalised on or remedied.[25] In the absence of systematic collaboration, oversight mechanisms can instead operate "in tension with one another, in the sense of having different concerns, powers, procedures and culture which generate competing agendas and capacities".[26] This can lead to uncertainty, confusion and, in some instances, competing mandates.[27]

Western Australia has complementary and overlapping agency responsibilities that provide a 'safety net' of coverage, whereby children and young people's interests are safeguarded by several overlapping levels of protection. Good communication between agencies avoids fragmenting responsibility and prevents confusion about roles, gaps in monitoring and ultimately weaker protection.

Certain oversight bodies, including the Commissioner for Children and Young People, are under additional statutory obligations to take reasonable steps to avoid the duplication of functions performed by other agencies thus rendering collaboration and communication exceedingly indispensable.[28]

Collaboration and information sharing arrangements, particularly in situations where oversight mandates overlap, can serve to streamline oversight making agencies more efficient. It is perhaps best illustrated by the situation in the juvenile justice system. For example, allegations of misconduct by youth justice workers could fall within the jurisdiction of the Corruption and Crime Commission or the Public Sector Commission, may have arisen as a direct result of complaints received by the Ombudsman or information obtained by the Office of the Inspector of Custodial Services, and could appropriately form the subject of a special inquiry by the Commissioner for Children and Young People or an aspect of a performance examination conducted by the Auditor General.

It is equally important to be cognisant of the effect that compliance burden can have on organisations and service providers.[29] Rigorous accountability mechanisms can practically impinge on agencies' capacity to carry out core functions. It is important therefore, that oversight measures are stringent without being so burdensome as to undermine an organisation's core business.[30] Oversight bodies should also have the capacity to collaborate with one another in order to meet legislative obligations not to duplicate the work of other bodies and to capitalise on intersecting mandates so as to reduce reporting burdens for service providers and departments.[31]

Features of best practice oversight mechanisms

The following table provides an overview of best practice, with respect to children and young people, for discrete oversight mechanisms. The content of the table was drawn from diverse academic literature on oversight of child services as well as previous consultations with children and young people undertaken by the Commissioner for Children and Young People on complaints and grievance processes.

Oversight mechanism	Strengths	Weaknesses	Best practice for children and young people	
Complaints handling and misconduct processes **Receipt and investigation of complaints about services or agencies**	Complaints mechanisms provide service users with an opportunity to express concerns about the provision of a service to a body external to the provider. Complaints mechanisms can alert organisations to poor service delivery or facility standards. Complaint information is an important resource for evaluating strengths and weaknesses in service delivery. Complaints mechanisms can provide redress to individual complainants. Complaints mechanisms operate continuously.	Complaints mechanisms are typically reactive. They require proactive complainants who know and are prepared to assert their rights and are able to identify maltreatment. Children and young people, particularly those who are vulnerable or disadvantaged for any reason, often do not possess the skills, knowledge or desire to seek out complaints bodies. Complaining without the support of an advocate can be impossible for children and young people with disability or communication difficulties. In many organisations that deliver services to children and young people, particularly closed environments like detention centres, there is a significant power imbalance between the provider and the service users. This can render children and young people reluctant to complain and fear repercussions for doing so. Complaints processes typically comprise multiple steps that can deter children and young people from pursuing complaints through to resolution. Complaints handling is resource intensive, which can affect a complaints handling body's ability to undertake systemic investigations.	**Statutory independence** Complaints mechanisms should be statutorily independent from government agencies and service providers. This includes being independent with respect to their functions and personnel. **Complemented by individual advocacy mechanisms** Complaints bodies should be complemented by individual advocates to help children make complaints and raise concerns about their treatment. **Proactive** Complaints handling bodies should proactively seek to elicit information from children and young people about their treatment. **Visible** Strategies to publicise external complaints systems need to include a range of methods that are effective in communicating with children and young people. **Accessible** Children and young people need to be informed who to make complaints to and how to make them. Complaints bodies must make a number of methods available for lodging complaints. **Resourcing** Complaints mechanisms should be adequately resourced in order to be able to exercise all functions effectively. **Culturally sensitive** Complaints mechanisms should be accessible to members of the public from linguistically and cultural diverse backgrounds. Effort should be made to ensure mechanisms are responsive to the needs of Aboriginal and Torres Strait Islander children and young people, and can adapt to meet cultural requirements.	**Responsive** Complaints systems must be responsive to children and young people once they have complained, staff must be trained to listen actively and respond quickly. **Confidential** All complaints systems should treat complainant's information as confidential. **Accountable** The specific needs of children and young people should be recognised in accountability and continuous improvement processes. **Flexible** Complaints mechanisms must be sensitive to the specific needs of children and young people, particularly children and young people with disability or who may have trouble making a complaint on their own behalf for any reason. Mechanisms should be prepared to deal with a guardian, friend, advocate or family member acting on behalf of a complainant. **Power to identify thematic trends** Complaints handling mechanisms should have the capacity to analyse complaints in order to identify and investigate thematic trends in complaints received. **Trustworthy** Complaints mechanisms should be trusted to do what they say and inspire public confidence.
Inspections and visits **Systematic inspection of and visits to services and facilities**	Inspection and visiting regimes are proactive and do not rely on individual complaints to expose poor service delivery or facility standards. Inspection and visiting regimes are an important source of information for providers and oversight bodies about what takes place in a facility or service. The mere presence of an inspection regime can motivate improvements to practice, procedure and facility standards, while also deterring breaches.	Where inspections take place relatively infrequently, they only provide a point-in-time snapshot of facility practice, process and procedure. Monitoring bodies are unable to compel compliance with inspection recommendations and findings. Inspections are resource intensive and impose an administrative burden on facilities, which affects the frequency at which they can be undertaken.	**Statutory independence** Inspection bodies should be statutorily independent from government agencies, service providers and facilities being inspected. This includes being independent with respect to their functions and personnel. **Staff and expertise** Inspection mechanism should have an appropriate number of trained inspectors with the expertise to understand and engage with children and young people. **Adequate resources** Inspection bodies should be adequately resourced to allow for systematic inspection and follow-up monitoring. **Frequency** Inspections and visits should take place systematically and at a frequency commensurate to the nature of the facility or service. **Inspection standards** Objective, sophisticated inspection standards should be developed for discrete services and facilities. **Unannounced inspections** Inspection mechanisms should have a legal basis to undertake unannounced inspections. **Culturally sensitive** In facilities with high numbers of Aboriginal and Torres Strait Islander children and young people, accommodation should be made to ensure inspection mechanisms are responsive to their needs and can adapt to meet cultural requirements. For example, by ensuring inspectors receive cultural awareness and cross-cultural communication training.	**Complaints referral** Inspections mechanisms should operate a system of complaints receipt, referral and follow-up. **Follow-up monitoring** Inspection mechanisms should have the power to ensure inadequate standards and gaps in service delivery are addressed and followed up. They should have the power to escalate concerns about persistent noncompliance to a relevant Minister or Parliament. **Collaborative** Inspection mechanisms should seek to collaborate, where possible, with service providers to promote best practice and negotiate improvements to service delivery. **Adequate powers** Inspectors should have the power to do all things necessary to be done for, or in connection with, the performance of their functions. This includes: • free and unfettered access to facilities, at any time • free and unfettered access to relevant documents • the ability to meet with children and young people confidentially • the ability to interview staff confidentially • the power to report on findings. **Resourcing** Financial and operational capacity should permit inspection mechanisms to exercise all powers when warranted.

Independent oversight

Oversight mechanism	Strengths	Weaknesses	Best practice for children and young people	
Individual advocacy **Provision of advice and support to individual children and young people**	Individual advocates can speak on a child or young person's behalf when required, help them to negotiate complaints or grievance mechanisms, and help them to make or understand decisions about their care or treatment. Individual advocates can help children understand and exercise their rights. Individual advocacy can complement and improve the operation of other oversight mechanisms, particularly complaints handling bodies and misconduct processes by receiving and referring complaints. Unlike other oversight mechanisms, individual advocates prioritise the interests of individual children and young people to the exclusion of sometimes conflicting parent, carer or service provider interests. Individual advocacy is tailored to the needs and vulnerabilities of individual children.	Effective individual advocacy depends largely on the skills, expertise and availability of advocates. Individual advocacy is resource intensive. Geographical distance in Western Australia can make it challenging to have independent advocates available to all children and young people.	**Staffing and expertise** Individual advocacy mechanisms should have an appropriate number of trained advocates to ensure support can be provided systematically and promptly when requested. This includes staff trained to communicate with and support vulnerable children and young people , including those with complex needs. **Statutory independence** Individual advocacy mechanisms should be statutorily independent from government agencies and service providers. This includes functional independence and independence of personnel. **Investigative powers** Advocates should have the power to investigate and follow-up concerns and complaints of children and young people. **Resourcing** Financial and operational capacity should permit individual advocacy mechanisms to exercise all powers when warranted. **Accountable** Individual advocates should be accountable for their service provision. **Culturally sensitive** In facilities and services with Aboriginal and Torres Strait Islander children and young people, individual advocates should ensure mechanisms are responsive to their needs and can adapt to meet cultural requirements. Staff should be trained in cross-cultural awareness and communication, and, if necessary, dedicated Aboriginal liaison staff should be employed.	**Accessible** Children and young people need to be informed about the existence and role of individual advocates. **Proactive** Advocates should proactively engage with children and young people. **Collaborative** Individual advocates should maintain a good relationship with service providers and government agencies. They should also communicate regularly with systemic advocacy bodies. **Best interests** Individual advocates should, in certain circumstances, be empowered to make 'best interests' determinations, while also being sensitive to each child or young person's needs and wishes. **Entry and access** Individual advocates should have statutory powers to enter facilities or services and meet privately with service users.
Systemic advocacy **Action taken to influence or engender systemic change, and to promote the rights and interests of children and young people**	Systemic advocacy's focus on broad, systems-level issues, such as policies, practices and procedures, which can lead to improved service delivery for groups and address the concerns of individuals.	It is difficult to measure the impact or success of systemic advocacy, apart from an agency's clear acceptance of and compliance with recommendations. The effectiveness of systemic advocacy depends on receptive agencies or government departments recognising weaknesses in policy, practice or procedure and being willing to implement recommendations. Advocacy bodies are often granted broad mandates that cover a wide breadth of issues. This can affect their ability to undertake sustained advocacy on specific issues.	**Staffing and expertise** Staff should have expertise in relevant areas, including child protection, juvenile justice and disability services. As well as a high level of skill in political analysis and awareness of evolving government priorities in order to advocate for, and negotiate changes to, policy, practice and legislation. **Statutory independence** Systemic advocacy mechanisms should be statutorily independent from government agencies and service providers. This includes functional independence and independence of personnel. **Participation of children and young people** Systemic advocacy mechanisms should consult with children and young people, in age appropriate ways, on issues that affect their lives and wellbeing, and encourage the participation of children and young people in decision making processes. **Accessible** Mechanisms should be accessible to children and young people and employ a variety of methods to seek their views and opinions. **Resourcing** Financial and operational capacity should permit systemic advocacy to be able to exercise all powers when warranted. **Culturally sensitive** Systemic advocacy bodies should ensure their work is reflective of the needs and interests of Aboriginal and Torres Strait Islander people by undertaking culturally sensitive consultation, ensuring staff are trained in cross-cultural communication, and Aboriginal and Torres Strait Islander staff are employed.	**Diverse functions** Systemic advocacy bodies should carry out a range of functions to promote the rights and interests of children, including: • monitoring compliance with legislation, policies and international obligations • scrutinising impending legislation and initiatives • conducting and coordinating research into best practice in fields involving children and young people • promoting the participation of children and young people in decision making processes • investigating systemic issues in service delivery and recommending changes to practice and procedure. **Follow-up monitoring** Systemic advocacy mechanisms should have the power and capacity to monitor facility or service provider compliance with recommendations to address systemic issues in service delivery. **Strategic planning** Systemic advocacy mechanisms require clear strategic goals to ensure a consistent and coherent advocacy direction. **Collaboration and communication** Systemic advocacy mechanisms should have the capacity to collaborate with other oversight mechanisms to capitalise on intersecting mandates, particularly individual advocates and complaints handling bodies. Through information sharing systemic advocacy bodies can remain aware of emerging trends and patterns in service delivery.
Inquiry and review **Targeted or thematic reviews, inquiries or investigations into systemic issues in service provision or facility standards**	Inquiries, reviews and investigations are able to undertake detailed examinations of systemic issues in policy, practice and procedure and recommend changes to improve service delivery. Oversight bodies with inquiry functions are typically invested with broad, coercive powers that permit comprehensive review.	Inquiries, reviews and investigations are resource intensive and can impose an administrative burden on service providers and facilities. Inquiries, reviews and investigations are often point-in-time and do not offer regular, ongoing monitoring. Inquiries, reviews and investigations typically focus on specific issues in policy, practice or procedure and alone do not provide comprehensive oversight of systems or facilities. The effectiveness of these mechanisms depends on receptive agencies being willing to accept and implement recommendations.	**Statutory independence** Inquiry and review mechanisms should be statutorily independent from the government agencies or service providers being reviewed or investigated. **Adequate powers** In the course of an inquiry or review, oversight agencies should have the power to do all things necessary to be done for, or in connection with, the performance of a review. This includes the power to: • visit or inspect any part of a particular facility • interview any relevant person, including staff, patients or detainees • require staff to provide assistance to investigators • inspect, or take copies of, any relevant document. **Reporting** Oversight bodies should have the power to publish reports of findings and recommendations.	**Participation of children and young people** Inquiry and review mechanisms should have the ability to seek the views of children and young people in the course of an investigation and to meet privately and confidentially with children and young people. **Follow-up monitoring** Inquiry and review mechanisms should have the resource capacity to monitor compliance with recommendations or findings. **Resourcing** Financial and operational capacity should permit investigative mechanisms to exercise all powers warranted in the course of an investigation. **Frequency** Oversight bodies with investigative functions should have the power and capacity to carry out inquiries

Oversight of services for children and young people in Western Australia

In order to examine the nature of oversight arrangements as they relate to children and young people, it is important to understand the organisations, services and facilities with which they come into contact.

Services are delivered in most areas of a child or young person's life and range from universal public services, like health and education, to private recreational associations and activities, such as sporting clubs and the Scout movement. These services are delivered by government, non-government or private providers and are subject to a broad range of funding and contracting arrangements. While all child and youth services should be subject to a level of oversight and accountability, this chapter will focus specifically on six sectors in which the number of children and young people present or their heightened vulnerability render them at an increased risk of abuse or maltreatment. These are out-of-home care services, mental health services, police custody, education, youth justice, and disability services.

The largest government agencies delivering public services to children and young people in Western Australia are the Departments of Communities, Justice, Health and Education. In addition to direct service provision these agencies also procure non-government organisations to deliver public services. Government-funded community sector services have become increasingly involved in the delivery of public services to children and young people in a range of fields, including child protection, youth justice and health and disability services. Privatising or contracting elements of public service delivery should not lead to diminished oversight and accountability. Nevertheless, contracting inevitably complicates the jurisdiction of external agencies that are largely responsible for the oversight of public sector service delivery. In the event that a public service is contracted to a private or non-government provider, it is essential that regulatory mechanisms remain robust in order to counteract the risk of an oversight deficit.[32] Comprehensive oversight and accountability standards should ensure that the public, through public officers, retain regulatory control over contracted services. Accordingly, independent external oversight agencies should be empowered to monitor services pursuant to the nature of the service provided, not the nature of the organisation providing it. In light of this, in addition to oversight of government provided services, this chapter equally assesses the level of oversight accorded to privatised, contracted and non-government organisations as a discrete group of providers delivering public services.

Scope of discussion

By understanding the relationships between the oversight agencies operating in these fields and delineating their jurisdiction and powers, this chapter seeks to identify areas of best practice as well as potential inefficiencies or duplications in the

current framework. In so doing, it describes the independent mechanisms responsible for the five primary aspects of oversight and monitoring in each field. These are:

1. complaints handling and misconduct processes
2. individual advocacy
3. inspections and visits
4. investigations and reviews
5. systemic advocacy

Statutory oversight bodies in WA

There are 11 bodies that comprise the core of Western Australia's framework of independent statutory oversight and accountability. Brief summaries of the work of these bodies are included at Appendix 1. The Corruption and Crime Commission and the Public Sector Commission have specific functions in relation to misconduct applicable across all public sector agencies. The Equal Opportunity Commission and the Office of the Information Commissioner provide avenues for complaints specifically related to discrimination and the *Freedom of Information Act*, respectively. Other than the gap in relation to oversight of misconduct in services provided through non-government services, the functions of these agencies are not described in detail.

The remaining seven bodies that are addressed in detail in relation to services for children and young people are:

1. Office of the Inspector of Custodial Services
2. Mental Health Advocacy Service
3. Chief Psychiatrist
4. Commissioner for Children and Young People
5. Health and Disability Services Complaints Office
6. Auditor General
7. Ombudsman.

These bodies have diverse functions that relate specifically and generally to the safety and wellbeing of children and young people. These functions range from the very broad, such as promoting and protecting the rights of all children and young people, to the very specific, such as reviewing circumstances that relate to the deaths of certain children. Many of these bodies are, to varying degrees, empowered to monitor and review organisational processes, procedures and practices and to advocate for the best interests of children and young people. In addition to monitoring and advocacy functions, a number of the State's independent oversight agencies are also invested with investigative and complaints handling functions. This includes investigating individual complaints and the systemic or thematic issues to which they give rise.

Internal monitoring and review

Internal monitoring and review processes play an important role in safeguarding the health and wellbeing of service users, and the continual improvement and development of service delivery, policy and practice. Organisations providing services to children and young people all, to a greater or lesser degree, operate internal systems of monitoring that comprise complaints processes, advocacy and support services, standards monitoring and review, or a combination thereof. Some organisations have established independent yet internal positions to provide a higher level of internal review, for example, the Commissioner for Victims of Crime and the Independent Assessors (Department of Communities).

While internal monitoring and review processes are not the focus of this report, they are an important part of the system for ensuring the safety and quality of services to children and young people. Done well, internal monitoring and review can provide efficient and timely opportunity for any corrective action for individuals and for systemic improvement. Independent external oversight provides the checks and balances needed for accountable and safe governance and is not intended to replace internal monitoring and review. For this reason, the following information on internal monitoring and review is included to provide context to the role of independent oversight agencies.

Internal complaints processes

Internal complaints processes are a fundamental part of ongoing organisational development and seek to ensure services are meeting the needs of the intended consumers.[33] They are an important mechanism for correcting mistakes and protecting people from abuse and mistreatment. All Western Australian government agencies are required by the Public Sector Commission to operate a complaints system that accords with the *Australian Standards for Customer Satisfaction – Guidelines for complaints handling in organisations*. The Ombudsman's Guidelines on Complaint Handling also provide information on the establishment of an effective complaints system.

The Commissioner for Children and Young People WA has developed best-practice guidelines for making complaints systems accessible and responsive to the needs of children and young people.[34] The guidelines hold that an effective, child friendly complaints system must be accessible, responsive, confidential and accountable.[35] It is the responsibility of all government agencies to develop complaints systems that accord with these principles in order to provide clients and service users, including children and young people, with an opportunity to express their views, be they as complaints about treatment or general feedback on service provision.

Despite best practice guidelines, complaints systems can be difficult to navigate, making the successful resolution of a complaint, to a large extent, dependent upon

the assertiveness of the complainant. Children and young people face particular barriers to making complaints, including lack of information on complaints systems, concerns about getting people into trouble or fearing repercussions, not being believed or taken seriously, concerns about breaches of confidentiality and lacking confidence in the outcome of making a complaint.[36] Inquiries have shown that these concerns are not unfounded.

Certain environments present a particular challenge for internal complaints handling. The Office of the Inspector of Custodial Services' report on an announced inspection of Banksia Hill Juvenile Detention Centre illustrates the unique obstacles many children and young people face when making complaints through internal processes. The Inspector noted that while the Department of Justice's internal complaints system, ACCESS, is available to detained young people, the "low numbers of complaints [lodged] during periods of considerable disruption" was concerning.[37] The Inspector also noted that many young people in the centre "had not heard of or did not understand the role of ACCESS".[38] While a number of detainees had raised concerns about the conduct of youth custodial services staff, they were reluctant to pursue formal complaints due to a lack of confidence in, or knowledge of, the departmental complaints processes.[39]

In order for a complaints system to be accessible and responsive to the needs of children and young people, complaints infrastructure must be accompanied by rights education and ongoing advocacy and support. Children should be informed of their right to complain, given assurances that their complaints "will be treated seriously, sensitively, [and] safely" and, ultimately, encouraged and supported during the process.[40] Passive complaints systems that rely on proactive complainants can be ineffective for children and young people for whom the process can be overwhelming. Illustrating this point, the Office of the Inspector of Custodial Services has noted that a single independent visitor report, prepared by an individual who meets with young people and actively seeks to elicit information about their treatment, "typically generated as many complaints as ACCESS fielded in two years".[41]

Internal advocacy and support

Mechanisms for systemic and individual advocacy have, to varying degrees, been established within some government agencies. While the extent to which such mechanisms are able to undertake robust, fearless criticism of internal departmental processes is limited by their level of independence, they nonetheless play an important role.

The Department of Communities' Advocate for Children in Care, an internal position providing advocacy services on behalf of children and young people in care, provides systemic and individual advocacy to varying degrees. On an individual level, the Advocate seeks to encourage child and youth participation by informing young

people about, and providing young people with, support during complaints handling processes. In addition to advocating on behalf of individual children and young people, the Advocate undertakes a level of systemic advocacy. This involves recording and reporting on themes in complaints and working with sector stakeholders to address systemic issues in service delivery that may be affecting the rights and wellbeing of children in care.

Certain government agencies also operate internal visitor services that provide individual advocacy and support to clients and service users. The Department of Justice's Aboriginal Visitors Scheme seeks to provide Aboriginal detainees, including children and young people held in police lockups, prisons and detention centres, with additional support. The scheme is intended to monitor the safety and wellbeing of Aboriginal and Torres Strait Islander people held in custody and advocate on behalf of individual detainees by advising officers on issues, including a detainee's healthcare needs and general wellbeing.

Internal monitoring and compliance

Agencies and service providers also undertake, to varying extents, internal standards and compliance monitoring. As outlined in the preceding section, internal monitoring does not adhere to a uniform set of criteria. Agencies are typically guided by human rights standards, good governance criteria, sector specific guidelines or internal rules. Internal monitoring allows agencies to improve operations internally while also identifying and addressing issues with service delivery. Internal standards monitoring is a foundational element of oversight and provides agencies with an opportunity to reflect actively and systematically on their service delivery.

Mapping independent oversight to children and young people's services

The following table provides a quick reference to the existing independent oversight agencies coverage of the key service providers for children and young people and their alignment to identified best practice in meeting the needs of children and young people.

Assessing the adequacy of oversight arrangement requires a pragmatic lens that considers the complexity of factors that impact on the practical effectiveness of oversight. The frequency at which a function is carried out or the extent of children and young people covered by a particular function can have a significant impact. For example, the Commissioner for Children and Young People has significant powers to conduct inquiries however this function has never been exercised and requires specific resourcing. Comments on the strengths and gaps provide further information in relation to the why a particular best practice rating has been provided.

Statutory independent external oversight

Children and young people

Alignment to best practice	
Met	✓✓✓
Partially met	✓✓
Independent oversight absent	✘

			Complaints handling	Individual advocacy	Inspections and visits	Investigations and reviews	Systemic advocacy	Misconduct processes	Key strengths	Gaps
Out-of-home care	***Government services***	**Foster care with family**	✓✓	✘	✘	✓✓	✓✓	✓✓✓	Ombudsman visits to out-of-home care service providers can increase awareness of independent complaints resolution. Ombudsman has power to assess service compliance with departmental safety standards.	Several bodies with powers to carry out reviews and investigations but infrequently exercised. No independent misconduct process for staff in non-government out-of-home care services. No independent individual advocacy to support children and young people to navigate the system and maximise the effectiveness of complaints processes. This is critical given the vulnerability of children and young people in care.
		Non-relative foster care	✓✓	✘	✘	✓✓	✓✓	✓✓✓		
		Residential care	✓✓	✘	✘	✓✓	✓✓	✓✓✓		
	Non-government services	**Foster care**	✘	✘	✘	✓✓	✓✓	✘		
		Residential care	✘	✘	✘	✓✓	✓✓	✘		
Youth justice		***Youth detention***	✓✓✓	✓✓	✓✓✓	✓✓✓	✓✓	✓✓✓	A range of independent mechanisms with comprehensive powers of review and investigation. Regular, proactive visits by individual advocates who support detainees to complain and monitor general wellbeing (detention only). Comprehensive complaints processes supported by individual advocacy (detention only). Regular, systematised inspections supported by the power to conduct follow-up visits and compliance monitoring (detention only).	No systematic monitoring of community corrections
		Community corrections	✓✓	✘	✘	✓✓	✓✓	✓✓✓		
Police custody			✓✓	✘	✘	✓✓	✓✓	✓✓✓	Independent misconduct body, the Corruption and Crime Commission, has comprehensive investigative powers.	Independent bodies with the power to conduct reviews of and investigations into police custody however they have not been exercised. No regular, systematic independent inspections of police custodial facilities. Inspector of Custodial Services has jurisdiction over only 6 of 125 facilities. No independent individual advocacy to support children and young people while detained. Complaints can be made to the Ombudsman however it is unclear if detained children and young people are made aware of their rights, including their right to complain.
Disability services	***Government services***		✓✓	✘	✘	✓✓	✓✓	✓✓✓	Specialist disability services complaints handling body. Disability services complaints can be made by a relative or carer on behalf of a service user.	Several bodies with powers to carry out reviews and investigations of disability services but not exercised. No regular, systematic independent inspections of disability services. No independent misconduct process for staff in department funded out-of-home care. No independent individual advocacy.
	Non-government services		✓✓	✘	✘	✓✓	✓✓	✘		
Mental health services	***Government services***		✓✓✓	✓✓✓	✓✓	✓✓	✓✓	✓✓✓	Specialist investigation and complaints handling body with specific oversight of health services. Proactive individual advocacy with broad powers of investigation and entry. Systematic, independent reviews of clinical practice. Multiple avenues to lodge complaints about mental health services, including to proactive advocates.	Several bodies with inspectorial powers however no systematic facility inspection. No independent misconduct process for staff in non-government mental health care services. Voluntary patients are not proactively visited or otherwise contacted by mental health advocates.
	Non-government services		✓✓✓	✓✓✓	✓✓	✓✓	✓✓	✘		
Education	***Government***		✓✓	✘	✘	✓✓	✓✓	✓✓✓	Comprehensive misconduct processes. Frequent inquiries, reviews or audits of the public education system.	No independent bodies with individual advocacy or inspection mandates. Inquiry and review powers either do not apply or are not exercised with respect to independent and catholic schools.
	Non-government		✘	✘	✘	✘	✓✓	✘		

Out-of-home care

Out-of-home care refers to the care of children and young people 0 to 17 years who, for reasons including child abuse, neglect and maltreatment, are unable to live with their families. At 30 June 2017, there were 4,795 children and young people in out-of-home care in Western Australia.[42] The majority (80%) were in private home-based care – 43 per cent in family foster care, 26 per cent in departmental non-relative foster care, and 11 per cent in funded service foster care.[43] The remaining children in out-of-home care, typically those with more complex needs and increased vulnerability, were in departmental residential care (2%) or funded service residential care (6%).[44] Of all children and young people in out-of-home care 71 per cent were in a department provided service.[45]

Around one-third (32%) of all children in care were aged give to nine years.[46] The next largest age bracket was 10 to 14 years (30%) followed by one to four years (22%) and 15 years and older (13%). Approximately three per cent of all children in out-of-home care are younger than one year old.[47]

At 30 June 2017, there were 2,603 Aboriginal and Torres Strait Islander children and young people in out-of-home care in Western Australia.[48] This constituted 54 per cent of all children and young people in out-of-home care in the State.[49]

Around two-thirds of all Western Australian children and young people in the out-of-home care system are on a placement of more than two years – 38 per cent of all children and young people in care are on placements of five years or more.[50]

Oversight arrangements

In Western Australia, the current multi-tiered system of oversight for the child protection and out-of-home care system is comprised of certain generalist independent oversight mechanisms, internal and external complaints processes, departmental specialist oversight and monitoring, standards and performance reporting requirements, pre-employment screening, and internal advocacy services. Independent oversight is largely carried in Western Australia out by:

- the Ombudsman
- the Auditor General WA
- the Commissioner for Children and Young People.

Complaints handling and misconduct processes

Independent oversight bodies

Ombudsman

Equal Opportunity Commission

Corruption and Crime Commission

Public Sector Commission

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Independence: All external complaints bodies and misconduct processes with jurisdiction over the out-of-home care system are statutorily independent and invested with broad investigative powers.

Visible: The Ombudsman in particular has strategies to publicise the availability of the office, including visiting out-of-home care service providers and facilities. This only applies to residential facilities and does not include the vast majority of children who are in foster or family based care.

Power to identify thematic trends: The Ombudsman analyses trends in complaints received in order to identify and investigate systemic issues in service delivery.

Complemented by individual advocacy: No independent statutory individual advocacy body in WA.

At least three types of complaints arising from conduct or practice in the out-of-home care system can be made to independent external complaints handling and misconduct bodies: complaints related to departmental administrative practice, complaints alleging unlawful discrimination, and complaints alleging staff misconduct.

Complaints to the Ombudsman must be made by an individual affected by the issue and must relate to an action, decision or omission by the Department. This precludes receipt of complaints about department funded non-government service providers.

The Ombudsman conducts visits to government and funded out-of-home care services in order to inform children and young people about the role of the Office and to provide them with an opportunity to make complaints directly.[51] In 2016, this included visits to:

- the Kath French Secure Care Centre

- two residential group homes in the Perth metropolitan area
- two residential group homes and one family group home in the Pilbara Region
- one residential group home in the Kimberley Region.

In 2016-17, the Ombudsman received 79 complaints related to child protection. It is unclear how many of those complaints related to out-of-home care services.[52]

Individual advocacy

Independent oversight bodies

None

Best practice alignment: Absence of a statutory individual advocacy body.

In the Western Australian child protection and out-of-home care system, individual advocacy is the responsibility of the Advocate for Children in Care. The Advocate, as an employee of the Department working in the Office of the Director General, is however, neither independent nor external. Independence, as a defining characteristic of external oversight, is achieved through independence of funding, location, power, resources and expenditure. Therefore, while the Advocate for Children in Care fills an important gap in oversight of the out-of-home care system, the mechanism's foundation does not accord with contemporary definitions of independent oversight. A 2016 consultation by the Commissioner for Children and Young People, focusing on raising concerns and making complaints in care, revealed that of the 81 children consulted 28 (35%) were aware of the existence of the Advocate while 53 (65%) had not heard of the position.[53]

Inspections and visits

Independent oversight bodies

None

Best practice alignment: No statutorily independent inspection body. Inspections of organisations operating in Western Australia's out-of-home care system are undertaken by Independent Assessors pursuant to the *Children and Community Services Act 2004*. Assessors, appointed and remunerated by the Department of Communities, can at any time, visit an out-of-home care facility in order to:

- inspect the facility
- inquire into the operation and management of the facility
- inquire into the wellbeing of any child in the facility
- see and talk with any child in the facility
- inspect any document relating to the facility or to any child in the facility.[54]

Any child in an out-of-home care facility, or a parent or relative of a child, may request that the person in charge of the facility arrange for an assessor to visit the

facility and see and talk with the child.[55] Notwithstanding specific requests, Independent Assessors also undertake a process of systematic visiting. Based on current inspection trends and timeframes, each out-of-home care service provider will be visited by an Independent Assessor at least once every six to eight years.[56]

While independent assessors fill a critical gap in the oversight of Western Australia's out-of-home care system, significant weaknesses in their mandate and ambiguity in their role and purpose have restricted the mechanism's effectiveness on a range of fronts. Centrally, the manner by which Assessors are appointed and the nature of their relationship with the Department render the mechanism insufficiently independent and robust for the purposes of effective external oversight.

Investigations and reviews

Independent oversight bodies

Ombudsman

Auditor General WA

Public Sector Commission

Commissioner for Children and Young People WA

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Independence: All mechanisms empowered to undertake investigations, inquiries or reviews into the out-of-home care system are statutorily independent from government and service providers.

Frequency: The Ombudsman has undertaken two own-motion investigations into issues related to out-of-home care. The Auditor General has undertaken one review in 2005. The Commissioner for Children and Young People has not exercised review functions in relation to out-of-home care. No oversight body is mandated or resourced to carry out systematic regular reviews of service delivery.

Adequate powers: All oversight bodies with the ability to conduct inquiries or investigations into out-of-home care are invested with comprehensive investigative powers.

A number of independent oversight bodies are invested with investigative functions relevant to the child protection and out-of-home care systems. While these functions are exercised infrequently they are able to provide a comprehensive review of discrete aspects of child protection that can ultimately precipitate systemic and individual advocacy in key areas. The agencies capable of carrying out reviews or investigations in the out-of-home care system include:

- the Ombudsman[57]
- the Auditor General WA[58]
- the Public Sector Commission[59]
- the Commissioner for Children and Young People.[60]

A key function of the Ombudsman is to improve the standard of public administration. One of the ways the Ombudsman does this is to undertake investigations of systematic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. In conducting an investigation, the Ombudsman has all the powers, rights and privileges of a standing royal commission under the *Royal Commissions Act 1968*.

The office of the Ombudsman has conducted two own-motion investigations into Western Australia's out-of-home care system. In 2011, the Ombudsman identified a need to undertake further investigation of child protection care planning and in so doing sought to examine how state government agencies were administering statutory care planning provisions.[61] The Investigation examined the internal policies of the then Department for Child Protection, the Department of Health and the Department of Education as well as relevant provisions of the *Children and Community Services Act 2004*. In 2006, the Ombudsman undertook an investigation into allegations concerning the treatment of children and young people in residential care. This investigation was borne out of a public interest disclosure made to the then Department for Community Development that raised concerns about the administrative framework in the Department's residential care facilities for the protection of children and young people from maltreatment. Both investigations addressed systemic issues in agency practice and resulted in changes to policies and practices in child protection and out-of-home care.

The Auditor General WA is able to conduct performance audits that provide Parliament with an assessment of the effectiveness and efficiency of public sector programs, and identify opportunities for improved service delivery. Unlike the Ombudsman, the Auditor's 'follow the dollar' powers permit examination of the way in which government funds are spent by contracted non-government services. The Auditor, therefore, has the capacity to examine the effectiveness of departmental out-of-home care services as well as funded community sector providers.[62] The Auditor General undertook a review, *Progress with Implementing Responses to the Gordon Inquiry*, in 2005.

The Public Sector Commissioner may, on their own initiative, conduct reviews or investigations into the functions, management or operations of any public sector body.[63] Reviews typically examine organisations, structures, systems, policies and processes while investigations consider specific actions, activities or questions of conduct. The Commissioner is yet to exercise these powers with respect to the child protection or out-of-home care system.

The Public Sector Commissioner is also able to conduct special inquiries into matters related to the Public Sector in which there is a clear and heightened public interest in the comprehensiveness and outcome of the inquiry.[64] The Commissioner may exercise this power on his own initiative or at the direction of the Minister.[65] The *Special Inquiry into the response of government agencies and officials to allegations of sexual abuse,* the only inquiry of this type related to child protection and out-of-home care, was a comprehensive, targeted review of specific abuse allegations that also made broad findings about systemic issues in the child protection and out-of-home care systems.[66]

The Commissioner for Children and Young People is able to conduct special inquiries into matters affecting the wellbeing of children and young people. For the purposes of a special inquiry the Commissioner may enter and inspect any place either with the consent of the owner or occupier, or with a warrant from a magistrate.[67] The Commissioner is entitled to require the attendance of any person to respond to questions under oath and to compel the production of documents.[68] Despite the Commissioner's legislative power to launch such an inquiry, he is not resourced to do so at his own discretion. Consequently, his ability to exercise this power independently is compromised. The Commissioner is yet to exercise this power.

Safety standards review

The Department of Communities has developed service standards that are applicable to all children in the CEO's care irrespective of the nature of the agency providing their out-of-home care arrangement. The quality of out-of-home care provision in Western Australia is monitored internally against these standards by the Department's Standards Monitoring Unit. Providing and funding services while also overseeing standards monitoring is not a best-practice model of objective oversight and can lead to perceptions that a conflict exists between the two competing functions. In recognition of this, as an element of the Department's ongoing reform of the out-of-home care system, the Department intends to cede an aspect of its safety standard monitoring to the Ombudsman. While it remains to be seen how this relationship will work, increasing objective third-party monitoring will, at least, strengthen the legitimacy of the system's oversight arrangements and hopefully lead to better outcomes for vulnerable children and young people.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young people in out-of-home care.

Follow-up monitoring: The nature of the Commissioner's systemic advocacy work means it is difficult to measure its impact or success.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct a special inquiry into identified systemic issues thus limiting functional independence.

Staffing and expertise: The Commissioner has staff with relevant expertise and experience in child protection and out-of-home care.

Systemic advocacy is undertaken by the Commissioner for Children and Young People. The Commissioner has a broad mandate to monitor the wellbeing of all children and young people in Western Australia, with a particular focus on the most vulnerable.[69] The Commissioner is, therefore, statutorily obliged to monitor developments in child protection legislation and oversee policies and practice in the out-of-home care system. To this end, the Commissioner has carried out a range of systemic advocacy, including consultation with children and young people in out-of-home care.

Discussion

Current oversight arrangements in the Western Australian out-of-home care system are marked by insufficiently robust preventive monitoring, and a lack of independent individual advocacy support. Proactive mechanisms that actively seek to elicit information from service users, staff and other relevant people about how services are being delivered, are critical in high-risk environments for abuse and maltreatment. This should include a regime of regular, comprehensive inspections and visits, and a network of proactive, well-resourced, trained individual advocates with the cultural competence and expertise to engage with children and young people in out-of-home care.

At present, Department provided out-of-home care residential services are inspected by a quasi-independent mechanism whose inspections are too infrequent, and standards insufficiently robust, for facilities to be monitored on systematic improvement and timely compliance with recommendations. Inspection and monitoring of the out-of-home care system should involve an objective consideration of the complete care experience of individual children and young people as well as systematic outcomes monitoring. Under the Department's current oversight regime this does not take place. It appears, based on completed assessments that the purpose of the Independent Assessor reviews is to examine individual facility experience and not the child's holistic care experience. As a result, issues that are relevant to the Department in a broader sense, such as case manager practice,

parental contact, education planning, IT issues and staff training, are not regularly reported on during follow-up audits. This role also does not extend to the vast majority of children in out-of-home care who are placed in foster care or family care.

The frequency and rigour of preventive oversight should increase as the vulnerability of children and young people increases. However, at present, the level of oversight of the Kath French Secure Care Centre, a facility designed to accommodate Western Australia's most vulnerable children and young people, while involving more frequent visits from Independent Assessors than other out-of-home care facilities, remains severely inadequate. Children and young people in the facility, almost all of whom suffer from mental illness or have experiences of trauma, neglect and abuse, are not routinely contacted or visited by advocates, and the facility is neither inspected nor visited by a dedicated independent oversight mechanism. While a child or young person held in the facility is permitted to ask to meet with an Independent Assessor, this does not appear to have occurred and Assessors have visited the facility only five times in the last four years.

Oversight of out-of-home care should be conducted within a transparent, coherent and comprehensive monitoring framework that is focused on ensuring the rights of children and young people are upheld, their needs met and a high standard of care provided. Effective, independent oversight is critical to ensuring the safety and wellbeing of vulnerable children, particularly those who lack the advocacy of capable parents.

The level of individual advocacy available to children and young people in care is inadequate. All child protection and alternative care models should be guided by the individual perspectives of children and young people. Children should have access to an independent third party advocate with whom they can not only raise issues that they may have about their care experience but from whom they can receive support navigating the out-of-home care system generally. The unique vulnerability of children and young people in care, and the absence of effective parental advocacy, renders this an indispensable form of oversight.

The lack of a regular, systematic visiting program by an independent advocacy mechanism not only undermines children and young people's right to participate in the making of decisions that affect their lives but also weakens the efficacy of complaints handling bodies.

Significant improvements to outcomes monitoring for children and young people in out-of-home care is also required.

Queensland: Office of the Public Guardian

The Office of the Public Guardian (OPG) is an independent statutory office that promotes the rights and interests of children and young people in out-of-home care or staying at a visitable site. In so doing, the OPG administers a community visitor

and a child advocacy program. OPG Community Visitors are statutorily permitted to visit children and young people at prescribed sites, including private homes (family-based care), residential care facilities, youth justice facilities, and mental health services.

- In visiting children and young people in care Community Visitors carry out a range of functions that include:
- developing a trusting and supportive relationship with individual children, so far as is possible
- advocating on behalf of individual children by listening to, giving voice to, and facilitating the resolution of, the child's concerns and grievances
- seeking information about, and facilitating access by the child to, support services appropriate to the child's needs provided by service providers
- inquiring into and reporting on the adequacy of information given to the child about their rights
- inquiring into and reporting on the physical and emotional wellbeing of the child
- inspecting the home or facility and reporting on its appropriateness for the accommodation of the child
- ensuring the child's needs are being met by persons caring for the child at the home or facility.

Recommendation 1

That a robust, comprehensive system of oversight for all children and young people in out-of-home care be established. This should include:

- Access to an independent advocate to support children and young people to raise concerns about their care.
- Monitoring of the application of policy and practice.
- Monitoring of the outcomes for children and young people in care.

Mental health services

Mental health services are provided publicly by the Western Australian Department of Health and non-government service providers procured through the Mental Health Commission, or privately by general practitioners and allied health professionals and non-government service providers. This includes Child and Adolescent Mental Health Services, emergency services provision, specialist youth services, general practitioner services, school psychologists and online mental health support.

The foundation of youth mental health service provision in Western Australia is Child and Adolescent Mental Health Services (CAMHS). Community CAMHS provides specialist community-based outpatient mental health services for young people across the State, namely infants and children and young people 17 years and under. CAHMS offer assessment, case coordination and multidisciplinary treatment services for children and young people with severe, complex and persistent mental disorders. Young people who have been discharged from an inpatient unit are equally able to access Community CAMHS for follow-up monitoring and support. Community CAMHS is available in 10 locations in the Perth metropolitan area as well as most regional areas.[70]

CAMHS also provide emergency mental health care through hospital emergency departments,[71] the Acute Response Team, and the Acute Community Intervention Team.[72] Community CAMHS deliver specialist inpatient and outreach services through a range of services, including:

- The Bentley Adolescent Unit, a 19-bed inpatient service for children and young people under 18 years (presently with a focus on 0 to 16 year-olds and clinically appropriate 17 year-olds).
- The Fiona Stanley Youth Unit, a 14-bed inpatient service for youth aged 16 to 24 years.
- Eight Youth Hospital in The Home, providing a contemporary alternative to mental health hospital admission and treatment for young people in the North Metropolitan Health District.
- Transition Unit, a recovery-based day program for 12 to 18 year-olds.
- Centre for Clinical Intervention, an outpatient and day patient eating disorders service providing consultation, education, assessment and intervention for 0 to 16 year-olds with eating disorders.

Reliable data that provides information about the mental health and wellbeing of Western Australian children and young people and the extent to which they suffer from mental health problems and disorders is not readily available.[73] In spite of this, a number of inquiries, consultations and research projects have sought to estimate the extent of the problem. The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* has identified young people as experiencing the highest prevalence and incidence of mental illness across the lifespan. Young people

with co-occurring mental health, alcohol and other drug problems are particularly at risk of poor outcomes because their age and stage of physical, neurological, psychological and social development makes them increasingly vulnerable. Evidence indicates that 75 per cent of mental illness emerges by the age of 25[74] and children with intellectual disability are three to four times more likely to experience a mental illness than other children.[75]

The Commonwealth Government's 2015 survey, *Young Minds Matter – The second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, found strong associations between a range of socio-demographic characteristics and rates of mental illness. The survey revealed that children and young people who were at-risk with respect to certain key health, wellbeing and social indicators were increasingly likely to suffer from, or be at risk of, developing a mental illness. For example, children and young people aged four to 17 years in low income families had a rate of mental illness or disorder approximately twice as high as those in high income families,[76] while those without a parent or carer in employment were significantly more likely to be suffering from a mental health problem than those with working parents. These children and young people were also more likely to be suffering from a range of other compound vulnerabilities, including contact with the criminal justice system and time spent in out-of-home care. Children and young people with parents who suffer from a mental illness are also at greater risk themselves of suffering from a mental health disorder.[77]

In light of this, children and young people who access mental health services are invariably at-risk in a range of areas connected to yet distinct from their mental health and wellbeing. These factors render such children and young people increasingly vulnerable to abuse and maltreatment, and significantly less likely to benefit from the protective factors that can both mitigate risk and increase health and wellbeing outcomes. Independent external oversight of service delivery that is holistic and robust is therefore critical to safeguarding the interests and wellbeing of children and young people and advancing their right to be heard on decisions that affect their health and wellbeing.

Oversight arrangements

Oversight of youth mental health services in Western Australia is undertaken through a framework of external monitoring and complaints mechanisms. This includes individual advocacy and support, dedicated clinical oversight and complaints handling, as well as a range of comprehensive investigative procedures. While each body has a distinct statutory mandate, department funded and department provided services are equally subject to a comprehensive system of oversight and monitoring. The independent statutory bodies primarily responsible for oversight of mental health services as they relate to children and young people include:

- the Mental Health Advocacy Service

- the Chief Psychiatrist WA
- the Health and Disability Services Complaints Office
- the Commissioner for Children and Young People
- the Ombudsman.

Complaints handling and misconduct processes

Independent oversight bodies

Ombudsman

Health and Disability Services Complaints Office

Mental Health Advocacy Service

Best practice alignment: Met

The most significant considerations affecting compliance include:

Complemented by individual advocacy mechanisms: The independent complaints and grievance mechanisms with jurisdiction over mental health services are supported by an independent individual advocacy mechanism, the Mental Health Advocacy Service.

Power to identify thematic trends: The Ombudsman and the Health and Disability Services Complaints Office are able to identify trends in complaints received in order to direct investigations into systemic issues in service delivery when required.

Flexible: The Health and Disability Services Complaints Office accepts complaints from relatives, representatives or carers of mental health patients. The Ombudsman will only accept complaints from individuals personally affected by an issue. It is unclear if either body is able to adapt its process to cater for the specific needs and vulnerabilities of children and young people with experiences of mental illness.

Complaints about mental health service provision can be made to the Health and Disability Services Complaints Office (HaDSCO). HaDSCO is a dedicated complaints handling agency with three main stages of complaints management: enquiry, assessment and complaint resolution, which includes negotiated settlement, conciliation and investigation. At the end of HaDSCO's assessment process, a complaint may be accepted, rejected or referred to a more appropriate agency. If HaDSCO cannot accept the complaint, information will be provided about other complaint resolution options.

Complaints can be made by the person who received the service, a relative, representative or carer, or a service provider on behalf of a person who received a service from another provider. Complaints must be made within 24 months of the date the service being complained about was provided.

HaDSCO accepts complaints against any individual or organisation that provides, or claims to provide, a mental health service. This includes:

- allied health professionals
- community mental health services
- mental health nurses
- non-governmental department funded mental health service
- private hospitals
- private psychiatric hospitals
- psychiatrists
- psychologists
- public hospitals.

In 2016-17, HaDSCO received 365 complaints about mental health services in Western Australia. Most complaints related to quality of clinical care, communication, or a decision making process.[78] Of these complaints, 15 per cent were made by a child or the parent of a child receiving a mental health service.[79]

HaDSCO is required to consult with the Australian Health Practitioner Regulation Agency (AHPRA) to determine which entity is more appropriately equipped to manage all or part of a complaint. AHPRA is the regulatory body responsible for the regulation and accreditation of 14 health professions in Australia. AHPRA cannot handle complaints related to specific mental health services but is able to investigate complaints concerning psychologists, psychiatrists and other registered practitioners working in mental health care. While HaDSCO and AHPRA will not deal with the same specific complaint contemporaneously, it is possible that discrete elements of a single complaint will be handled by both agencies.

The Mental Health Advocacy Service has a statutory mandate to inquire into and seek to resolve complaints made to mental health advocates about the detention of, or the treatment and care being provided to, certain mental health patients.[80] Advocates often attempt to resolve issues directly with staff members. If an Advocate cannot resolve an issue, or if they consider it appropriate to do so, they are able to refer the complaint to the Chief Advocate.[81] The Chief Advocate is subsequently able to provide reports about any issue raised to the individual in charge of the relevant mental health service, the Minister, the Chief Psychiatrist, the Mental Health Commissioner and the Director General of the Department of Health.[82] In 2016-17, Advocates dealt with 46 allegations of physical and sexual abuse across 13 hospitals and two hostels. Of these allegations, 21 concerned staff abuse, 17 concerned patient-on-patient abuse, while five related to police abuse.[83] Advocates received a further 18 complaints about the use of restraint and four about the use of seclusion.[84]

Complaints about the mental health services provided by the Department of Health, as well as complaints about HaDSCO's decision making and practices can be made to the Ombudsman.

Individual advocacy

Independent oversight bodies

Mental Health Advocacy Service

Best practice alignment: Met.

The most significant considerations affecting compliance include:

Investigative powers: The Mental Health Advocacy Service (MHAS) has the power to investigate and follow-up concerns and complaints of children and young people. MHAS is also able to investigate systemic issues that arise as a result of individual advocacy work.

Proactive: MHAS proactively engages with patients as well as responding to requests from children and young people.

Entry and access: Individual youth advocates have comprehensive statutory powers to enter facilities and meet privately with patients and service users.

Expertise: Individual mental health advocates should have the skills and experience to be able to engage effectively with children and young people with experiences of mental illness. Apart from being a specialist mental health body, MHAS is statutorily obliged to employ a youth advocate.

Individual advocacy and support for children and young people in the mental health system is provided by the Mental Health Advocacy Service. The Mental Health Advocacy Service was established by the *Mental Health Act 2014* to provide advocacy support to specific mental health patients identified under the Act. These persons are primarily those subject to involuntary treatment orders, either as a hospital inpatient or on a Community Treatment Order. However, the Act also includes the following identified persons eligible for advocacy support:

- Individuals who have been referred for an assessment to consider whether they should be made involuntary.
- Individuals on Hospital Orders, made under the *Criminal Law (Mentally Impaired Accused) Act 1996*, who have been charged with a criminal offence and referred for psychiatric assessment.
- Mentally impaired accused people on Custody Orders in an authorised hospital or the community pursuant to the *Criminal Law (Mentally Impaired Accused) Act 1996*.
- Private psychiatric hospital residents.

- Voluntary patients in a class of identified persons in a direction issued by the Minister for Mental Health.[85]

In light of concerns about large numbers of voluntary child and youth patients being ineligible for advocacy support, a 2017 Ministerial Direction, titled *Classes of Voluntary Patient Direction 2016*, expanded the classes of children and young people eligible to access support to include:

- A child who is being treated, or who is seeking admission or is proposed to be provided treatment, by or in a public hospital, or an authorised hospital.
- A child who has been assisted in the previous six months by an Advocate and is being treated, or is proposed to be provided treatment, by or in a community mental health service.

An advocate must visit or otherwise contact a child or young person within 24 hours of receiving a request, or being notified of a request, for support. Every child who is made an involuntary patient under the Act, or who is detained under the *Mentally Impaired Accused Act,* must be contacted by an Advocate within 24 hours of such a determination.[86] Notwithstanding their statutory obligation to contact certain patients, an Advocate is equally entitled to contact an identified person at any time.[87] In order to facilitate compliance with these requirements, the Chief Advocate is notified by mental health services of every individual who is made involuntary in Western Australia.

When making contact with an identified person an advocate must:

- inquire into the extent to which they have been informed of their rights and the extent to which those rights have been upheld
- inquire into or investigate any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect, their health, safety or wellbeing
- inquire into and seek to resolve any complaints they may have about the condition of their treatment and, if necessary, support them to make complaints to a specific mental health service or the Health and Disability Services Complaints Office
- assist and represent them in proceedings before the Mental Health Tribunal or the State Administrative Tribunal
- advocate for and facilitate their access to other services.[88]

Mental Health Advocates are granted broad powers of enquiry and rights of attendance on mental health wards, psychiatric hospitals and other mental health facilities. This includes the rights to attend wards, hospitals or facilities at any time considered appropriate, to speak with patients, to inquire into the admission, referral or detention of a patient, to inquire into the provision of treatment or care, and, unless the patient objects, to view and copy medical files.[89]

The Act requires that in carrying out functions with respect to children and young people, a person or body, including Advocates, must have regard to the best interests of the child while also seeking to ascertain, to the extent practicable, the wishes of the child and their parent or guardian.

The Advocacy Service also employs a specialist Aboriginal Advocate who can, when necessary, be requested to work with children and young people by the Youth Advocate.

Inspections and visits

Independent oversight bodies

Mental Health Advocacy Service

Chief Psychiatrist WA

Ombudsman

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Frequency: Advocates are required to visit patients within a certain period of time. The Chief Psychiatrist visits hospitals and health services when he considers it appropriate to do so. Systematic inspections are not undertaken. However, the Chief Psychiatrist visits services in the course of clinical reviews.

Adequate powers: The Chief Psychiatrist has broad inspectorial powers, including the power to carry out unannounced inspections. The Mental Health Advocacy Service has comprehensive powers of entry and access.

Follow-up monitoring: The extent to which follow-up monitoring is undertaken is unclear.

Coverage: Powers to visit and inspect apply to mental health services as well as hospital wards.

Visits to mental health services and wards are conducted by the Mental Health Advocacy Service. As discussed, all children who are made involuntary patients under the *Mental Health Act 2014* are required to be visited or otherwise contacted by an Advocate within 24 hours of such a determination. A child who is a voluntary patient and in accordance with the above Ministerial Direction requests contact with an Advocate, must be contacted within 24 hours. A child detained under the *Mentally Impaired Accused Act* must also be visited or otherwise contacted by an Advocate within 24 hours.

The Chief Psychiatrist WA is also statutorily empowered to visit authorised hospitals and mental health services. All visits may be carried out at any time without notice

and are intended to provide the Chief Psychiatrist with an opportunity to receive feedback from consumers, carers and clinicians. While the Chief Psychiatrist is able to visit authorised hospitals whenever he considers it appropriate to do so, he is only permitted to visit mental health services if he reasonably suspects that proper standards of treatment and care have not been or are not being maintained.[90] To this end, while being inspectorial in nature, these powers are not exercised systematically.

Investigations and reviews

Independent oversight bodies

Mental Health Advocacy Service

Chief Psychiatrist

Health and Disability Services Complaints Office

Ombudsman

Auditor General

Commissioner for Children and Young People

Best practice alignment: Met

The most significant considerations affecting compliance rating include:

Independence: There are a number of independent bodies capable of conducting reviews into the provision of mental health services to children and young people.

Frequency: The Chief Psychiatrist is undertaking systematic clinical standards and services reviews of all mental health services in Western Australia. All other bodies exercise review powers in response to critical incidents or identified systemic issues.

Follow-up monitoring: Oversight bodies operating in this field have the capacity to carry out follow-up monitoring however the extent to which it takes place is unclear.

Reporting: All investigation and review mechanisms have the power to report publicly on findings.

The Mental Health Advocacy Service is empowered to conduct investigations into any matter relating to the conditions of mental health services that are adversely affecting, or are likely to adversely affect, the health, safety or wellbeing of patients.[91] Such an investigation may also include an inquiry into systemic issues affecting patient rights.

The Chief Advocate may report to the service provider, the Minister, the Chief Psychiatrist, the Commissioner for Mental Health, or the Director General of the

Department of Health on any issue that arises during the course of an investigation and must be kept informed of the progress of departmental inquiries, reviews and, ultimately, findings.[92]

In the course of an investigation, the Mental Health Advocacy Service is permitted to:

- attend mental health wards, hospitals or facilities
- visit and speak with patients
- inquire into the admission, referral or detention of a patient and the provision of treatment or care to that patient
- view and copy medical files and other documents
- do anything necessary or convenient for the performance of this function.[93]

While the Mental Health Advocacy service may look at any matter affecting health and wellbeing, the Chief Psychiatrist WA monitors clinical treatment and care.[94] The Chief Psychiatrist has established a Clinical Monitoring Program through which they undertakes Clinical Standards and Service Reviews, Targeted Reviews, and Thematic Reviews.

Clinical Standards and Service reviews involve routine auditing and monitoring of mental health services. The Chief Psychiatrist is currently undertaking reviews of all mental health services in Western Australia. Each review lasts between two and four weeks and consists of a comprehensive clinical record review and face-to-face staff feedback. Clinical record reviews seek to assess the quality of clinical care as evidenced in the written clinical record, while face-to-face staff feedback is designed to provide feedback to managers on key areas of clinical governance. It is envisaged all mental health services in the State will have been reviewed by June 2018.

Targeted Reviews are undertaken to investigate concerns or allegations about the standards of psychiatric care provided to an individual patient or group of patients, or when there are concerns about the overall performance of a particular mental health service. Targeted Reviews can be conducted on the own-motion of the Chief Psychiatrist or upon request by the Director General of the Department of Health.

Thematic Reviews examine discrete areas of clinical practice across multiple mental health services operating in specific areas. The Chief Psychiatrist has completed several thematic reviews into topics including clinical governance, adherence to clinical policy and legislation, and the provision of psychical health care to mental health patients.

The Chief Psychiatrist is able to review any decision of a private psychiatrist with respect to the treatment of an involuntary patient, either detained in a private general hospital or under a Community Treatment Order, and either affirm, vary, revoke or substitute another treatment decision.

The Chief Psychiatrist is also notified of all uses of seclusion and bodily restraint and monitors events to assess compliance with the relevant provisions of the *Mental Health Act 2014*.

The Health and Disability Services Complaints Office (HaDSCO) is able to undertake investigations into systemic issues relating to the provision of mental health services. HaDSCO investigations seek to determine if any unreasonable conduct on the part of a service provider has occurred and, when necessary, identify areas for improvement. These investigations ultimately seek to provide recommendations to the Department and providers to encourage the continuous development of enhanced service provision.

HaDSCO investigations can be undertaken at the direction of the Ministers for Health, Mental Health, or Disability Services or if a complaint cannot be resolved through conciliation and warrants investigation. Investigations are typically collaborative, however, when necessary, HaDSCO is empowered to summons individuals or documents, apply for warrants to enter premises, inspect premises and take copies of documents.[95]

The Ombudsman is empowered to undertake own-motion investigations into systemic and thematic patterns and trends arising from complaints received and from child death and family and domestic violence fatality reviews. One such investigation was the Ombudsman's *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*.[96] Through this investigation, the Ombudsman was able to assess referrals to the Child and Adolescent Mental Health Service, examine subsequent risk assessments, treatment and discharge planning and evaluate service coordination. Unlike the thematic inquiries and clinical reviews undertaken by other bodies, Ombudsman investigations are uniquely placed to assess the efficacy of service provision holistically by examining interagency coordination as well as environmental and contextual risk factors that impact upon service delivery.

The Commissioner for Children and Young People is able to conduct inquiries into matters affecting the wellbeing of children and young people. For the purposes of a special inquiry, the Commissioner may enter and inspect any place either with the consent of the owner or occupier, or with a warrant from a magistrate.[97] The Commissioner is entitled to require the attendance of any person to respond to questions under oath and to compel the production of documents.[98] Despite the Commissioner's legislative power to launch such an inquiry, he is not resourced to do so at his own discretion. Consequently, his ability to exercise this power independently is compromised. The Commissioner is yet to exercise this power however an inquiry into the mental health and wellbeing of children and young people in Western Australia, was conducted under the Commissioner's powers under section 19 (f) of the *Commissioner for Children and Young People Act 2006* in 2011.

A follow up report to monitor the implementation of the recommendations from the inquiry was undertaken in 2015.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People

Mental Health Advocacy Service

Best practice alignment: Partially met.

The most significant considerations affecting compliance rating include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young people with mental illness.

Follow-up monitoring: The nature of the Commissioner's systemic advocacy work means it is difficult to measure its impact or success but has undertaken review of previous recommendations.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct a special inquiry into identified systemic issues thus limiting functional independence.

Staffing and expertise: The Mental Health Advocacy Service is a specialist body with expertise in mental health service delivery. The Commissioner's office has expertise in working with children and young people.

Systemic advocacy is undertaken by the Commissioner for Children and Young People. The Commissioner has a broad mandate to monitor the wellbeing of all children and young people in Western Australia, with a particular focus on the most vulnerable. Children and young people suffering from mental illness not only experience lower health outcomes but are increasingly vulnerable with respect to a range of diverse wellbeing indicators. As a result, the Commissioner's advocacy has focused on ensuring that health planning places a high priority on the mental health and wellbeing of children and young people and their families and has sought to underscore that while adolescents are increasingly vulnerable to mental illness, children equally experience mental health issues that can manifest as social, emotional or behavioural problems.[99]

The Mental Health Advocacy Service (MHAS) undertakes systemic advocacy in the mental health sector by promoting compliance with the *Mental Health Act 2014* and the Charter of Mental Health Care Principles. MHAS also advocates generally for systemic changes to policies and procedures based on issues identified in the course

of their individual advocacy. Recently, MHAS has undertaken systemic advocacy on a range of diverse issues.

Discussion

Oversight of mental health services delivered to children and young people in Western Australia is undertaken by a number of generalist and specialist complaints handling and monitoring bodies. This includes a best practice individual advocacy organisation with broad powers of entry and access, a specialist complaint handling body, and an independent statutory mechanism responsible for clinical oversight and monitoring.

The MHAS, to a large degree, accords with contemporary best practice with respect to the provision of individual advocacy support to children and young people. MHAS is statutorily required to employ a specialist youth advocate, trained in youth issues and familiar with agencies and services for children and young people, and applies a best interests approach in advocating for, and providing support to, children and young people receiving treatment for mental illness. Advocates are, importantly, permitted to meet with children and young people in both public and private facilities and respond to requests for support while also proactively meeting with, or otherwise contacting, young patients. The recent inclusion of children and young people who are voluntary patients being treated, or seeking admission to be treated in a public or authorised hospital, as a class of identified persons for the purpose of accessing advocacy support, was an important expansion of the mandate of MHAS that will ensure greater access to advocacy support. This could be strengthened by allowing MHAS to speak with all children and young people classified as voluntary patients proactively, rather than relying on a request from the child or young person.

Children and young people receiving mental health services are able to complain about their treatment, or the practice and procedures of services providers, to the Ombudsman, if the service was provided, or is being provided, by the Department of Health, and the Health and Disability Services Complaints Office (HaDSCO), for all complaints that relate to an individual or organisation that provides, or claims to provide, a mental health service. HaDSCO's broader mandate means that all mental health services provided in Western Australia are subject to the jurisdiction of an independent complaints handling body. The existence of the Mental Health Advocacy Service equally means that children and young people seeking to make a complaint can be supported to do so by an independent youth advocate during the process. The extent to which children and young people accessing mental health services are informed of their right to access these complaints handling bodies, independent of the Mental Health Advocacy Service, is however unclear. Importantly, the Health and Disability Services Complaints Office accepts complaints from relatives, representatives or carers of mental health patients and does not require vulnerable children and young people to make complaints on their own behalf.

Mental health services, in addition to receiving regular visits from mental health advocates, are equally subject to the jurisdiction of the Chief Psychiatrist who is statutorily obliged to monitor the treatment and clinical care of mental health patients. As a consequence, the Chief Psychiatrist is invested with broad inspectorial powers that include the right to carry out unannounced visits and inspections of mental health service. However, while he is able to exercise these powers in the course of systematic reviews of clinical standards, the Chief Psychiatrist is not an inspectorial body responsible for undertaking regular inspections of facilities independent of his clinical monitoring role.

Oversight of mental health services in Western Australia is the responsibility of a largely comprehensive framework of independent bodies that carry out a number of discrete oversight functions ranging from the provision of specialist child and youth advocacy support to the monitoring of clinical service provision. While no single body is responsible for the systematic inspection of mental health facilities the Chief Psychiatrist's oversight of seclusion and restraint, as well as his specific focus on clinical standards and general rights of entry, access and inspection, and the Mental Health Advocacy Service's right to enter facilities and meet with children and young people, mean that mental health service providers are subject to a level of preventive oversight and monitoring. Further development of the role of these agencies to increase the systematic inspection of facilities and review of practices such as restraint and seclusion, and the proactive engagement with children and young people admitted to treatment on a voluntary basis would improve the independent oversight for this particularly vulnerable cohort of children and young people.

Gaps in regular monitoring of the outcomes for children and young people's mental health and the adequacy of treatment provision in WA would also provide an important additional oversight of the mental health system in WA. The need for quality data is an important consideration, particularly in relation to prevention and early intervention.

Recommendation 2

That strategies to improve the oversight for children and young people in relation to mental health services are considered including:

- Systematic inspection of facilities and review of practices such as restraint and seclusion.
- Proactive engagement of independent advocacy with voluntary patients.
- Independent monitoring of the outcomes for children and young people's mental health and the adequacy of treatment provision in WA.

Education system

In Western Australia, compulsory education begins in pre-primary and continues until the end of Year 12. For children in this age bracket there are three schooling options: public education in government schools, private education in independent schools, or home schooling.

Public education is administered by the Department of Education through public schools and independent public schools. The Department provides public education to approximately 300,000 students in 802 public schools, 441 of which are Independent Public Schools. The Department, through the Country High School Hostels Authority, also has residential colleges in eight regional centres. The colleges accommodate up to 900 students from isolated areas in the State without access to a secondary school.

Non-government school education is regulated by the Department of Education and delivered by governing bodies registered under Part 4 of the *School Education Act 1999*. There are 309 non-government schools in Western Australia with approximately 150,000 students.[100]

Oversight arrangements

School education in Western Australia falls into two broad categories: government schools and non-government schools, within which there are catholic and independent schools. Oversight arrangements depend to a large extent on the nature of the school. In practical terms, this means that while government schools are subject to the generalist independent public mechanisms, such as the Ombudsman, Corruption and Crime Commission, etc., non-government schools are, generally speaking, only overseen by those mechanisms with individual or class specific mandates, such as the Equal Opportunity Commission.

Complaints handling and misconduct processes

Independent oversight bodies

Ombudsman

Equal Opportunity Commission

Public Sector Commission

Corruption and Crime Commission

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Independence: Students in the public education system can lodge complaints with a number of independent complaints handling and misconduct bodies.

Individual advocacy mechanisms: Complaints processes are not supported by individual advocacy mechanisms.

Visible: While no mechanism operating in this area proactively informs students about their right to complain, the Ombudsman has commenced discussions with the Department of Education to undertake a regular program of visits to residential hostels in metropolitan and regional Western Australia.

In Western Australia, pursuant to section 118 of the *School Education Act,* the Department of Education is under a statutory obligation to put in place mechanisms capable of addressing complaints that may arise in the course of its service provision.[101] These mechanisms must also reflect, in line with Western Australia's Whole of Government Complaints Management Strategy, the principles of the Australian Standard on Complaints Handling.[102] As a result, the Department operates an internal complaints handling system through which students, parents, members of the community, and employees of the Department in their private capacity are entitled to lodge complaints about the provision of education or the conduct of any department employee. In accordance with department policy, when a verbal or written complaint is made to a principal, director or manager, they shall endeavour to resolve the issue at a school, district or central office level, provided it is appropriate to do so.[103] All parties are nevertheless entitled to request that a complaint be referred to an independent external oversight or complaints handling body for resolution. In the event that a complaint is referred to an external agency, the Department may choose not to pursue an internal investigation.[104] Independent mechanisms capable of receiving complaints about individuals or issues in the education system include:

- the Ombudsman, if the issue concerns the decision making and practices of the Department
- the Equal Opportunity Commission, if the complaint involves unlawful discrimination against any party.

If the complaint relates to the conduct or decision making of staff at a non-government school it will fall outside the jurisdiction of the Ombudsman.

In 2016-17 the Ombudsman received 40 complaints about the Department of Education.[105] In the same period the Equal Opportunity Commission received 17 complaints of unlawful discrimination related to the education system.[106]

All Department of Education employees are required to report suspected breaches of discipline or instances of misconduct. Breaches of discipline and misconduct concern behaviour that fails to meet the requirements of relevant regulations, codes and policies – this includes a failure to comply with the Department's Code of Conduct,

the Western Australian Public Sector Commission Code of Ethics or relevant provisions of the *Public Sector Management Act*. In the first instance all misconduct should be reported internally to a principal or line manager and must be reported to the Standards and Integrity directorate, however, depending on the nature of the alleged breach staff and students are entitled to report misconduct directly to one of the following external oversight bodies:

- the Corruption and Crime Commission, if the misconduct constitutes serious misconduct
- the Public Sector Commission, if the breach of discipline constitutes minor misconduct
- the Office of the Auditor General, if the complaint relates to misuse of public resources.

The Teacher Registration Board of Western Australia (TRBWA) is the regulatory body responsible for the professional registration of all Western Australian teachers. Pursuant to the *Teacher Registration Act 2012* the Board is empowered to take action against unregistered individuals working in Western Australian schools as teachers and to administer independent disciplinary and impairment review processes. Under the Act, any member of the public may make a complaint to the Board concerning the conduct of a registered teacher. The Board investigates such complaints as appropriate and, in so doing, must regard the best interests of the child as paramount.[107] Upon receipt of a complaint the Board will, as necessary, provide details of the complaint and all other relevant information to one or a number of the external oversight bodies with jurisdiction over the education system, these include the Corruption and Crime Commission and the Public Sector Commission.

In 2015-16, the TRBWA received 15 complaints from members of the public about the conduct of registered teachers.[108] In the same period, the Corruption and Crime Commission received 289 allegations of serious misconduct of Department of Education employees.[109]

Individual advocacy

Independent oversight bodies

None

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

- Children and young people in the education system are typically less vulnerable, can rely on parental advocacy.
- Vulnerable populations require additional support to access complaints systems.

- Consequences of certain practices such as suspensions, exclusions and behaviour management practices can have a significant impact on individual children and young people.

There is currently no independent oversight mechanism with a mandate to provide individual advocacy and support to children and young people in the Western Australian education system.

Inspections and visits

Independent oversight bodies

None

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

While the Ombudsman is permitted to inspect schools in the course of an own-motion investigation there is currently no systematic independent inspection regime for the education system. This includes government, catholic and independent schools as well as residential colleges.

The Ombudsman is empowered to carry out inspections of and visits to Western Australian schools in the course of an own-motion investigation. Building on the Ombudsman's program of visits to vulnerable children in the child protection and juvenile justice systems, the Ombudsman has commenced discussions with the Department of Education to undertake a regular program of visits to residential colleges in metropolitan and regional Western Australia. There is currently, however, no systematic independent inspection regime for the education system.

There is a comprehensive system of departmental outcomes monitoring that includes visits to government schools and interviews with staff. These departmental review processes and site visits are, however, not intended to be inspectorial and differ depending on the nature of the school. The Director General of Education is permitted to inspect, with or without notice, any Catholic or Independent school.[110] This is, however, not undertaken systematically.

Investigations and reviews

Independent oversight bodies

Ombudsman

Auditor General WA

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Independence: Several independent oversight bodies are invested with investigative and review functions.

Adequate powers: These oversight bodies have broad powers including the right to visit and inspect schools, interview relevant persons, and require the production of relevant documents.

Frequency: A number of reviews and audits into issues related to the school-age education system have been carried out. No oversight body undertakes systematic reviews of the education system.

A number of independent oversight bodies are invested with broad investigative functions relevant to the education system. While these functions are exercised infrequently, they can provide a comprehensive review of discrete aspects of the education system and can ultimately precipitate systemic advocacy in key areas.

The Ombudsman is empowered to undertake own-motion investigations of any matter within the Ombudsman's jurisdiction. The Ombudsman is able to investigate matters related to the administrative decision-making and practices of the Department of Education, which, as a consequence, permits review of the decision-making and practices in all public and independent public schools.

The Auditor General WA is able to conduct performance audits that provide Parliament with an assessment of the effectiveness and efficiency of public sector programs, and identify opportunities for improved service delivery. The Auditor's 'follow the dollar' powers also permit examination of the way in which government funds are spent by contracted non-government services. As the Department of Education (previously Department of Education Services) partially funds non-government schools to deliver education services, the Auditor General is permitted to assess the efficacy and performance of those funding arrangements. The Auditor General has undertaken a raft of performance reviews into issues in education and training, including reports on:

- Vocational Education and Training for Year 11 and 12 Students in Public Schools (2016)
- Information and Communication Technology in Education (2016)
- Moving On: The Transition of Year 7 to Secondary School (2014)
- Behaviour Management in Schools (2014)
- Every Day Counts: Managing Student Attendance in Western Australian Public Schools (2009)

There is currently no independent external oversight mechanism capable of undertaking thematic or targeted reviews or investigations into systemic issues in independent or Catholic schools.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young people and has undertaken a range of work in the area of school-age education.

Follow-up monitoring: The nature of the Commissioner's systemic advocacy work means it is difficult to measure its impact or success.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct a special inquiry into identified systemic issues thus limiting functional independence.

Staffing and expertise: The Commissioner has staff with specific expertise and experience in school-age education.

Systemic advocacy is undertaken by the Commissioner for Children and Young People. Positive engagement in education is a primary determinant of a child's lifelong health and wellbeing. As such, the Commissioner has carried out a broad range of systemic advocacy related to education and engagement.

Discussion

Intense public interest in the State's education system has amplified scrutiny of the Department's operations, which has in turn led to increasingly sophisticated internal mechanisms. Independent oversight, to the extent that it exists, is largely confined to external complaints handling and misconduct processes applicable only to government schools. If a student, or affected person, wished to complain about the decision-making or practices of a non-government school, they would have access to the Ombudsman to the extent that their complaint related to the decision-making or practices of the Department of Education itself. However, in practical terms, complaints handling is managed internally while misconduct processes are handled either by the individual school, or in the case of catholic schools, the Catholic Education Office, or by the Teacher Registration Board in relation to the professional conduct of a teacher.

The significance of engagement in education on the outcomes for children cannot be underestimated. Practices such as suspensions, exclusions, and behaviour management, particularly the use of seclusion and restraint, should be subject to

independent statutory oversight given the potential for such practices to have a significant deleterious impact on the individual child.

Due to the nature of school-age education, oversight in the form of individual advocacy is arguably less important in the education system than in other areas where the majority of children are doing well and parents are capable of raising issues when required. However, for specific groups of children, such as those in out-of-home-care, or those with disability, independent advocacy is important.

Recommendation 3

That a robust, comprehensive system of independent oversight for vulnerable children and young people in the education system be established. This should include:

- Systematic inspection and investigation of facilities and the implementation of policy and practice in relation to the use of suspensions, exclusions, and behaviour management, particularly the use of seclusion and restraint.
- Monitoring of outcomes for vulnerable groups of children and young people including Aboriginal and Torres Strait Islander children, children with disability, children in the youth justice and/or out-of-home care systems.

Police custody

Children and young people can be held in police custody for a variety of reasons. Children and young people are particularly vulnerable during periods in which they are held in police custody. This vulnerability can be exacerbated by the traumatic or distressing circumstances that frequently precede arrest and detention as well as the varying risk factors to which young offenders are predisposed. In light of this, various inquiries and reviews have recommended that, save for exceptional circumstances, children and young people not be detained in police custody.[111]

Reasons for being held in police custody include pending the determination of bail by a magistrate, where bail has been granted but no responsible adult can be found, or where a child or young person is remanded in custody prior to transport to Banksia Hill Juvenile Detention Centre, located in the Perth metropolitan area. For children and young people in regional areas, this can see young people detained in police custody for periods in excess of 24 hours. The Auditor General has observed that this situation "creates additional risks as these facilities are not designed for the purpose of detaining young people".[112]

The number of children and young people formally involved in the youth justice system is small. Information on the number of children and young people arrested and detained in police lockups, and the length of time for which they are held, is not readily available. However, reports indicate that Aboriginal children and young people in regional centres are disproportionately affected by the practice.

Children and young people detained in police custodial facilities are particularly vulnerable with respect to a range of health and wellbeing indicators and face diverse and complex challenges connected to, and independent of, their offending behaviour. These challenges include experiences of neglect, trauma or abuse, psychological and cognitive issues, educational disengagement and substance misuse.[113] Moreover, the high rates of mental illness and cognitive impairment among children and young people who come into contact with the criminal justice system dictate that any period of incarceration can serve to intensify disadvantage, exacerbate symptoms and ultimately escalate offending behaviour.[114]

The high numbers of Aboriginal children and young people who are arrested and detained in police lockups, the high rates of Fetal Alcohol Spectrum Disorder, communication difficulties and educational disengagement amongst this group, and the effect this can have on cognitive and psycho-social functioning, their ability to understand consequences and general impulsivity, leaves Aboriginal children and young people uniquely and perilously susceptible to periods in detention, particularly in facilities that have not been designed or intended to hold children and young people for long periods of time.[115]

Oversight arrangements

Issues with the appropriateness of police lockups as places of juvenile detention coupled with the unique vulnerability of children and young people during their initial contact with police, render it essential that independent oversight of all police custodial facilities in which children and young people are being or are likely to be held is robust and comprehensive.

In Western Australia, there is no independent systemic oversight of police custodial facilities. To the extent that independent external oversight exists, it is the responsibility of:

- the Ombudsman
- the Auditor General WA
- the Commissioner for Children and Young People WA
- the Office of the Inspector of Custodial Services.

Complaints handling and misconduct processes

Independent oversight bodies

Ombudsman

Corruption and Crime Commission

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Complemented by individual advocacy mechanisms: Complaints handling processes are not supported by individual advocacy.

Accessible: There are concerns about children and young people's knowledge of external complaints processes.

Visible: It is unclear what strategies are used within police lockups to promote external complaints processes.

Complaints about the Western Australian Police can be made to the Ombudsman. In 2016-17 the Ombudsman received 162 complaints related to police administration, a small number of these involved allegations arising from arrest and detention.[116] It is unclear how many of these complaints were made by children and young people.

Children and young people seeking to complain about treatment that could amount to misconduct are entitled to lodge complaints directly with the Corruption and Crime Commission (CCC). While internal misconduct investigations focus largely on the potential criminal conduct of individual officers, CCC investigations assess the conduct of officers while also seeking to identify systemic flaws in policies, practice and procedures. The CCC receives allegations of police misconduct through the

receipt of individual complaints and mandatory notifications under the CCC Act. In the context of police lockups, mandatory notifications must be made by the Commissioner of Police with respect to "reviewable police actions".[117] A reviewable police action is any action taken by an officer or employee that could constitute conduct that is unlawful, unjust, oppressive, or improperly discriminatory.[118] Upon receipt of an allegation the CCC makes a preliminary assessment on the utility of an investigation. In determining whether to proceed with an investigation, the Commission must have regard to the seniority of the officer to whom the allegation relates, the occurrence or potential occurrence of serious misconduct and the need for the issues raised to be addressed independently by an external oversight body.[119] In practical terms, this means that the vast majority of allegations are investigated internally. If the Commission determines however that an external investigation is appropriate, it can elect to investigate the matter itself or in conjunction with the relevant internal investigatory mechanism. The CCC may alternatively decide that the matter would be more appropriately dealt with by another oversight body, such as the Ombudsman, or that the relevant issues render it amenable to internal investigation. In the event that an allegation is referred back to the police for investigation, the CCC may oversee the conduct of the internal inquiry.[120]

Complaints handling in police lockups

The final report of the Community Development and Justice Standing Committee *Inquiry into custodial arrangements in police lockups* noted that information regarding internal complaints processes was not made readily available to detainees and that "[t]he avenues by which members of the public can complain about minor matters relating to their time in custody are not generally known".[121] This finding is particularly concerning for children and young people who, for a variety of reasons, are reluctant to make complaints themselves. Opaque internal complaints processes can heighten barriers to participation and make systems more difficult to navigate, which render children less likely to complain.

Individual advocacy

Independent oversight bodies

None

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

There are no independent oversight mechanisms that provide individual advocacy services to children and young people who are arrested and detained in police lockups. Police are, however, required to notify a responsible adult as soon as practicable after a young person is taken into custody.

Individual advocacy and support is particularly critical for children and young people deprived of their liberty. In light of their heightened vulnerability, it has been recommended that no young person should be interrogated by police without a parent, responsible person, or representative of a relevant organisation present.[122] However, there is no independent oversight mechanism responsible for systematically visiting or otherwise contacting and providing advocacy services to children and young people held in police custodial facilities. While the WA Police Lock-up Manual requires staff to facilitate interaction between detainees and Aboriginal Visitors when requested, the Visitors Scheme is not an independent mechanism and is only available to Aboriginal detainees.

Inspections and visits

Independent oversight bodies

Office of the Inspector of Custodial Services

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

Coverage: Independent inspection bodies should have the right to visit and inspect all places where children and young people are held. Currently the Office of the Inspector of Custodial Services is permitted to visit 6 of 125 police lockups in the State.

Inspection standards: Inspections should review all aspects of service delivery and include rights monitoring not simply compliance with internal policies and procedures.

There is currently no independent oversight mechanism with a mandate to inspect all police custodial facilities in Western Australia. The Office of the Inspector of Custodial Services has jurisdiction to inspect court custody centres and six prescribed lockups in regional Western Australia. Prescribed lockups are day-stay facilities where people are held in custody for the purpose of court proceedings. People are not held overnight in prescribed lockup facilities or court custody centres. The Inspector does not have jurisdiction to inspect the remaining 119 lockups in the State.

Investigations and reviews

Independent oversight bodies

Auditor General WA

Ombudsman

Commissioner for Children and Young People WA

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Independence: All mechanisms empowered to undertake investigations, inquiries or reviews into police custodial arrangements are statutorily independent.

Frequency: The Auditor General has conducted an inquiry into the juvenile justice system that included consideration of police custodial arrangements. The Ombudsman and Commissioner for Children and Young People have not exercised their respective review functions in relation to police custodial arrangements.

Adequate powers: All oversight bodies with the ability to conduct inquiries or investigations into police custodial arrangements are invested with comprehensive investigative powers.

The Auditor General is able to conduct performance audits of WA Police programs and practices that provide Parliament with an assessment of effectiveness and efficiency, and identify opportunities for improved service delivery. The Auditor General has undertaken a number of performance examinations related to the Western Australian Police. Notably, the 2008 performance examination, titled *The Juvenile Justice System: Dealing with Young People under the Young Offendes Act 1994*, highlighted the inappropriateness of police station custody facilities for detaining children and young people.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People WA

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young people in contact with the criminal justice system. However, the Commissioner has undertaken limited advocacy in the area of children and young people police custody.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct a special inquiry into identified systemic issues thus limiting functional independence.

Staffing and expertise: The Commissioner has staff with relevant expertise and experience in working with children and young people.

Systemic advocacy is undertaken by the Commissioner for Children and Young People. The Commissioner has a broad mandate to monitor the wellbeing of all children and young people in Western Australia, with a particular focus on the most vulnerable. Therefore, while children and young people who come into contact with the criminal justice system comprise a very small proportion of the overall population, due to their extreme vulnerability, the Commissioner is statutorily obliged to focus on their rights, interests and wellbeing in the work of the office. To this end, the Commissioner has carried out a broad range of work related to the various forms of youth justice detention, and has consistently advocated that, in line with the State's statutory regime, children and young people only be detained as a last resort.

Discussion

There is a clear need for systematic independent inspection of police custodial facilities. While the Office of the Inspector of Custodial Services has statutory authority to inspect a limited number of prescribed lockups, he is not permitted to enter and inspect all other lockups operated under the mandate of the Commissioner for Police.

Preventive monitoring of Western Australian police custodial facilities, to the extent that it is undertaken, is insufficiently rigorous to effectively ensure the consistent fulfilment of detainee rights. The Office of the Inspector of Custodial Services noted in relation to the internal review of police lockups by Prison Superintendents, during the Community Development and Justice Standing Committee's inquiry into custodial arrangements in police lockups that:

> *…overall, these visits do not constitute an adequate oversight process: they apply only to selected sites, are limited in scope, and are undertaken by another government agency not an independent oversight body.*[123]

The report of the parliamentary inquiry made a number of findings related to detainee rights and identified a range of concerns in policy and practice that demonstrate the utility of systematic and rigorous external oversight as a tool of rights protection.

Despite being inappropriate places of detention for children and young people, the lack of alternative accommodation in regional Western Australia dictates that, for the safety of the children and young people themselves, and for other practical reasons, time in a police custodial facility is sometimes unavoidable. Banksia Hill Juvenile Detention Centre in Perth is the State's only juvenile detention facility, which means that children or young people detained in regional areas awaiting a court appearance can only be held in a court custody centre, or if this is unavailable, an ordinary police lockup. While the Office of the Inspector of Custodial Services has oversight of any aspect of custodial service delivery, it is not clear, when a child or young person is

held in a police lockup due to the unavailability of a court custody centre, if they are in Corrective Services or police custody. To avoid this uncertainty, and to ensure that all police lockups in Western Australia are subject to comprehensive external oversight, the jurisdiction of the Office of the Inspector of Custodial Services should be amended to include all lockups operated under the mandate of the Commissioner for Police. Such a change would also satisfy key obligations under the *Optional Protocol to the Convention Against Torture*.

Recommendation 4

That a system of comprehensive independent oversight of the detention of children and young people in police custody be introduced in WA.

Youth justice

In Western Australia, youth justice is the responsibility of the Department of Justice (former Department of Corrective Services) which also administers adult custodial facilities and the Department of Communities for community corrections services. Governing legislation for youth justice is set out in the *Young Offenders Act 1994* and *Young Offenders Regulations 1995*.

More than 96 per cent of children and young people in Western Australia have little or no contact with the justice system. Children and young people can be under the supervision of the youth justice system in either the community or in detention. On an average day there are 727 children and young people under youth justice supervision in Western Australia – approximately 82 per cent are living in the community.[124] Of these children and young people, two-thirds are Aboriginal or Torres Strait Islander and 80 per cent are male.[125]

All children and young people aged 10 to 17 years, both male and female, held on remand or sentenced to a period of detention, are accommodated at Banksia Hill Juvenile Detention Centre. Female detainees, three-quarters of whom identify as Aboriginal, are housed in a separate wing of the facility and represent approximately six per cent of all detainees.[126] On an average night, during the June quarter of 2016, around 142 young people were detained at Banksia Hill Juvenile Detention Centre – 94 per cent were male and 45 per cent were on remand.[127]

The rate of Aboriginal children and young people in detention in the same quarter was 64 per 10,000, or approximately 77 per cent of all detainees held at Banksia Hill Juvenile Detention Centre.[128] On average, this equated to 109 Aboriginal children and young people – 95 per cent of whom were male.[129]

Oversight arrangements

Independent external oversight youth justice services in WA is the primary responsibility of:

- the Office of the Inspector of Custodial Services
- the Ombudsman
- the Auditor General
- the Commissioner for Children and Young People.

Complaints handling and misconduct processes

Independent oversight bodies
Ombudsman
Health and Disability Services Complaints Office
Equal Opportunity Commission

Public Sector Commission

Corruption and Crime Commission

Best practice alignment: Met.

The most significant considerations affecting compliance include:

Accessibility: There are a number of complaints handling bodies to which children and young people can complain directly. The Ombudsman visits Banksia Hill Juvenile Detention Centre to promote his complaint handling function approximately twice a year.

Complemented by individual advocacy: Children and young people in detention can access support through the Independent Visitors to make complaints and navigate complaints processes. The Office of the Inspector of Custodial Services can also refer complaints to appropriate bodies.

Power to identify thematic trends: The Office of the Inspector of Custodial Services and the Ombudsman are able to identify complaints trends in order to direct investigations into systemic issues in service delivery.

Proactive: Independent Visitors proactively seek to elicit information from detainees about their treatment.

Children and young people in the youth justice system can make complaints through the four key complaints agencies. In addition, those in the detention centre can raise complaints in regard to health issues through the Health and Disability Services complaints office.

As part of the Ombudsman's proactive visiting program to vulnerable children in the child protection and juvenile justice systems, the Ombudsman visits Banksia Hill Juvenile Detention Centre. These visits raise awareness for youth in detention and provide them with an opportunity to make complaints or discuss any concerns directly with staff. Visits occur approximately twice a year. Visits also involve meetings between senior staff to discuss trends and issues in complaints received by the Ombudsman's office as well as targeted complaint handling training delivered by Ombudsman staff for youth custodial officers and senior staff.

In 2016-17, the Equal Opportunity Commission received 16 complaints relating to correctional and detention services.[130] It is unclear how many of these were made by children and young people.

Detainees at Banksia Hill Juvenile Detention Centre alleging staff misconduct can complain directly to the Corruption and Crime Commission or the Public Sector Commission. If the Office of the Inspector of Custodial Services suspects on reasonable grounds that a matter constitutes serious misconduct, they are statutorily obliged to report their concerns to the Corruption and Crime Commission.[131]

Youth justice services staff exercise considerable discretionary power, for example, over the use of sanctions. In addition, the vulnerability of detainees suffering from cumulative trauma necessitate comprehensive and robust misconduct processes.

Individual advocacy

Independent oversight bodies

Office of Inspector of Custodial Services – Independent Visitor Service

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Statutory independence: The Independent Visitor Service has a legislative foundation and is administered by the Office of the Inspector of Custodial Services however Visitors are appointed by the Minister, and are employed on a voluntary basis.

Coverage: No individual advocacy for children and young people in the community corrections area.

Frequency: Independent Visitors are statutorily required to visit Banksia Hill Juvenile Detention Centre and meet with detainees at least once every three months.

Entry and access: Independent Visitors have statutory powers to enter facilities and meet privately with detainees.

Collaborative: Visitors are able to receive and refer complaints to the Office of the Inspector of Custodial Services who refers them to the Ombudsman.

Individual advocacy in Banksia Hill Juvenile Detention Centre is largely provided through the Independent Visitor Service. Pursuant to the *Inspector of Custodial Services Act,* independent visitors are required to visit and inspect designated custodial facilities at least once every three months.[132] While independent visitors are appointed by the Minister, the program is managed by the Office of the Inspector of Custodial Services.

Independent visitors undertake a range of diverse advocacy functions, including collecting, recording and referring complaints about treatment or conditions and providing detainees with information about community support agencies. Visitors are also able, when requested, to speak on a detainee's behalf to facility staff or administration.

Inspections and visits

Independent oversight bodies

Office of the Inspector of Custodial Services

Independent Visitors Service

Best practice alignment: Met.

The most significant considerations affecting compliance include:

Statutory independence: The Office of the Inspector of Custodial Services has legislated independence.

Frequency: Systematic inspections are carried out Banksia Hill Juvenile Detention Centre at least once every three years.

Follow-up monitoring: Monitoring visits are carried out systematically at least six times per year at Banksia Hill Juvenile Detention Centre.

Adequate powers: The Office of the Inspector of Custodial Services has broad inspectorial powers, including free and unfettered access to the facility, the power to carry out unannounced inspections, the ability to interview staff confidentially, and the power to issue 'show cause' notices in the event persistent noncompliance becomes a safety or human rights risk.

Inspection standards: Inspections are undertaken against sophisticated independent standards and policies.

Under the *Inspector of Custodial Act 2003*, the Office of the Inspector of Custodial Services (OICS) is required to inspect and report on all places of detention at least once every three years. Inspections are conducted more frequently if the Inspector deems it necessary. This has been the case at Banksia Hill Juvenile Detention Centre in recent years.

While inspections can be announced or unannounced, few unannounced inspections have been carried out. Successive inspectors have noted that there is generally more benefit in providing notice of impending inspections to ensure staff are made available for meetings and required documentation is prepared.[133]

Inspection reports highlight concerns in service delivery and areas for improvement. Recommendations can relate to discrete problems identified in Banksia Hill Juvenile Detention Centre, or systemic issues that exist broadly across the sector. These recommendations and the Department's responses are included in a report tabled in Parliament.

In addition to triennial inspections, OICS undertakes a process of continuous visiting. This allows for performance to be monitored and problems identified on an ongoing basis. While the inspector is statutorily entitled to inspect any custodial facility at any time and on any number of occasions[134], formal liaison visits are undertaken at least four times per year. Banksia Hill Juvenile Detention Centre and other facilities

considered high risk are formally visited at least six times per year. In light of ongoing unrest in the facility, 13 liaison visits were conducted in 2016-17. These visits are in addition to those conducted in the course of specific reviews or progress monitoring.

OICS is equally responsible for the oversight of transport of children and young people in custody. To this end, the inspector may have free and unfettered access to a vehicle used to transport detainees or a detainee in such a vehicle.[135]

Independent visitors visit their allocated prison or detention centre at least once every three months to talk with staff and detainees. Following a visit, independent visitors immediately debrief the superintendent or deputy superintendent of the facility so that matters can be resolved as soon as possible. Independent visitors subsequently prepare short reports to inform the inspector of issues raised during the visit. These reports include a record of all complaints made by or on behalf of a prisoner and help the inspector to identify systemic issues within the facility.

The *Young Offenders Act 1994* (WA) equally prescribes that a judge or magistrate of the Children's Court or an authorised justice of the peace is entitled to enter and inspect a juvenile custodial facility at any time.[136] Nevertheless, they do not have a specific role in the regular monitoring or inspection of youth custodial facilities.

Investigations and reviews

Independent oversight bodies

Office of the Inspector of Custodial Services

Ombudsman

Auditor General

Commissioner for Children and Young People

Best practice alignment: Met

The most significant considerations affecting compliance include:

Independence: A number of statutorily independent oversight bodies have the capacity to carry out investigations of, or reviews into, issues relating to youth justice.

Coverage: Systematically applied in relation to detention facilities but not in community corrections.

Follow up monitoring: The Office of the Inspector of Custodial Services monitors compliance with recommendations and action on findings.

Adequate powers: All bodies have broad investigative powers including the right to visit or inspect any part of a particular facility, interview children and young people and staff, and inspect, or take copies of, any relevant document.

The Office of the Inspector of Custodial Services (OICS) is empowered to undertake occasional reviews of custodial services. Reviews examine aspects of a custodial service, or an individual or group's custodial experience. Reviews may also include an examination of administrative arrangements for providing that service. Since 2012, OICS has reviewed a wide range of topics relating to security, safety, rehabilitation and management, including:

- *Banksia Hill Juvenile Detention Centre behaviour management practices* (report released in July 2017)
- the circumstances preceding, and in response to, a major disturbance at the facility in 2013.[137]

OICS also routinely includes Banksia Hill Juvenile Detention Centre in broader reviews. Findings related to children and young people are typically separate from adult findings as the circumstances, policies and impacts are generally different.

Reviews, like inspections, lead to reports with findings and recommendations. Unlike inspection reports, there is no requirement for reviews to be tabled in Parliament and made public. However, for reasons of transparency, accountability and system improvement, OICS' practice is to table and publicly release reports unless there are privacy or security concerns. If the inspector does decide not to table a report, confidential copies are sent to the Standing Committee on Public Administration.

The Ombudsman has the power to undertake own motion investigations with respect to youth justice and Banksia Hill Juvenile Detention Centre.

Pursuant to section 25 of the *Auditor General Act 2006,* the Auditor General WA is empowered to undertake performance examinations of public agencies to provide Parliament with assessments of the effectiveness and efficiency of public programs and activities and thereby identify opportunities for improved performance. Following such an examination the Auditor General provides Parliament with a list of recommendations to improve efficiency and effectiveness. The Public Accounts Committee of the Western Australia Parliament's Legislative Assembly can monitor departmental implementation of the Auditor's recommendations. The Auditor General has conducted three performances examinations into issues related to youth justice:

- *The Juvenile Justice System: Dealing with Young People Under the Young Offenders Act 1994* (2008)
- *The Banksia Hill Detention Centre Redevelopment Project* (2013)
- *Diverting Young People Away from Court (2017).*

The Commissioner for Children and Young People is able to conduct special inquiries into matters affecting the wellbeing of children and young people. For the purposes of a special inquiry, the Commissioner may enter and inspect any place either with the consent of the owner or occupier, or with a warrant from a magistrate.[138] The Commissioner is entitled to require the attendance of any person to respond to questions under oath and to compel the production of documents.[139] The Commissioner is also statutorily required to avoid duplicating the work of other agencies. The Commissioner is therefore yet to exercise this power.

Multiple reviews into youth custodial services – Banksia Hill Disturbance 2013

Four independent oversight agencies are statutorily empowered to conduct reviews or investigations into conditions or administrative arrangements related to juvenile justice in Western Australia. However, rather than being a source of unnecessarily duplicative review, coordination between agencies has managed to capitalise on these intersecting mandates. The major disturbance at Banksia Hill Juvenile Detention Centre on 20 January 2013 precipitated a coordinated response from all four oversight agencies and resulted in investigations by the Office of the Inspector of Custodial Services and the Auditor General WA. The Inspector was directed by the Minister for Corrective Services to review "the context of the incident and its contributing or causal factors; security infrastructure and practices; the adequacy of emergency management planning and responses; and the subsequent housing of detainees at Hakea Prison".[140] The Auditor General contemporaneously undertook a performance audit of the project to redevelop Banksia Hill Juvenile Detention Centre in 2009, noting that while done independently, "together the two [investigations] provided Parliament with a fuller picture" of the circumstances leading up to the incident.[141] The Ombudsman increased regular visits to Banksia Hill Juvenile Detention Centre to observe conditions, meet with staff and detainees and provide detainees with an opportunity to make complaints to the Office and provided relevant information to the Office of the Inspector of Custodial Services. The Ombudsman equally seconded his Principal Legal and Investigating Officer to the Office of the Inspector for the duration of the directed review.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young

people in youth justice. The Commissioner has undertaken specific work on human rights standards in youth detention and work on youth justice generally.

Follow-up monitoring: The nature of the Commissioner's systemic advocacy work means it is difficult to measure its impact or success.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct a special inquiry into identified systemic issues thus limiting functional independence.

Systemic advocacy in the field of youth justice is undertaken by the Commissioner for Children and Young People. Children that come into contact with the criminal justice system, while comprising a very small proportion of the overall population, are, for the reasons outlined above, among the State's most vulnerable children. To this end, the Commissioner has consistently advocated, in line with international human rights standards and domestic legislation, children and young people be detained as a last resort.

Discussion

Children and young people in the youth justice system are more likely to have experienced trauma, discrimination and disadvantage, have low levels of education, mental or cognitive impairments, and come from families with limited capacity to advocate on their behalf, and are therefore generally less capable of understanding and exercising their rights than other children and young people. They are less likely to complain about abuse and less likely to recognise maltreatment which, as a result, places them in greater need of specialist advocacy and support.

Oversight of children and young people in the community corrections system is restricted to access to complaints mechanisms and ad hoc investigations and reviews. The absence of individual advocacy and more systematic review of the application of policy and practice, at a community level and monitoring of the outcomes for children and young people under the youth justice system as a whole, is a significant deficiency in the oversight of the treatment of a vulnerable group of children and young people.

In order to oversee the strict observance of domestic laws, regulations and policies, as well as international human rights standards, youth detention facilities should be visited regularly by independent experts appointed by, and responsible to, a competent authority distinct from those in charge of the administration of the facility. In addition to regular visits and inspections, detained children and young people should have access to qualified, independent advocates to monitor their wellbeing and help them to access complaints processes.

Almost every child and young person at Banksia Hill Juvenile Detention Centre is vulnerable for a range of reasons. It is estimated that more than three-quarters of

all detainees held at Banksia Hill Juvenile Detention Centre have a serious mental health problem. Incidents of self-harm and attempted suicide have been increasing. The Office of the Inspector of Custodial Services reported in 2017 that there were 196 incidents of self-harm and attempted suicide in the previous year. This is five times higher than the number in 2014.[142] Around one-third of detainees have Foetal Alcohol Spectrum Disorder.[143] Many will have had extensive experience in the out-of-home care and child protection systems. On 31 March 2017, there were 21 young people in Banksia Hill Juvenile Detention Centre in the care of the former Department for Children Protection and Family Support.[144] It has also been estimated that children with disability, particularly those with an intellectual or cognitive impairment, are significantly over-represented at Banksia Hill.[145] The level of oversight at Banksia Hill accords with the extreme vulnerability of the children and young people held in the facility. Banksia Hill is subject to a comprehensive system of oversight and monitoring led by the Office of the Inspector of Custodial Services. OICS is invested with comprehensive powers and a statutory mandate to undertake systematic inspections. This includes follow-up visits to monitor compliance with recommendations and assess progress on the findings of prior inspection reports. The inspector's systematic inspections, coupled with regular thematic reviews of practice and procedure and liaison visits by OICS staff, means that all important aspects of facility experience are subject to regular oversight and review.

The inspector, while proscribed from investigating individual complaints, is permitted to receive and refer complaints to an appropriate external complaints handling body with jurisdiction over juvenile detention: the Ombudsman, the Health and Disability Services Complaints Office or the Equal Opportunity Commission. The Ombudsman has recently commenced biannual visits to Banksia Hill to meet with detainees and promote the availability of the Ombudsman's office as an avenue for external resolution of complaints. Knowledge of external complaints handling bodies, as well as multiple avenues through which complaints can be made, is particularly important in closed facilities, such as detention centres, where the institutional power dynamic can further exacerbate children and young people's reluctance to complain about their treatment.

The inspector's systematic inspection and visiting regime, the regular visits and individual advocacy support provided by independent visitors and the range of independent oversight bodies that have, and exercise, powers to conduct investigations into custodial services means that there are no conspicuous gaps in the oversight regime applicable to juvenile detention. The effectiveness of the Office of the Inspector does however, like all independent oversight bodies, depend to a certain extent on the openness of the Department to recommendations for improvement. In the event that the inspector suspects on reasonable grounds that there is, or has been a serious risk to the security, control, safety, care or welfare of a detainee, he is able to issue a 'show cause' notice to require a response from the Department or action from the Minister. The inspector cannot, however, compel

compliance, and defensiveness or resistance from the Department is enough to inhibit improvement to practice and procedure.

Recommendation 5

That a robust, comprehensive system of oversight for all children and young people in the youth justice system be established. This should include:

- Access to an independent advocate to support children and young people to raise concerns about their treatment and support.
- Monitoring of the application of policy and practice.
- Monitoring of the outcomes for children and young people under the care and supervision of the youth justice system.

Disability services

In Western Australia, disability services are provided or funded by the Department of Communities – Disability Services (Disability Services), various Western Australian government agencies, and the Australian government.

Disability Services funds and provides diverse services for children and young people living with disability. These services range from disability advocacy support to therapy and accommodation services. In 2016-17, in addition to a number of departmental services, Disability Services funded 161 non-government organisations to deliver community services around the State.[146]

The Western Australian government also provides disability services through other agencies, including Justice and Education.

In 2009, the Australian Bureau of Statistics estimated that 8.3 per cent of 0 to 14 year-olds in Western Australia were living with a disability.[147] In 2012, data collected through the Western Australian Health and Wellbeing Surveillance System similarly estimated that 8.4 per cent of children and young people aged 0 to 15 years had some form of disability.[148]

In 2012, the Disability Services Commission identified 6,667 children and young people in WA as accessing a disability services.[149]Aboriginal children and young people represented 6.3 per cent of all disability service clients. Nationwide, 63.6 per cent of all people with a disability accessed support through a private or non-government service provider.[150]

Children and young people with disability are more likely to experience communication difficulties and psychological or cognitive impairments which, coupled with their significantly higher rates of engagement with services and institutions, renders them uniquely vulnerable to abuse and maltreatment.[151] Children and young people with disability spend more time in institutional contexts than non-disabled children and are 'handled' more often and by a greater number of adults while there. This is largely because children with disability who have high physical support needs require assistance from adults to help them carry out daily tasks. However, frequent contact with non-family carers can make it more difficult for children and young people with disability to distinguish between acts intended to assist and physical or sexual abuse, while communication challenges can inhibit their ability to make complaints or raise concerns about their treatment.[152] Children and young people with disability are, therefore, estimated to be around three times more likely than the general population to be victims of physical and sexual abuse.[153]

Oversight arrangements

In Western Australia, this oversight is largely undertaken through internal mechanisms. External oversight arrangements include a dedicated complaints

handling body however lack specialist independent individual advocacy and support. Government provided disability services are, however, subject to a range of comprehensive investigative procedures.

Complaints handling and misconduct process

Independent oversight bodies

Ombudsman

Health and Disability Services Complaints Office

Equal Opportunity Commission

Corruption and Crime Commission

Public Sector Commission

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Expertise: The Health and Disability Services Complaints Office is a specialist complaints body with expertise in the provision of disability services.

Flexible: The Health and Disability Services Complaints Office accepts complaints from relatives, representatives or carers of people with disability. The Ombudsman will only accept complaints from individuals personally affected by an issue. It is unclear if either body is able to adapt its process to cater for the specific needs and vulnerabilities of children and young people with disability.

Complemented by individual advocacy: Children and young people with disability are not supported to complain by an independent individual advocacy mechanism.

Complaints about disability services can be made to the Health and Disability Services Complaints Office (HaDSCO).

In 2016-17, HaDSCO received 87 complaints about disability services in Western Australia. Most complaints related to services costs, service delivery or a failure to address individual needs.[154] Almost half of these complaints were made by a child or the parent of a child.[155]

Allegations of abuse and neglect of people with disability can be made to the National Disability Abuse and Neglect Hotline. Any person is able to complain about treatment or report abuse. The Hotline works with carers to find ways to deal with allegations, including advising callers on how to complain about abuse and neglect at the local level.

Complaints related to Commonwealth services, including Disability Employment Services, Australian Disability Enterprises or Advocacy Services funded under the *Disability Services Act 1986*, can be made to the Complaint Resolution and Referral Service (CRRS). The CRRS also investigates allegations of abuse and neglect that have been referred by the National Disability Abuse and Neglect Hotline. Complaints can be made directly to the CRRS on any aspect of a Department provided or funded service.

In WA, complaints concerning the decision-making and practices of the Department of Communities can be made to the Ombudsman. In 2016-17 the Ombudsman received three complaints relating to the then Disability Services Commission.[156] The Ombudsman is statutorily precluded from accepting complaints concerning department funded non-government services.

Children and young people with disability are able to make complaints alleging unlawful discrimination to the Equal Opportunity Commission.[157] In 2016-17, of all complaints received by the Commission, 22.8 per cent related to allegations of unlawful discrimination on the grounds of disability or impairment.[158] It is unclear how many related to disability services or were made by children and young people.

Complaints alleging unlawful discrimination contrary to the *Disability Discrimination Act 1992* (Cth) can be lodged with the Australian Human Rights Commission. Complaints can relate to state and commonwealth funded and provided services. In 2015-16, of all complaints received by the Commission, 37 per cent were lodged pursuant to the *Disability Discrimination Act*. It is unclear how many related to disability services or were made by children and young people.

Individual advocacy

Independent oversight bodies

None

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

Statutory independence: There is no independent body with a mandate to deliver individual advocacy services in the disability sector. Individual advocacy services are delivered exclusively by non-government providers.

There is no independent oversight mechanism dedicated to providing individual advocacy support to children and young people engaging with disability services. There are, however, a range of non-government organisations, funded through the former Disability Services Commission in accordance with the Funded Advocacy Program, that provide specialist individual advocacy to children and young people with disability.[159]

Currently, three disability organisations are funded by Department of Communities – Disability Services to provide individual advocacy that includes advocacy for children, young people, and their families.

Seven Western Australian disability organisations are funded by the Commonwealth through the National Disability Advocacy Program (NDAP) to provide individual advocacy, three are additionally funded to undertake systemic advocacy activities. Under the WA National Disability Insurance Scheme local area coordinators also provide a degree of individual advocacy to children and young people with disability to ensure their rights and interests are upheld.

Children and young people suffering from cognitive impairments and mental disabilities may also be eligible for advocacy support from the Mental Health Advocacy Service when being treated within the mental health system.

Inspections and visits

Independent oversight bodies

None

Best practice alignment: Not met.

The most significant considerations affecting compliance include:

Independence: Inspections of disability services are carried out by the Department of Communities. There is no independent inspection body with jurisdiction over disability service providers or facilities.

There is currently no oversight mechanism with a mandate to carry out systematic inspections of Western Australia disability services. The Ombudsman is, however, empowered to enter and inspect premises in the Ombudsman's jurisdiction in the course of an own-motion investigation. This includes the power to inspect state government disability services and premises.

Monitoring of service provision is undertaken internally by the Department of Communities – Disability Services. Service providers are required to carry out an annual self-assessment through which they examine the efficacy of their service provision. During this process, service providers are encouraged but not required to seek the views of service users, families and carers.[160] The Department then carries out independent quality evaluations through which, every three years, independent quality evaluators assess a service's compliance with the National Standards for Disability Services. This process involves consultation with service users, families and carers.

Investigations and reviews

Independent oversight bodies

Health and Disability Services Complaints Office

Ombudsman

Auditor General

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Frequency: There are a number of bodies capable of conducting investigations or reviews of disability services however these powers have been infrequently exercised with respect to issues related to disability services.

Follow-up monitoring: The extent to which the bodies with jurisdiction in this area monitor compliance with recommendations is unclear.

Reporting: All bodies have the capacity to report publicly on the findings of investigations, inquiries or reviews.

The Health and Disability Services Complaints Office (HaDSCO) is able to undertake investigations into systemic issues relating to the provision of disability services. HaDSCO investigations seek to determine if any unreasonable conduct on the part of a service provider has occurred and, when necessary, identify areas for improvement. Following an investigation HaDSCO provides recommendations to the department and relevant service providers in order to encourage changes to service provision.

HaDSCO investigations can be undertaken at the direction of the Ministers for Health, Mental Health, or Disability Services or if a complaint cannot be resolved through conciliation and warrants investigation. Investigations are typically collaborative, however, HaDSCO is able to summons individuals or documents, apply for warrants to enter premises, inspect premises and take copies of documents when required.

The Ombudsman is empowered to initiate any investigation of its own motion (that is, the investigation need not arise from a complaint or a referral from Parliament). Own-motion investigations can relate to any matter within the Ombudsman's jurisdiction and are undertaken with all the powers of a standing Royal Commission. Ombudsman investigations are able to consider the actions of public authorities holistically by examining interagency coordination and interagency collaboration. This is not, however, generally able to investigate issues arising from services provided by funded non-government organisations (although may be able to in certain circumstances set out in the Ombudsman's legislation). The Ombudsman has not undertaken an own motion investigation into issues related to the disability services sector.

The Auditor General WA is empowered to undertake performance examinations of public agencies to provide Parliament with assessments of the effectiveness and efficiency of public programs and activities and thereby identify opportunities for improved performance. The Auditor General has not recently undertaken a performance audit into the disability services sector. The Auditor General's 'follow the dollar' powers permit financial reviews of department funded disability services.

The Commissioner for Children and Young People has the power to undertake a special inquiry into issues related to the provision of disability services. The Commissioner is, however, yet to exercise this power.

Systemic advocacy

Independent oversight bodies

Commissioner for Children and Young People

Best practice alignment: Partially met.

The most significant considerations affecting compliance include:

Diverse functions: The Commissioner for Children and Young People carries out a range of diverse functions to promote the rights and interests of children and young people with disability. This includes consultation, research and report writing.

Follow-up monitoring: The nature of the Commissioner's systemic advocacy work means it is difficult to measure its impact or success.

Resourcing: The Commissioner is resourced to undertake general systemic advocacy however must request funding to conduct special inquiries into identified systemic issues thus limiting functional independence.

Systemic advocacy is undertaken by the Commissioner for Children and Young People. The Commissioner has a broad mandate to monitor the wellbeing of all children and young people in Western Australia, with a particular focus on the most vulnerable.[161] The Commissioner's advocacy has focused on ensuring the participation of children and young people with disability and upholding their right to be heard and participate meaningfully in their community and society more broadly.

Discussion

Children and young people with disability experience a range of risk factors that render them uniquely vulnerable to abuse. Factors including social stigma, discrimination, lack of social support, a mental or cognitive impairment and communication difficulties increase their risk of experiencing abuse in care institutions and decrease their chance of attaining minimum health and wellbeing outcomes. Accordingly, it is essential that oversight of disability services is comprehensive and robust.

Oversight arrangements in the Western Australian disability services sector, while featuring a specialist independent complaints process, are marked by the lack of independent bodies with mandates to provide individual advocacy support and carry out systematic visits, inspections and monitoring. The heightened vulnerability of children and young people with disability, characterised by marginalisation and widespread communication challenges, render disability services high-risk environments for abuse and maltreatment and proactive oversight particularly critical.

Children and young people with disability can require the expertise of specialist independent advocacy support to navigate disability services or make informed decisions about a range of complex and sensitive issues, including sterilisation, entering state care, and recognising and complaining about maltreatment. Individual disability advocates can enable children and young people to participate in the decision-making processes that safeguard and advance their human rights, wellbeing and interests[162] and guard against advice or support being unduly or improperly influenced by family, carer or service provider interests.

An individual advocate's mandated focus on the wishes or best interests of each child or young person contributes to the integrity of decision-making processes and ensures an objective pursuit of the child's fundamental needs and interests.

In Western Australia, while there is currently no independent oversight mechanism dedicated to providing individual advocacy support to children and young people engaging with disability services there are a number of non-government organisations, funded by the Department of Communities or the National Disability Advocacy Program, that provide specialist individual advocacy to children and young people with disability. While these organisations play an important role in the promotion and protection of children and young people's rights, there is an inherent conflict in government agencies funding community sector advocacy support for children and young people who rely on the services of those same agencies.

Children and young people with disability need to be supported by an advocacy service that is independent with respect to funding, power, resources and expenditure and that supports those who engage with disability services as well as those who are more isolated, vulnerable or disadvantaged for any reason. To this end, a comprehensive assessment of the advocacy needs of Western Australian children and young people with disability should be undertaken with a view to strengthening current arrangements.

There is equally a need for systematic preventive oversight of disability services. While the Ombudsman and the Commissioner for Children and Young People are empowered to enter and inspect premises in the course of an own-motion investigation or special inquiry disability services are not subject to a regime of regular inspection and visits. The Department's Independent Quality Evaluations are

not frequent enough (taking place every three years) nor adequately independent to constitute a best-practice preventive inspection mechanism.

There are a range of preventive oversight regimes for disability services operating in a number of jurisdictions around the country. These models of preventive oversight could prove instructive in the event of an examination of the adequacy and efficacy of Western Australia's current arrangements. Victorian disability services are, for example, visited and inspected systematically by a network of community visitors. The Disability Services Commissioner is also invested with comprehensive inspectorial powers to be exercised in response to crises and critical incidents.

Disability services inspections in Victoria

Community Visitors

In Victoria, proactive monitoring of disability services is carried out by a network of community visitors. Community Visitors are independent, statutory appointments mandated to visit and inspect any premises where a disability organisation is providing residential services. Most visits are announced however Community Visitors are permitted to make unannounced visits as well as visits in response to critical incidents. During visits Community Visitors are to inquire into all things related to a person's care and treatment, including the appropriateness and standard of the premises, as well as receive complaints and assess compliance with the provisions of the *Disability Act 2006* (Vic).

During visits, Community Visitors are entitled to exercise a range of inspectorial powers. Powers include the right to inspect any part of the premises in which the residential service is being provided, meet with any resident, inspect documents and make enquiries related to the provision of services.

Disability Services Commissioner

The Victorian Disability Services Commissioner is also invested with broad investigative and inspectorial powers. In August 2017, these powers were strengthened to include the right to conduct own initiated investigations into allegations of abuse and neglect of an individual or systemic nature and visit and inspect certain premises of disability services without a warrant. The Commissioner is equally mandated to provide education and information about preventing and responding to abuse.

In carrying out inspections the Commissioner and his officers are permitted to:

1. make enquiries in relation to relevant persons with a disability

2. obtain access to relevant documents to examine, copy, and remove them

3. obtain access to medical records with the consent of the individual

4. see and interview a person with a disability, their relatives, support persons, staff and volunteers.

Inspection powers are, however, not exercised systematically but in response to critical incidents or time critical concerns that affect the safety and wellbeing of people with a disability in a disability service.

Recommendation 6

That a robust, comprehensive system of oversight for all children and young people with disability be established. This should include:

- Access to an independent advocate to support children and young people to raise concerns about their treatment and support.
- Monitoring of the application of policy and practice.
- Monitoring of the outcomes for children and young people with disability.

Conclusion

This exercise has identified the existing status of monitoring and oversight arrangements of child and youth services in Western Australia. Oversight of the various services, organisations and facilities with which children and young people interact is the responsibility of a diverse range of bodies whose ability to exercise jurisdiction can depend on the nature of the service being provided, its funding and, in many instances, the young people involved.

The extent to which these bodies accord with best practice principles of oversight for children and young people varies markedly between sectors. For example, while Western Australia's single juvenile detention facility is monitored by a comprehensive regime of best practice oversight and accountability through the Office of the Inspector of Custodial Services, oversight of police custodial facilities is, conversely, marked by an almost total absence of independent preventive monitoring.

This lack of preventive monitoring is, in many respects, characteristic of Western Australia's oversight arrangements generally. With the exception of youth detention and, to a lesser extent, the mental health sector (whose inspections are arguably insufficiently systematised to be considered comprehensive), few Western Australian service providers are exposed to a wide-ranging regime of preventive oversight.

Additionally, while most sectors are subject to the jurisdiction of reactive complaints handling bodies that broadly accord with best practice principles, the general lack of proactive individual advocacy can compromise their effectiveness, particularly with respect to organisations that provide services to or have frequent contact with vulnerable or disadvantaged children and young people.

There are three broad areas of Western Australia's oversight arrangements in which improvement is needed to strengthen the robustness of the existing framework. This includes:

1. Increasing and strengthening preventive oversight mechanisms.
2. Recognising individual advocacy as a keystone of oversight of child and youth services.
3. Addressing the gaps in oversight created as a result of private and non-government sector contracting.

Preventive oversight

Proactive mechanisms monitor facility standards by actively informing oversight bodies about how services are being delivered and by collecting information on the safety, health and wellbeing of clients, users or detainees. Services that cater to the needs of vulnerable children and young people or that are high-risk environments for abuse or maltreatment are particularly in need of proactive oversight that does not

rely on assertive, informed service users being aware of and prepared to enforce their rights.

Regular visits, systematic inspections and formalised individual advocacy are able to identify systemic abuse, maltreatment and rights-inconsistent practice without needing to rely solely on the complaints of often-marginalised children and young people. Moreover, and perhaps equally as important, service providers can use information collected through preventive oversight to inform themselves on issues in their service they did not know about, or had overlooked. To this end, preventive monitoring can identify gaps in service provision between what ought to be and what is, and, through available expertise and an understanding of best practice, recommend solutions to systemic problems in policy and practice.

Western Australia's generally comprehensive system of complaints and misconduct mechanisms notwithstanding, few services, with the notable exception of Banksia Hill Juvenile Detention Centre, are subject to an inclusive preventive regime of systematic inspection, visits and review. No agency, for example, mandated to carry out inspections or visits to children in Western Australia's out-of-home care or disability services sectors does so with sufficient universality, timeliness or frequency to constitute a systematic method of ongoing preventive oversight and service improvement. As high-risk environments for abuse and maltreatment, it is in these areas that existing proactive oversight needs to be strengthened, expanded or modified, or new mechanisms established, to accord with accepted best practice.

Individual advocacy

In order for reactive and preventive mechanisms to function effectively children require reliable advocacy. Individual advocacy refers to a broad range of functions that include receiving and referring complaints, and supporting and assisting individual children to access services or obtain redress. Ordinarily, individual advocates also play a role in promoting the interests of individual children, monitoring facility compliance with statutory obligations, conducting research into best practice service provision, and scrutinising pending legislation or initiatives.[163]

Individual advocacy can equally serve to strengthen the efficacy of other oversight mechanisms operating in the same field. Reactive mechanisms, to the extent that they rely on vulnerable children and young people being both aware of their rights and prepared to enforce them, are ill-equipped to provide comprehensive oversight of child and youth services. For children and young people, particularly those with vulnerabilities that restrict their ability to participate in decision-making or speak on their own behalf, reactive mechanisms can be practically inaccessible. Similarly, the efficacy of preventive mechanisms can also be strengthened by informed and supported service users being aware of their rights and prepared to engage with monitoring processes.

Notwithstanding the need, there are few oversight mechanisms with dedicated mandates to carryout individual advocacy for children and young people in Western Australia. While service users, clients and detainees invariably have access to uneven and inconsistent forms of internal and non-governmental advocacy only those children and young people held in Banksia Hill Juvenile Detention Centre or accessing mental health care receive regular, systematised support from dedicated, independent external advocates.

Consistent with best practice models of oversight and accountability for child and youth services, access to an individual advocate to assist with administrative difficulties, provide support during grievance processes and offer objective, unqualified advice about care or treatment is as important as the establishment of complaints and monitoring agencies.[164] To the extent that children do not have access to this type of assistance their ability to participate in decision making processes that affect their lives and interests is seriously undermined.[165]

This mapping exercise has demonstrated that there is a pressing need for a more comprehensive network of individual advocates to assist children and young people both to access and to navigate government and non-government services. All children and young people engaging with child and young people's services, particularly those who are vulnerable or disadvantaged for any reason, should have access to an individual advocacy mechanism that is statutorily independent, adequately resourced, and actively facilitates their participation in decision making processes.[166]

Private and non-government organisations

While contracting can complicate the jurisdiction of external oversight agencies, privatising elements of public service delivery should not lead to diminished oversight and accountability. When a government agency funds a private or non-government organisation to deliver a public service to vulnerable children and young people it is essential that regulatory mechanisms remain robust so as to guard against the risk of an unintended oversight deficit.[167]

Despite this need it is nevertheless clear that department funded child and youth services in Western Australia are generally subject to less rigorous external oversight than department provided services. This is largely explained by services only being subject to the jurisdiction of generalist oversight bodies invested with exclusively public mandates that preclude oversight of private or non-government organisations. For example, while the Ombudsman is able to receive complaints from children and young people in department *provided* disability services he is not able to receive complaints from children and young people in department *funded* services unless the complaint relates to the decision-making or practice of the department.

As contracting increases and government retracts from traditional areas of public service delivery, such as out-of-home care and disability services, new and adaptable oversight regimes need to be developed to cater to these shifting dynamics. Certain Australian jurisdictions have sought to address this change by creating new, specialist oversight and accountability agencies while others have focused on expanding or modifying existing bodies to cover non-government service delivery. For example, specialist oversight agencies with class-specific mandates, such as the Health and Disability Services Complaints Office, avoid gaps in oversight by being invested with jurisdiction over certain types of individual or service, irrespective of the sector. Some jurisdictions have alternatively sought to expand the jurisdiction of generalist bodies to avoid community sector gaps in oversight. The Queensland Ombudsman, for example, is able to investigate administrative actions "taken for, or in the performance of functions conferred on, an agency, by an entity that is not an agency," which necessarily includes private and non-government service providers delivering public services.

Both solutions can lead to greater oversight coverage and increased accountability of organisations that provide what are, in essence, public services to vulnerable or disadvantaged children and young people. Independent external oversight agencies, be they specialist or generalist, should ideally be empowered to monitor child and youth services pursuant to the nature of the service being provided, not the nature of the organisation providing it.

Appendices

Appendix 1: Oversight bodies

Descriptions of all independent oversight agencies in Western Australia, including their functions, powers and jurisdictions

1.1 Ombudsman WA

The Ombudsman has broad powers of oversight, pursuant to the *Parliamentary Commissioner Act 1971*. These powers have both specific and general application to the safety and wellbeing of children and young people and are primarily exercised in pursuit of the office's four principal functions:

1. Receiving, investigating and resolving complaints about State Government agencies, local governments and universities.
2. Reviewing certain child deaths and family and domestic violence fatalities.
3. Improving public administration for the benefit of all Western Australians through own motion investigations and education and liaison programs with public authorities.
4. Undertaking a range of additional functions, including statutory inspection and monitoring functions.[168]

Complaints resolution

One of the primary functions of the Ombudsman is the receipt and resolution of complaints about the decision making and practices of public authorities that fall within the Ombudsman's jurisdiction. Complaints must affect the complainant personally and, except in certain circumstances, the matters alleged in the complaint must have occurred within the previous 12 months and not be eligible for resolution by a court or tribunal.[169]

The Ombudsman can commence an investigation into a complaint about a matter that is within his jurisdiction. The Ombudsman also has discretion to refer a matter back to the agency the subject of complaint, or to refer a complainant to a more appropriate agency to deal with their complaint. For vulnerable people, including children and young people, the Ombudsman can and does exercise discretion to investigate any complaint in the first instance, or to facilitate the complainant having their complaint dealt with by another agency, including the agency the subject of complaint.

An investigation seeks to gather information about the nature of the complaint in order to ascertain whether the relevant agency has acted contrary to law, unreasonably, unjustly, or oppressively, has been improperly discriminatory, has

made a discretionary decision for an improper purpose, has taken into account irrelevant considerations or failed to consider relevant considerations, has failed to provide reasons for a decision when reasons should have been given, has based a decision wholly or partly on a mistake of law or fact, or has acted wrongly.[170] Upon the conclusion of an investigation the Ombudsman may recommend action be taken to remedy the situation, including the review of a decision, changes to administrative practices, an apology, or a form of compensation. Although the Ombudsman is unable to compel action, in the last decade 100% of the Ombudsman's recommendations have been accepted. Furthermore, in monitoring the implementation of recommendations, the Ombudsman is able to request that an agency report on steps that have been taken or are proposed to be taken to give effect to recommendations. The Ombudsman can also, if no steps that seem to the Ombudsman to be appropriate have been taken within a reasonable time of making recommendations, report to the Premier and Parliament.[171]

Own-motion investigations

The Ombudsman endeavours to improve public administration by undertaking investigations of systemic and thematic patterns and trends arising from complaints made to the Ombudsman and from child death and family and domestic violence fatality reviews. The Ombudsman has all the powers, rights, and privileges of a standing Royal Commission under the *Royal Commissions Act 1968*, including the power to inspect government facilities and request access to relevant documentation. Upon the conclusion of an investigation the Ombudsman can make recommendations to the agency. The Ombudsman can request that an agency report on steps that have been taken or are proposed to be taken to give effect to the recommendations, including reporting on the reasons if no such steps have been or are proposed to be taken. If unsatisfied with the response the Ombudsman may provide a copy of any report and recommendations to the Premier and table a report in Parliament.[172]

In 2015-16, a report of a major own motion investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities was finalised and tabled in Parliament, and in 2016-17, significant work was undertaken by the Ombudsman on an own motion investigation into ways to prevent or reduce child deaths by drowning. Previous own motion investigation reports tabled in Parliament by the Ombudsman include:

- investigation into ways that State government departments and authorities can prevent or reduce suicide by young people
- investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths
- planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the *Children and Community Services Act 2004.*

Child Death Reviews

The Ombudsman also exercises a Child Death Review function through which he reviews certain investigable deaths. A death is investigable pursuant to the Act when it occurs under any of the following circumstances:

In the two years before the date of the child's death:[173]

- The Chief Executive Officer of the Department for Child Protection and Family Support had received information that raised concerns about the wellbeing of the child or a child relative of the child.
- Pursuant to the *Children and Community Services Act 2004,* the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child.
- Any of the actions listed in section 32(1) of the *Children and Community Services Act* 2004 was done in respect of the child or a child relative of the child.
- The child or a child relative of the child was in the CEO's care, or protection proceedings were pending in respect of the child or a child relative of the child.

In determining whether or not a death is an investigable death the Ombudsman is provided with information from both the Coroner and the Department for Child Protection and Family Support regarding the circumstances or conditions of a particular death. This information will include a summary detailing the Department's past involvement with the deceased child. If the Ombudsman determines that the death is an investigable death it must be reviewed. If the death is a non-investigable death the Ombudsman can elect to investigate the death at his own discretion. The conduct or otherwise of a discretionary review depends on a range of factors, including the circumstances surrounding the child's death and the level of involvement of the Department for Child Protection and Family Support or other public authorities in the child's life. In reviewing the circumstances under which the particular child death occurred, the Ombudsman seeks to identify patterns and trends in incidents in order to prevent or reduce future child deaths.[174]

Youth Awareness and Accessibility Program

Building on a number of systems already in place, the Ombudsman began significantly improving systems to enhance access to his office for children and young people in 2015-16, including a proactive visiting program to vulnerable groups of children in the child protection system. This included recent visits to:

- the Kath French Secure Care Centre
- three residential group homes in the Perth metropolitan area
- one family group home in the Perth metropolitan area
- one residential group home in the Mid West region.

The Ombudsman has also increased regular visits to Banksia Hill Juvenile Detention Centre and engagement with the community sector under the Regional Awareness and Accessibility Program. These proactive visits provide an additional avenue for vulnerable groups of children and young people to voice concerns about treatment or conditions while also providing them with information about the role of the Ombudsman.

The then-Department for Child Protection and Family Support's *Building a Better Future - Out-of-Home Care Reform in Western Australia*, proposed a new role for the Ombudsman, namely, to improve independent oversight of the child protection system in in Western Australia through the monitoring all out-of-home-care organisations against a new set of safety standards. These changes aim to provide independent oversight of the child protection system in Western Australia.

1.2 Office of the Inspector of Custodial Services

The Office of the Inspector of Custodial Services is responsible for the independent statutory oversight of custodial services, including Banksia Hill Juvenile Detention Centre. The Inspector reports directly to Parliament and is mandated to monitor the rights of detainees, assess staff performance and review facility practices, processes and procedures. In so doing, the Inspector is independent as to scope, content and methodology of activities. OICS reports are publically available at www.oics.wa.gov.au

Inspections

Under the *Inspector of Custodial Services Act* 2003, the Inspector is required to inspect and report on all places of detention, as well as prescribed lockup facilities, at least once every three years. Inspections are conducted more frequently where there is a need, which has been the case at Banksia Hill Juvenile Detention Centre in recent years.

Inspections can be either announced or unannounced, but few unannounced inspections have been carried out. Successive Inspectors have found there is generally more benefit in providing notice so that the department and centre staff are available for meetings, and information is provided. However, liaison/monitoring visits are commonly conducted with little or no notice.

At the end of the one or two week period of inspection, the Inspector briefs centre staff and management, and head office, on key findings. This gives the department an opportunity to discuss findings are implement changes before publication of the final report.

Inspection reports highlight concerns in service delivery and outline areas for improvement. Report recommendations can relate to discrete problems identified in

a particular facility or to systemic issues that exist broadly across the sector. These recommendations and the department's response thereto are included in a final report tabled in Parliament.

Liaison/monitoring visits

In addition to triennial inspections, OICS undertakes a process of continuous visiting. This allows for performance to be monitored and problems identified on an ongoing basis.

OICS visits most prisons at least four times a year. Higher-risk prisons and Banksia Hill Juvenile Detention Centre are visited at least six times a year. When necessary, visits will be even more frequent. In 2016-17, 13 liaison visits were conducted to Banksia Hill. In addition, the Inspector or staff conducted a number of other visits for reviews, which included Banksia Hill, and to be updated on specific issues.

Liaison/monitoring visits can be announced or unannounced. Usually some notice is given so that facilities can help OICS engage with staff and people in custody. However it is common for such visits to be conducted at short notice. Unannounced visits are conducted when necessary or appropriate.

Independent Visitors Scheme

Under the *Inspector of Custodial Services Act,* the Minister appoints independents visitors (IV) on the advice of the inspector, and the inspector administers the service on behalf of the Minister. The IVs are a highly qualified and diverse group of community volunteers who bring skill, insight, and common sense to the role. They make an invaluable contribution to resolving issues and improving oversight. People held in custody are able to tell IVs their views and to raise concerns about their treatment and conditions.

Independent visitors attend their allocated prison or detention centre at least once every three months to talk with people in custody and staff. Before leaving the facility, IVs debrief with the superintendent or deputy so that matters can be resolved as soon as possible. Following their visit they are required to make a short report to the Inspector in writing, and to include in that report a record of any complaint made by or on behalf of a prisoner. The reports help the Office of the Inspector of Custodial Services monitor the prison or detention centre, and can be useful in identifying thematic issues within the prison system.

OICS assesses the report and sends it to Corrective Services with comments and requests for additional information. Corrective Services then returns the report with its responses. Information gathered by the IVs provides another valuable sources or independent information into the office.

Reviews

The Inspector is also empowered to undertake occasional reviews of custodial services. Reviews examine aspects of a custodial service, or an individual or group's custodial experience. Reviews may also include an examination of administrative arrangements for providing that service. Since 2012, OICS has reviewed a wide range of topics relating to security, safety, rehabilitation and management.

OICS has done specific reviews of Banksia Hill Juvenile Detention Centre on behaviour management practices and following the riot in 2012. The office also routinely includes Banksia Hill Juvenile Detention Centre in broader reviews. Findings for youth are usually separated from adult findings as the circumstances, policies and impact are generally different.

Reviews, like inspections, lead to reports with findings and recommendations. Unlike inspection reports, there is no requirement for reviews to be tabled in Parliament and made public. However, for reasons of transparency, accountability and system improvement, OICS practice is to table and publicly release reports unless there are privacy or security concerns. If the Inspector does decide not to table a report, confidential copies are sent to the Standing Committee on Public Administration.

Individual complaints

OICS is unable to investigate individual complaints made by staff, prisoners, detainees or their families. While the Inspector may seek to understand and explore systemic issues that arise from individual complaints he cannot facilitate their resolution. Individual grievances arising from time spent in a custodial facility fall within the jurisdiction of the Ombudsman, the Equal Opportunity Commission and, in certain circumstances, the Health and Disability Services Complaints Office.

The inspector is similarly proscribed from investigating criminal matters. If an issue involving purported criminality is brought to the attention of the Inspector it will be referred to the Western Australian Police. If the matter involves allegations of serious or minor misconduct the inspector is under a legislative obligation to report the matter to the Corruption and Crime Commission or the Public Sector Commission, respectively.

1.3 Chief Psychiatrist WA

The Chief Psychiatrist WA is an independent statutory officer who holds powers and duties as prescribed by the *Mental Health Act 2014* (MHA 2014). The powers invested in the Chief Psychiatrist impose a governance responsibility over any Mental Health Service and other specified agencies that seek to influence the delivery of mental health treatment and care to the Western Australian community. The Chief Psychiatrist WA reports to State Parliament through the Minister for Mental Health

and provides advice to the Minister about the provision of mental health services for the State. The Chief Psychiatrist WA provides an annual report which, by statute, must be tabled by the Minister for Mental Health in Parliament.

The Chief Psychiatrist WA, pursuant to Section 515 of the MHA 2014 is responsible for overseeing the treatment and care of all voluntary, involuntary, mentally impaired accused detained at an authorised hospital, and all persons referred under section 26(2), or (3)(a) or 36(2) for examination by a psychiatrist.

Practically, this means oversight of standard of care for patients within the majority of public sector mental health services, some non-government organisations funded to provide public mental health care, private psychiatric hospitals, and certain individuals within private psychiatric hostels.

The Chief Psychiatrist WA discharges the above responsibility by publishing under section 547(2) of the Act, standards for the treatment and care to be provided by mental health services and overseeing compliance with those standards. The Chief Psychiatrist views matters through a safety and quality lens, considering both the individuals' needs (consumer, carer, clinician) and broader systemic issues (e.g. equity of access and services).

Office of the Chief Psychiatrist

A Deputy Chief Psychiatrist and a team of staff assist the Chief Psychiatrist in the discharge of statutory responsibilities while ensuring the rights of people with lived experience of mental illness are upheld.

The Chief Psychiatrist leverages standards through a number of functions and strategies, including:

- A reporting system
    - Clinicians and services providers are, by statute, required to report on a range of notifiable events, including where there may be a negative outcome (e.g. death, restraint, seclusion, among others) but also to track certain processes and treatment (e.g. Electroconvulsive Therapy (ECT), segregation of children from adult inpatients, off-label prescribing to children who are involuntary patients, and emergency psychiatric treatment, among others).
- A reviewing system
    - The Chief Psychiatrist, through their team, undertakes regular, formal clinical reviews of services, as well as informal service visits to have two-way feedback with consumers, carers and clinicians.
    - These formal reviews involve site visits, medical record scrutiny and interviews with staff, consumers and carers – recommendations are provided to services following these Reviews.

    - The Chief Psychiatrist may undertake a targeted review into an individual case.
- An approving and authorising system
    - Approving ECT services.
    - Authorising hospitals (that may take involuntary patients) and (as well as training) Mental Health Practitioners who may perform functions in the MHA 2014.
- A support system
    - A helpdesk for clinicians to discuss difficult clinical, ethical and MHA-interface issues.
    - Strategic education sessions around the MHA 2014 and standards.
- An interjurisdictional role
    - A mental health safety and quality interface with other agencies both intra- and interstate, including providing data to national processes.

The Chief Psychiatrist WA is not a primary complaint agency, the Office of the Chief Psychiatrist provides advice to the Health and Disability Services Complaints Office (HaDSCO), and has a role in certain complex situations relating to individuals where standards of care are implicated.

1.5 Mental Health Advocacy Service

The Mental Health Advocacy Service was established pursuant to the *Mental Health Act 2014* to provide advocacy support to specific mental health patients prescribed in the Act.

- advocates are broadly empowered to assist certain classes of people identified under the Act. These persons are primarily involuntary patients and individuals on Community Treatment Orders. They also include:
- individuals who have been referred for an assessment to consider whether they should be made involuntary
- individuals on Hospital Orders who have been charged with a criminal offence and referred for psychiatric assessment
- mentally impaired accused people on Custody Orders in an authorised hospital or the community pursuant to the *Criminal Law (Mentally Impaired Accused) Act* 1996
- private psychiatric hospital residents.

Every child who is made an involuntary patient under the Act must be contacted by an advocate within 24 hours of such a determination. Individuals who are waiting to be assessed by a psychiatrist and who request contact with an advocate must be contacted within three days. Other requests for contact must be responded to "as soon as practicable", or within seven days. A child detained under the *Mentally*

Impaired Accused Act, however, must be visited or otherwise contacted by an Advocate within 24 hours.

In order to facilitate compliance with these requirements, the Act therefore mandates that the Chief Advocate be notified by relevant mental health services of every individual who is made involuntary in Western Australia. When making contact with an identified person an advocate must, according to the Act:

- inquire into the extent to which they have been informed of their rights and the extent to which those rights have been upheld
- inquire into and seek to resolve any complaints they may have about the condition of their treatment and, if necessary, support them to make complaints to the Health and Disability Services Complaints Office
- assist and represent them in proceedings before the Mental Health Tribunal or the State Administrative Tribunal
- advocate for and facilitate their access to other services.

Investigations

Advocates are also empowered to conduct investigations into any matter relating to conditions of mental health services that are adversely affecting, or are likely to adversely affect, the health, safety or wellbeing of patients. Such an investigation may include an inquiry into systemic issues affecting patient rights.

The Chief Advocate may report to the service provider, the Minister, the Chief Psychiatrist, the Commissioner for Mental Health, or the Director General of the Department of Health on any issue that arises during the course of an investigation. The Chief Advocate must subsequently be kept informed about the outcome of additional inquiries.

Powers

In pursuit of the goals of the agency, Mental Health Advocates are granted broad powers of enquiry and right of attendance on mental health wards and in psychiatric hospitals and other mental health facilities. These powers also include the right to:

- attend such wards, hospitals or facilities at any time the advocate considers appropriate
- visit and speak with patients
- inquire into the admission, referral or detention of a patient and the provision of treatment or care to that patient
- view and copy medical files and other documents unless the patient objects
- do anything necessary or convenient for the performance of their functions.

In carrying out functions with respect to children and young people advocates must have regard to the best interests of the child while also seeking to ascertain, to the

extent that it is practicable, the child's wishes and the wishes of parents and guardians.

1.6 Auditor General WA

In accordance with the *Auditor General Act 2006*, the Auditor General scrutinises the public sector to ensure there is proper accountability of taxpayers' resources and that the resources are not wasted – rather, that they are used efficiently and effectively to benefit all Western Australians.

Accordingly, the Auditor General is an ally of the people and Parliament. He must act, and be seen to be acting, independently in carrying out all his powers and duties. To preserve this independence and objectivity, the Auditor General does not comment on the merits of or criticise government policy. The Auditor General also does not normally investigate criminal matters or complaints relating to individuals, but may investigate systemic issues arising through such complaints.

Independent reports tabled in Parliament by the Auditor General assist parliamentarians and the public to have a better understanding of the performance of public sector agencies. They also assist agency management to improve governance and control environments and the cost effectiveness and responsiveness of their services.

Financial Audits

Each year the Auditor General audits and provides opinions on, the annual financial statements and key performance indicators of over 200 public sector organisations, including government departments, statutory authorities, corporatised entities, universities and state training providers (TAFE colleges). These audits provide assurance to Parliament that the financial statements and KPIs are based on records and are fairly presented. Most annual audits also produce an audit opinion on financial controls.

Performance Audits – broad scope and narrow scope

Each year the Auditor General conducts a number of performance audits on a varied range of topics. Broad scope performance audits primarily focus on the effective and efficient management and operation of agency programs and activities. Narrow scope audits tend to focus more specifically on agency compliance with legislation, policies and accepted good practice. These audits serve to highlight issues surrounding regulatory, financial and administrative processes within agencies. Performance audit topics are selected by the Auditor General following an exhaustive process, which also takes into account requests for audits from Parliament, the government or the broader community.

Information Systems Audits

Information systems audits focus on the general computer controls of agencies with significant computer environments to determine whether these effectively support the accuracy and integrity of agency financial statements and KPIs. In addition, the Auditor General conducts audits each year of a sample of important non-financial computer applications.

'Follow the Dollar' Powers

In delivering the different types of work listed above, the Auditor General may use 'follow the dollar' powers provided by the *Auditor General Act 2006*. These powers allow the Auditor General to evaluate the way in which government funds are spent by organisations tasked to do so, such as non-government organisations or partner organisations. Importantly, this 'follow the dollar' function allows for all government expenditure to be analysed, no matter who was awarded a grant, contract or tender.

Public Interest Disclosures

Under the *Public Interest Disclosure Act 2003*, the Auditor General investigates disclosures made to the Office that relate to substantial, unauthorised, irregular use or mismanagement of public resources. Results of such investigations if significant may lead to the Auditor General tabling a report in Parliament.

1.7 Commissioner for Children and Young People

The Commissioner for Children and Young People has a broad oversight mandate composed of discrete functions with powers ranging from advocacy to inquiry. While these functions relate to all children and young people, the Commissioner must have special regard to the interests and needs of Aboriginal and Torres Strait Islander children and young people, and children and young who are vulnerable or disadvantaged for any reason. The Commissioner's oversight monitoring functions broadly encompass wellbeing monitoring, complaints monitoring, and monitoring of legislation, policies, practices and services. The Commissioner's constituent legislation confers the power to monitor both how agencies respond to complaints made by children and discernible trends in the nature and frequency of the complaints.

Systemic advocacy

The Commissioner for Children and Young People undertakes a broad advocacy role with respect to the rights and interests of children and young people. The scope of the Commissioner's advocacy role is not defined in the Act, however the advocacy carried out by the Commissioner extends beyond merely speaking on children's

behalf or providing opportunities to incorporate children and young people into the work of the office. It also involves:

- ensuring that systems are appropriately equipped to recognise the rights and needs of children and young people
- seeking the views of children and young people and working to include them in decision making processes
- promoting the participation of children and young people in the making of decisions that affect their lives
- promoting and monitoring the wellbeing of children and young people
- monitoring and reviewing written laws, policies, practices and services affecting the wellbeing of children and young people
- conducting and promoting research into matters relating to the wellbeing of children and young people.

The Commissioner frequently makes recommendations to government, based on evidence-based research and broad consultation that seek to strengthen systems that safeguard rights and wellbeing of children and young people.

Complaints monitoring

The *Commissioner for Children and Young People Act 2006* also provides the Commissioner with certain functions aimed at monitoring how agencies deal with complaints made by children, as well as to monitor trends in those complaints. This means any complaint about services that are provided by public agencies to children and young people. Complaints can, therefore, concern any service provided by any government department.

The Commissioner's current complaint monitoring includes providing guidelines to all agencies regarding the development of accessible and responsive complaints systems for children and young people. These guidelines are also supported by an ongoing survey of government agencies to monitor both the use of the guidelines and the nature of complaints made by children and young people.

1.8 Health and Disability Services Complaints Office

The Health and Disability Services Complaints Office (HADSCO) is an independent statutory authority that provides an impartial resolution service for complaints relating to health, disability and mental health services in Western Australia and the Indian Ocean Territories. HaDSCO is established under the *Health and Disability Services (Complaints) Act 1995*. The office also has responsibilities under Part 6 of the *Disability Services Act 1993* to manage complaints relating relating to the provision of disability services and responsibilities under Part 19 of the *Mental Health Act 2014* to manage complaints about mental health services. Each Act contains similar provisions setting out the arrangement for the management of complaints about health, disability and mental health services in Western Australia.

Complaints Management Process

Under its legislation, HaDSCO manages complaints using a resolution based approach, aiming to resolve complaints as informally as possible and in the most timely and efficient manner. HaDSCO has three main stages in its complaints management process, enquiry, assessment and complaint resolution including; negotiated settlement, conciliation and investigation.

During the enquiry stage, HaDSCO provides information about its complaints process and advice about how to raise a complaint with the service provider. If the complaint is outside HaDSCO's jurisdiction, an alternative complaint body that may be able to assist may be suggested. HaDSCO may also refer individuals to advocacy services for assistance. HaDSCO can receive verbal complaints but they must be confirmed in writing.

In assessing complaints, HaDSCO ensures the complaint relates to the provision of a health, disability or mental health service delivered in Western Australia; the individual and their representative, if required, have provided their signed authorisations; the complaint relates to an incident that occurred within the last two years; the individual, or their representative, have attempted to resolve the complaint with the service provider in the first instance and the complaint is within HaDSCO's legislative jurisdiction.

HaDSCO is required by law to consult with the Australian Health Practitioner Regulation Agency to determine which entity is the more appropriate agency to manage all, or part of the complaint.

At the end of HaDSCO's assessment process a complaint may be accepted, rejected or referred to a more appropriate agency. If HaDSCO cannot accept the complaint information will be provided about other complaint resolution options.

Complaint resolution pathways

There are a number of factors considered by HaDSCO when making a decision about which complaint resolution pathway is the most appropriate to manage the complaint; negotiated settlement, conciliation and investigation.

In negotiated settlement HaDSCO facilitates the exchange of information between both parties to assist in resolving a complaint by negotiatiing an outcome acceptable to both the individual and the service provider. Conciliation involves a face-to-face meeting facilitated by HaDSCO whose role is to encourage the settlement of the complaint. HaDSCO staff will arrange for the provider and the person who made the complaint to hold informal discussions about the complaint; and assist them to reach an agreement. An investigation is aformal process to determine whether any unreasonable conduct occurred in providing a health, disability or mental health service.

Education and training

HaDSCO's Stakeholder Engagement Strategy outlines its commitment to deliver a series of individual engagement projects related to information on its operations, updated and future plans; consultation with stakeholders to listen and acknowledge concerns and provide feedback; involvement with stakeholders to ensure that concerns are considered and where appropriate, reflected in relevant processes; collaboration with stakeholders to obtain input to formulate solutions and incorporate their advice and recommendations to achieve positive outcomes and empowering stakeholders by providing advice, resources and tools to empower their decision-making.

1.9 Equal Opportunity Commission

The Equal Opportunity Commission was established pursuant to the *Equal Opportunity Act 1994* and has three broad oversight roles. The first is to provide a means of redress to individuals by investigating and attempting to conciliate allegations of unlawful discrimination. The second is a preventive education role that seeks to promote and encourage recognition of the principles of equality of opportunity in a number of areas of life, including employment, education, and the provision of goods and services. The third is to undertake investigations into systemic discrimination, which involves identifying areas of concern and making recommendations for improvement.

Complaints

The Commissioner is empowered to investigate and attempt to conciliate allegations of unlawful discrimination on one of more of the grounds protected under the Act. A complaint can be lodged either by an individual, an individual on their own behalf and on behalf of others, or a relevant union. Complaints must be made in writing and relate to an incident that has occurred in the previous 12 months. Upon receipt of a complaint, the Commissioner will undertake a preliminary assessment and, if the complaint falls within the jurisdiction of the Act, assign a Conciliation Officer to investigate and conciliate the complaint. In the event that a complaint cannot be conciliated, the Commissioner may choose to refer the matter to the State Administrative Tribunal.

Community education and training

The Equal Opportunity Commission, which was established to provide expertise and support to the Commissioner, is the State's foremost authority on issues of diversity and discrimination. The Commission also undertakes community outreach and education that seeks to improve public awareness and understanding of the principles of equal opportunity, and increase knowledge of the Act.

Inquiries and reviews

The Commissioner is empowered, pursuant to section 80 of the Act, to undertake investigations into systemic unlawful discrimination and to develop and monitor recommendations aimed at remedying identified concerns. The Commissioner is also able to review the laws of the State and to consult with government, business, and industrial and community groups in order to achieve improvements in conditions affecting persons who are subjected to discrimination in the areas of life covered by the Act.

1.10 Public Sector Commission

The Public Sector Commissioner has a monitoring and oversight role under the following pieces of Western Australian integrity legislation:

- *Public Sector Management Act 1994* (PSM Act)
- *Public Interest Disclosure Act 2003* (PID Act)
- *Corruption, Crime and Misconduct Act 2003* (CCM Act)

Monitoring public adminitration and management

Through an annual survey program the Commissioner monitors:

- the state of public sector administration and management, assesses compliance with standards and ethical codes, and workforce managementg processes (PSM Act)
- public authorities' compliance with public interest disclosure processes (PID Act)
- how effectively public authorities are responding to misconduct (CCM Act).

The Commissioner is required to report annually on the state of public administration and management to the Western Australian Parliament, public authorities and the community.

Oversight of misconduct

Minor misconduct is behaviour that could reasonably lead to termination of a public officer's employment if proved. The Commissioner is responsible for oversight of the minor misconduct of public officers and for misconduct prevention and education under the CCM Act. Notifications of suspected misconduct made by public authorities and individuals allow this role to be performed. Responses can range from taking no further action to referring the matter to the Corruption and Crime Commission or investigating the matter itself.

Serious misconduct, and all misconduct involving police or elected members in State or local government, falls under the Corruption and Crime Commission's jurisdiction.

Other monitoring and oversight tools

The Commissioner has a range of other legislative powers to monitor and oversee the public sector, including:

- special inquiries – generally reserved for serious matters where there is a heightened public interest and a need for comprehensive examination of the issues. A special inquiry may be commeneded on the Commissioner's initiative or at the direction of the Minister (s. 24H of the PSM Act)
- seviews – typically concern the functions, management or operation of public sector bodies (s.24B of the PSM Act).
- investigations – undertaken in relation to specific actions, activities or questions of conduct of any public sector body (s.24 of the PSM Act), a public interest disclosure as a proper authority or named authority (ss. 8 & 9 of the PID Act)
- examinations – a simply inquiry function not involving the use of legislative powers.

Any person can approach the Commission

Importantly, the CCM Act and PID Act states any person can report minor misconduct or lodge a public interest disclosure, including children and young people. Through the Commission's advisory serivce, infromation and advice about navigating the State's integrity and oversight framework can be provided to any person who calls or writes for assistance.

1.11 Corruption and Crime Commission

The Corruption and Crime Commission is a permanent investigative commission that seeks to improve the integrity of the Western Australian public sector by reducing the incidence of misconduct therein. The Commission assesses and investigates allegations of serious misconduct by public officers, including police officers and employees, State Government employees and members of parliament as well as all employees of public universities and elected members of local governments.175 This includes monitoring serious misconduct investigations undertaken internally by public sector agencies. Pursuant to the Act all Principal Officers of public authorities must notify the Commission of any matter which they suspect on reasonable grounds concerns or may concern serious misconduct.176 Also pursuant to the Act, any individual who becomes aware of serious misconduct can report it to the Commission. This includes members of the public and individual government employees. While the Commission must assess every reported allegation of serious

misconduct it focuses investigations on areas where the risk of serious misconduct and corruption is greatest.

Serious misconduct

Serious misconduct by public officers is corrupt or criminal conduct that tends to show a deliberate intent for an improper purpose and occurs in instances in which a public officer abuses authority for personal gain, causes detriment to another person, or acts contrary to the public interest.[177] The CCC is also responsible for investigating all police misconduct. Police misconduct refers to all forms of misconduct that constitute a 'reviewable police action'.[178] Upon receipt of an allegation of serious misconduct or police misconduct the Commission may choose to investigate the allegation independently, investigate the allegation in cooperation with another external oversight body, investigate in cooperation with an appropriate internal mechanism, refer the matter to a more appropriate review body or decide to take no action. If the Commission decides to refer the matter it may choose to monitor the progress of the investigation and review the outcome. If the Commission, however, decides to commence action independently and forms an opinion that corruption or serious misconduct has occurred it may recommend disciplinary action be taken against the public officer or that the officer be charged with a criminal offence.

1.12 Information Commissioner

The Information Commissioner is an independent statutory officer established by the *Freedom of Information Act 1992*. The Commissioner is invested with a range of oversight functions under the Act however is primarily responsible for providing independent external review of decisions made by State and local government agencies on access applications and requests to amend personal information under the Act. The Commissioner carries out this function in response to complaints made by any individual who is dissatisfied with an agency's decision on internal review. The Commissioner attempts to resolve all complaints informally and through a process of conciliation. However, to the extent that a complaint cannot be resolved in this manner, the Commissioner is empowered to issue a formal decision that confirms, varies or sets aside the agency's initial decision. Importantly, the Commissioner's decision is legally binding and is only subject to appeal to the Supreme Court on questions of law.

In addition to conciliation and review, the Commissioner undertakes outreach to ensure that State and local government agencies and the public are aware of their possible rights and responsibilities under the Act. The Commissioner also advises Parliament on legislative and administrative changes that could be made to advance the object and purpose of the Act.

Appendix 2: Independent oversight arrangements in Western Australia by sector

		Complaints handling Mechanisms that receive and investigate complaints about services or agencies	**Misconduct processes** Mechanisms that receive and investigate allegations of misconduct	**Individual Advocacy** Mechanisms that provide children and young people with individual advice and support	**Inspections and visits** Mechanisms that *systematically* inspect or visit services and facilities	**Inquiries and reviews** Mechanisms empowered to conduct ad hoc thematic or targeted reviews, inquiries or investigations	**Systemic advocacy** Mechanisms that promote the rights and interests of children and young people generally and encourage systemic change
Out-of-home care	**Department provided** **Services** Government services	**Ombudsman** Complaints related to the decision-making and practices of the Department of Communities Proactive visiting program to Department services to inform children and young people in care about the existence and work of the Ombudsman (five residential group homes and the Kath French Secure Care Centre visited in 2016). The Ombudsman does not visit children in foster care or family care. **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct		**Independent Assessors** Quasi-independent mechanism, inspects facilities on average every 6-8 years	**Ombudsman WA** Own-motion investigations into aspects of public administration **Two own-motion investigations have been conducted into out-of-home care.** **50 child death review investigations in 2016-17** **Auditor General WA** Financial and performance audits **No audits of out-of-home care services have been conducted** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into out-of-home care have been conducted** **Public Sector Commission**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people
	Non-government services	**Ombudsman** Complaints from children in the care of the CEO, residing with a non-government service provider, about the Department Proactive visiting program to Department funded services to inform children and young people in care about the existence and work of the Ombudsman (five residential group homes and the Kath French Secure Care Centre visited in 2016)				**Auditor General WA** Financial and performance audits using follow-the-dollar powers if needed **No audits of out-of-home care have been conducted** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

		Equal Opportunity Commission Complaints related to allegation of unlawful discrimination				**No inquiries into out-of-home care have been conducted**	
Police custody		**Ombudsman** Complaints related to the decision-making and practices of the Western Australian Police **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Corruption and Crime Commission** All police misconduct		**Office of the Inspector of Custodial Services** Prescribed lockups only **Limited coverage (6 of 125 lockups)**	**Ombudsman** Own-motion investigations into the decision making and practices of public authorities **No investigations into police custody have been conducted** **Auditor General WA** Financial and performance audits **No audits of police custody have been conducted**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people
Youth justice	**Juvenile detention**	**Ombudsman** Complaints related to the decision-making and practices of the Department of Justice Proactive visiting program to Banksia Hill to inform detained children and young people about the existence and work of the Ombudsman **Health and Disability Services Complaints Office** Complaints related to the provision of health services in Banksia Hill **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct	**Independent Visitors Services** Meets with detainees, refers complaints, discusses concerns about treatment and raises issues with the Superintendent	**Office of the Inspector of Custodial Services** Inspections are conducted at least once every three years, more frequently when required. Liaison/monitoring visits are conducted at least six times per year, more frequently when required **Independent Visitors Services** Visits are conducted at least once every three months	**Office of the Inspector of Custodial Services** Occasional reviews of custodial services **Two reviews into issues at Banksia Hill Juvenile Detention Centre have been conducted** **Ombudsman** Own-motion investigations into the decision making and practices of public authorities **No investigations into youth detention have been conducted** **Auditor General WA** Financial and performance audits **Two performance reviews into issues related to youth detention have been conducted** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into youth detention care have been conducted**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

	Community corrections	**Ombudsman** Complaints related to the decision-making and practices of the Department of Justice **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct			**Ombudsman** Own-motion investigations into the decision making and practices of public authorities **Auditor General WA** Financial and performance audits **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people
Education	**Government schools**	**Ombudsman WA** Complaints about the decision making and practices of the Department of Education **Teacher Registration Board WA** Complaints related to registered teachers **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct **Auditor General WA** Misconduct relating to misuse of public resources **Teacher Registration Board WA** Allegations related to registered teachers			**Ombudsman** Own-motion investigations into the decision making and practices of public authorities **No investigations into police custody have been conducted** **Auditor General WA** Financial and performance audits **Five performance reviews related to education and training have been conducted since 2009** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into the education system have been conducted**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people
	Non-government schools	**Teacher Registration Board WA** Complaints related to registered teachers **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Teacher Registration Board WA** Allegations related to registered teachers			**Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into the education system have been conducted**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

Mental health	**Department provided**	**Ombudsman** Complaints about the decision-making and practices of Department provided mental health services **Mental Health Advocacy Service** Complaints related to the detention of identified patients at, or the treatment or care that is being provided to identified persons by, mental health services **Health and Disability Services Complaints Office** Complaints related to public or private organisations and the Disability Services Commission **Australian Health Practitioner Regulation Agency** Complaints related to qualified health practitioners **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct	**Mental Health Advocacy Services** Provides support and advocacy services to identified persons (s.348 Mental Health Act. Advocates are required to visit involuntary child patients within 24 hours) **Chief Psychiatrist WA** Provides oversight and advocacy services to public sector mental health patients, some patients in NGO services, and private psychiatric hospitals	**Chief Psychiatrist WA** Announced and unannounced inspections of or visits to mental health services **Mental Health Advocacy Service** Advocates are required to visit or contact all involuntary child patients within 24 hours	**Ombudsman** Own-motion investigations into the decision making and practices of public authorities **One own-motion investigation conducted into issues related to mental health services** **Auditor General WA** Financial and performance audits using follow-the-dollar powers if needed **No audits of the mental health system have been conducted** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into out-of-home care have been conducted** **Health and Disability Services Complaints Office** Investigations into broad systemic issues related to the provision of health, disability or mental health services **Chief Psychiatrist WA** Targeted reviews to investigate standards of psychiatric care. Thematic reviews into particular clinical areas. **All mental health services will undergo clinical standards and service review between 2016-18** **Mental Health Advocacy Service** Investigations into any matter relating to the conditions of mental health services adversely affecting the health, safety or wellbeing of patients **This function is yet to be exercised**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people **Mental Health Advocacy Service** The Mental Health Advocacy Service advocates for systemic changes to the mental health system. **Chief Psychiatrist WA** The Chief Psychiatrist undertakes systemic advocacy on issues identified through visits and reviews.
	Department funded	**Health and Disability Services Complaints Office** Complaints related to public or private organisations and the Disability Services		**Mental Health Advocacy Services** Provides support and advocacy services to identified persons (s.348 Mental Health Act. Advocates are required to	**Chief Psychiatrist WA** Ad hoc announced and unannounced inspections of or visits to mental health services	**Auditor General WA** Financial and performance audits **No audits of the mental health**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

		Commission. **Mental Health Advocacy Service** Complaints related to the detention of identified patients at, or the treatment or care that is being provided to identified persons by, mental health services **Australian Health Practitioner Regulation Agency** Complaints related to qualified health practitioners **Equal Opportunity Commission** Complaints related to allegation of unlawful discrimination		visit involuntary child patients within 24 hours) **Chief Psychiatrist WA** Provides oversight and advocacy services to public sector mental health patients, some patients in NGO services, and private psychiatric hospitals	**Mental Health Advocacy Service** Advocates are required to visit or contact all involuntary child patients within 24 hours	**system have been conducted** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries into out-of-home care have been conducted** **Health and Disability Services Complaints Office** Investigations into broad systemic issues related to the provision of health, disability or mental health services **Chief Psychiatrist WA** Targeted reviews to investigate standards of psychiatric care. Thematic reviews into particular clinical areas. **All mental health services will undergo clinical standards and service review between 2016-18** **Mental Health Advocacy Service** Investigations into any matter relating to the conditions of mental health services adversely affecting the health, safety or wellbeing of patients **This function is yet to be exercised**	**Mental Health Advocacy Service** The Mental Health Advocacy Service advocates for systemic changes to the mental health system. **Chief Psychiatrist WA** The Chief Psychiatrist undertakes systemic advocacy on issues identified through visits and reviews.
Disability services	**Department provided**	**Health and Disability Services Complaints Office** Complaints related to public or private organisations and the Disability Services Commission. **Australian Health Practitioner Regulation Agency** Complaints related to qualified health practitioners **Ombudsman** Complaints about the decision-making and practices of the Department	**Public Sector Commission** Investigates allegations of minor misconduct **Corruption and Crime Commission** Investigates allegations of minor misconduct		**Ombudsman** Has jurisdiction to investigate the Department of Communities and can inspect Department provided disability services. **Not a systematic inspection regime**	**Ombudsman** Own-motion investigations into the decision making and practices of public authorities **No own motion investigations conducted into issues related to disability services** **Auditor General WA** Financial and performance audits **No audits conducted into issues related to disability services** **Commissioner for Children and Young People**	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

		Equal Opportunity Commission Complaints related to unlawful discrimination on the grounds of impairment **Australian Human Rights Commission** Complaints related to unlawful discrimination on the grounds of disability or impairment contrary to *Disability Discrimination Act 1992* (Cth)				Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries conducted into issues related to disability services** **Health and Disability Services Complaints Office** Investigations into broad systemic issues related to the provision of health, disability or mental health services	
	Department funded	**Health and Disability Services Complaints Office** Complaints related to public or private organisations and the Disability Services Commission. **Australian Health Practitioner Regulation Agency** Complaints related to qualified health practitioners **Equal Opportunity Commission** Complaints related to unlawful discrimination on the grounds of impairment **Australian Human Rights Commission** Complaints related to unlawful discrimination on the grounds of disability or impairment contrary to *Disability Discrimination Act 1992* (Cth)				**Auditor General WA** Financial and performance audits using follow-the-dollar powers if needed **No audits conducted into issues related to disability services** **Commissioner for Children and Young People** Special inquiries into any matter affecting the wellbeing of children and young people **No inquiries conducted into issues related to disability services** **Health and Disability Services Complaints Office** Investigations into broad systemic issues related to the provision of health, disability or mental health services	**Commissioner for Children and Young People** The Commissioner advocates for all children and young people

Glossary

Term	Definition
Aboriginal	The Commissioner acknowledges the unique contribution of Aboriginal people's culture and heritage to Western Australian society. For the purpose of this report the term 'Aboriginal' encompasses Western Australia's diverse cultural and language groups and also recognises those of Torres Strait Islander descent.
Advocacy mechanism	An advocacy mechanism is an oversight function that seeks to promote the interests of children and young people generally; monitor compliance with international and domestic obligations; conduct research to promote best practice; support and assist individual children to access services and complaints mechanisms; encourage structures that enable the participation of children in decision-making processes.
Complaints handling body	A complaints handling body is an oversight body responsible for the receipt, investigation and resolution of complaints.
Children and young people	The *Commissioner for Children and Young People Act 2006* defines 'children and young people' to mean people under the age of 18 years.
External oversight	External oversight refers to functions of oversight conducted by bodies independent of government with a statutory foundation.
Foster care	Foster care is a type of home-based care whereby a child or young person is not necessarily placed with someone who they know.

Government agency	A government agency is a permanent or semi-permanent organisation in the machinery of government that is responsible for the administration of specific functions.
Internal monitoring and review	Internal monitoring and review refers to functions of oversight conducted by government agencies with respect to services they provide or fund.
Out-of-home care	Out-of-home care refers to children and young people younger than 18 years unable to live with their families who have been placed with alternative caregivers on a short or long-term basis.
Quasi-independent oversight mechanism	A quasi-independent oversight mechanism is an oversight mechanism that accords with most but not all of the criteria of an independent oversight mechanism.
Relative/kinship care	Relative or kinship care is a type of home-based care whereby a child or young person is placed with a relative or someone they already know.
Residential care	Residential care is a type of out-of-home care whereby children and young people are placed in a residential setting and are accompanied by paid staff.

Acronym	Meaning
ABS	Australian Bureau of Statistics
AIC	Australian Institute of Criminology
ACCESS	Administration of Complaints, Compliments and Suggestions - branch of the Professional Standards Division Integrity Directorate

	responsible for the administration of complaints
AIHW	Australian Institute of Health and Welfare
CCC	Corruption and Crime Commission
CCYP	Commissioner for Children and Young People
CROC	United Nations Convention on the Rights of the Child
DCS	Department of Corrective Services (now Department of Justice, Corrective Services)
DCPFS	Department of Child Protection and Family Support (now Department of Communities, Child Protection Family Support)
DOJ	Department of Justice
FASD	Fetal Alcohol Spectrum Disorder
HaDSCO	Health and Disability Services Complaints Office
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
OCP	Office of the Chief Psychiatrist
OICS	Office of the Inspector of Custodial Services
OWA	Ombudsman Western Australia
PSC	Public Sector Commission
SMU	Standards Monitoring Unit – Department of Communities body responsible for implementing

	standards monitoring and assurance processes
TRBWA	Teacher Registration Board of Western Australia
WA	Western Australia

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