CPP

Child Protection Panel

Making children safer

The wellbeing and protection of children in immigration detention and regional processing centres

May 2016

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Acknowledgements

The Child Protection Panel (the Panel) would like to thank the Secretariat staff for their assistance and support during the conduct of this review and development of this report.

Throughout the review, the Panel has had significant opportunity to discuss progress with the Secretary of the Australian Government Department of Immigration and Border Protection, as well as with the Australian Border Force Commissioner.

The Panel members met a large number of departmental and service provider staff, and wish to express their appreciation for the time, energy and input provided through those discussions. Similarly, members note the assistance and engagement of representatives of the Government of Nauru at site visits to the regional processing centre (RPC).

The Panel also greatly appreciated the insights, access to facilities and contributions provided by officers and service provider staff at held detention facilities and at Nauru RPC.

Summary

Since the Child Protection Panel (the Panel) commenced its work in March 2015, there has been a profound change to the immigration detention environment and that at the regional processing centre (RPC) in Nauru. The number of children in detention facilities or the RPC has decreased very significantly. This is the result of a major effort to move children and their families into community settings within Australia, and the Government of Nauru implementing 'open centre' arrangements while the processing of transferees' claims is expedited.

These shifts have not reduced the relevance of this report. Community detention is now the primary form of detention of children awaiting status resolution in Australia. The Panel's recommendations will further promote the wellbeing and protection of children in community detention. Further, some of the Panel's recommendations, such as incident inquiry, internet security, information management and intelligence, have broader application beyond the child protection context.

A key emphasis for the Panel has been a focus on strategies to improve child wellbeing, as well as improving the responses of the Australian Government Department of Immigration and Border Protection (the Department) to incidents involving children. Since the Panel commenced its work, the Department has already responded positively to many of the Panel's observations.

This report contains both formal recommendations and embedded observations. The embedded observations – although not formal recommendations – are important; the Panel encourages the Department to consider the totality of the report when considering responses.

The Panel has commented in detail on, but purposely not made recommendations in relation to, Nauru RPC, as this facility is operated by the Government of Nauru.

The Panel acknowledges that this review commenced during the amalgamation of the Department of Immigration and Border Protection and the Australian Customs and Border Protection Service into a new Department of Immigration and Border Protection. The Panel also notes that the period to which its work relates was one in which the Department was under significant operational pressure because of the large number of maritime arrivals.

Within this report:

- Chapters 1 to 3 relate to the establishment of the Panel, provide background information and discuss the Panel's methodology.
- Chapters 4 to 6 deal with each of the three environments that the Panel has reviewed, and Chapter 7 deals with the needs of vulnerable people.
- Chapter 8 brings together the areas where policies and practices can be improved to support the wellbeing and protection of children.

Responding to the terms of reference

The terms of reference call for the Panel to 'ensure that a comprehensive and contemporary framework for the Department relating to the protection of children is in place'.

Importantly, the Department's Child Safeguarding Framework has now been finalised, providing high-level guidance for staff and service providers. A key recommendation of the Panel is the completion of the policy architecture that supports this Child Safeguarding Framework, and the alignment of service provider policies and key departmental roles.

The terms of reference further call for the Panel to 'assess the adequacy of departmental and service provider policy and practice around the management of incidents of abuse, neglect or exploitation involving children'.

The Panel assessed 242 incidents of child abuse. Responses to just over half of the cases were assessed by the Panel as adequate or good. The response to child victims was comparatively better than the response to persons of interest (POIs).

The Panel has observed that the held detention environment shifted considerably during its tenure. For matters reviewed throughout this process, and indeed early in the Panel's existence, departmental service providers tended to control incidents and responses, with the Department, in many cases, playing a secondary role. A greater emphasis on accountability for departmental officers has led to a significant capability improvement in relation to the Department's ability to respond to incidents.

Observations on the data

The most vulnerable victim group identified through the case reviews was children under the age of 6 years, who made up 40 per cent of the victims. Of this group, 70 per cent were males.

Just over 75 per cent of POIs were adults, with males represented at twice the proportion of females. Service provider staff or subcontractors represented less than 10 per cent of the POIs.

The data show that nearly 25 per cent of cases featured child victims who had previously been reported as being the subject of earlier child abuse.

There was a relatively small group of 22 POIs that the Panel would characterise as recidivists, as they featured in approximately 25 per cent of all cases.

The Panel notes that, notwithstanding the serious nature of many incidents reviewed, less than 1 per cent of all cases resulted in criminal convictions.

There has been a very high level of compliance by the Department and its service providers, achieving a 95.3 per cent rate against the mandatory reporting requirements in each state and territory jurisdiction.

Key findings

Incident reporting and categorisation

High-quality incident reporting is critical to establishing a good basis for investigation and effective action. This is an area where considerable improvement is required. Incident reports often tended to be very brief, with inadequate description of what was reported or observed. The Panel was also of the view that improvements to complaint management systems were generally warranted, as there was a pattern of premature closure of matters and a lack of transparency in the complaint process.

The categorisation of incidents needs to be strengthened to accurately identify the number, nature and seriousness of incidents – including improving consistency across different service providers.

Child safeguarding inquiries

There is a need to significantly strengthen the Department's capacity to conduct child safeguarding inquiries into incidents of child abuse. This will call for stronger leadership from senior operational staff, including coordination of multi-agency forums to facilitate the outcomes of child protection safeguarding inquiries. It is essential that inquiries are not finalised until all available facts are established and effectively responded to, even if a criminal investigation cannot proceed.

The Panel noted that the Department and service providers often lacked the capability to effectively respond to complex incidents.

Improving management of information flow

The Panel found that there was a need to improve the flow of detainee- and transferee-related information within and outside the Department. Staff need to know where this information is held and how it can be accessed. In the longer term, integrating the currently fragmented information holdings relating to children and their families will be important.

When privacy considerations restrict the flow of necessary information, this can be largely overcome by seeking consent from detainees and transferees to share such information.

Community detention capability

There is a need to strengthen the capability of community detention service providers to ensure that staff have the skills to identify and act on emerging risks to children, and respond effectively to critical incidents. There is also a need to develop case management protocols relating to children to inform placement decisions and identify support needs. This latter observation applies equally in held detention.

The Panel acknowledges that it had the least amount of time to work on community detention cases, which is arguably the most important area moving forward. There is important work to be undertaken on identification and management of risk in the community detention environment.

Risk management

The Panel found that the current approach to risk management focuses broadly on physical security and good order of detention facilities. In community detention, the Panel found no risk frameworks in place. It is important that the Department works with service providers to extend existing risk assessment mechanisms to ensure that they specifically address the safety of children in detention and those who are a threat to children.

External relationships

The Panel notes that, in promoting the wellbeing and protection of children, the Department must work in close cooperation with state and territory authorities – both child protection and others. It is important that the Department continue to build strong relationships with those authorities to enable the reciprocal flow of information about child protection matters and establish a common understanding of the processes followed by each party so that complex cases can be effectively resolved.

The Panel noted steps taken by the Government of Nauru to improve its child protection services, and the improved capability of its local police, supported by Australian Government officials.

List of recommendations of the Panel

1. That the Department review its operational framework for community detention to ensure that the:
    a. current and emerging risks to children and families in the changing community detention environment are fully understood and acted upon
    b. services available to detainees are tailored to their needs, including enhanced support and transitional arrangements. [Section 6.1]

2. That the Department work with community detention service providers to strengthen performance around:
    a. the capability of service provider and subcontractor staff to identify and act upon emerging risks to the safety of children
    b. the capability of front-line support staff to respond to critical incidents
    c. rationalising reporting arrangements between the Department, service providers and subcontractors. [Section 6.3]

3. That the Department review the management of unaccompanied minors (UAMs) in community detention, to ensure that:
    a. contractual arrangements for the provision of day-to-day care of UAMs include expertise in out-of-home care, as well as settlement services
    b. a 'transition from care' scheme is established that extends current levels of support to UAMs beyond their 18th birthday where this is required, especially for the purpose of completing school. [Section 7.2]

4. That the Department give effect to the Child Safeguarding Framework (the Framework), by:
    a. finalising the stated policies, procedural instructions, operating procedures and supporting material that underpin the Framework
    b. ensuring that service provider and subcontractor policies that support child wellbeing and protection are amended to align with the Framework
    c. ensuring that Detention Superintendents and Field Compliance Operations Superintendents have the necessary authority and knowledge to fulfil their accountabilities under the Framework. [Section 8.2]

5. That the Department complete a review of the implementation and effectiveness of the Framework within 18 months of its endorsement, with particular focus on the:
    a. effective exercise of accountability and control by Detention Superintendents and Field Compliance Operations Superintendents
    b. quality assurance and policy roles of the Child Protection and Wellbeing Branch

c. use of the ‘triple track’ approach to incident response. [Section 8.2]

6. That the Department continue to build sound working relations with state and territory authorities on child protection matters, to:
    a. ensure the reciprocal flow of information about child protection matters
    b. establish a common understanding of the processes followed by each party so that complex cases can be effectively resolved
    c. seek to brief law enforcement, judicial and mental health authorities to enhance their understanding of Australian Government immigration detention arrangements
    d. seek the leave of the relevant court or tribunal to appear and make submissions relating to a held or community detention issue. [Section 8.3]

7. That the Department develop an enhanced incident categorisation system, in conjunction with service providers, that accurately identifies the number, nature and seriousness of incidents, including child abuse. [Section 8.4]

8. That the Department strengthen its capacity to conduct child safeguarding inquiries by:
    a. ensuring effective leadership and management of inquiries by Detention Superintendents and Field Compliance Operations Superintendents
    b. requiring service providers to deliver accurate and complete incident reporting
    c. establishing regular multi-agency forums to coordinate and facilitate the outcomes of child protection investigations
    d. ensuring that inquiries are not finalised until all available facts are established and effectively responded to
    e. ensuring that any complaint withdrawals are fully documented and transparent. [Section 8.4]

9. That the Department develop, in conjunction with relevant service providers, case management standards for children in immigration detention. Further, the Department should design a complex-case management protocol, in consultation with Detention Superintendents and Field Compliance Operations Superintendents, within the ambit of the Child Safeguarding Framework. [Section 8.5]

10. That the Department ensure that Detention Superintendents and Field Compliance Operations Superintendents, service providers and subcontractors are aware of, and have access to, appropriate professional services that are required in complex child wellbeing and protection cases. [Section 8.6]

11. That the Department:
    a. extend its risk assessment mechanisms to ensure that they specifically address the safety of children in immigration detention, including
        i. children under the age of six years and others known to be at high risk of abuse

ii. recidivist persons of interest

b. introduce a risk assessment process around the movement of children and their families

c. extend the National Detention Placement Model to include the needs of, and mitigation of the risks faced by, children and families in immigration detention. [Section 8.9]

12. That the Department identify, assess and effectively respond to:

    a. children who have been the victims of abuse on multiple occasions

    b. persons of interest who have been involved in multiple child abuse incidents. [Section 8.9]

13. That the Department continue to implement the findings of the review of internet safeguards conducted by the Detention Assurance Team, including:

    a. the restriction of data-transfer capability

    b. the capacity to identify users of departmental computers in immigration detention facilities

    c. a regular review of data access records to identify unlawful and inappropriate access

    d. age-appropriate access to online and other digital media. [Section 8.10]

14. That the Department improve its management of case-related information, including by:

    a. developing a mechanism to ensure that officers who need this information know where it is and how to access it

    b. integrating the currently fragmented information holdings relating to children and their families in immigration detention. [Section 8.13]

15. That the Department:

    a. ensure that all relevant information on the history and background of the child and the person of interest is communicated to all relevant stakeholders (including state and territory authorities) when the child or person of interest is moved within or outside the immigration detention network

    b. seek consent, where necessary, from the detainee concerned to authorise the sharing of information to enhance the services to be provided – or consider if there are other grounds to lawfully disclose the information. [Section 8.13]

16. That the Department develop its intelligence capability in the immigration detention network to address child abuse risks, in line with the findings of the Integrated Intelligence Capability Review, so that:

    a. the incidence of child abuse is reduced

    b. intelligence products are used to inform decision making. [Section 8.14]

17. That the Department consider providing a copy of this report to the Royal Commission into Institutional Responses to Child Sexual Abuse, drawing its attention to the enhancements that could be made to Australia's mandatory reporting arrangements. [Section 8.15]

1 An independent review

In March 2015, the Australian Government Department of Immigration and Border Protection (the Department) commissioned an independent Child Protection Panel (the Panel) to review incidents of abuse, neglect and exploitation of children (hereinafter referred to as child abuse Ð refer to Appendix 1, Glossary) in its detention facilities in Australia, in community detention and at regional processing centres (RPCs). The Panel was also required to propose improvements to policies and practices. This review followed the release of the Australian Human Rights Commission's ***The forgotten children: National Inquiry into Children in Immigration Detention 2014*** (AHRC 2014), and the ***Review into recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru*** (the Moss Review, DIBP 2015a) relating to reports of child abuse at Nauru RPC.

The need for an independent review was further influenced by changes within the Department – specifically, the amalgamation of the Australian Customs and Border Protection Service with the Department of Immigration and Border Protection in July 2015. This merger resulted in a new operating model for the Department, and an opportunity to reconsider historical practices around the management of detention services and policy.

1.1 The Child Protection Panel

When establishing the Panel, the initial terms of reference (ToR – refer to Appendix 2) were settled in March 2015.

The Panel was granted the status of a secondary Australian Government body (DoF 2015) by the Department of Finance in May 2015.

In forming the Panel, the Department sought a diverse skillset to reflect the broad nature of the review. It was agreed that expert assistance in the areas of law enforcement, child protection and governance would be of greatest benefit. Accordingly, the Panel was formally established and comprised:[1]

- a person with significant law enforcement experience – John Lawler AM APM, previously the Chief Executive Officer of the Australian Crime Commission
- a person with significant child protection systems experience – Margaret Allison, previously the Director-General of the Department of Communities, Child Safety and Disability Services (Queensland)
- a person with significant public administration experience – Dominic Downie, previously a Senior Executive in the Australian Public Service (APS) with significant roles, including in the design of the APS leadership capability framework.

[1] Short biographies of members of the Child Protection Panel are at Appendix 3.

The Panel was formally announced by the Minister for Immigration and Border Protection, the Hon. Peter Dutton MP (the Minister), on 9 May 2015 (Dutton 2015).

1.1.1 Terms of reference of the Panel

The Panel's ToR are at Appendix 2. The key elements of the Panel's ToR are as follows:

> The purpose of this Panel is to ensure that a comprehensive and contemporary framework for the Department relating to the protection of children is in place. This will be done by assessing the adequacy of departmental and service provider policy and practice around the management of incidents of abuse, neglect or exploitation involving children. Based on this assessment, the Panel will provide recommendations for ongoing improvement.
>
> In relation to incidents of abuse, neglect or exploitation involving children the Panel will:
>
> - critically review responses by the Department and its service providers in onshore detention environments, including community detention, and at regional processing centres, to reported incidents which occurred since 1 January 2008
> - provide independent advice to the Secretary in relation to the effectiveness and correctness of departmental and service provider policy and procedure around the management, response, and reporting of incidents involving children, and
> - make recommendations to strengthen arrangements around the management, response, and reporting of incidents involving children.

This review is the first to assess, in detail, such a large number of incidents[2] of child abuse across all Australian detention settings and at the RPCs. Because this is the first independent review initiated by the Department itself, Panel members were able to interrogate all available documents related to these incidents, including from service providers and relevant authorities.

This unparalleled access gave the Panel a unique window into the work of the Department, its service providers and related authorities. In turn, the Panel has been able to make targeted recommendations about the adequacy and appropriateness of the Department's management of incidents involving children in detention. In addition to this report and a preliminary discussion paper (see the Issues Paper at Appendix 4), the Panel infused the findings and lessons of its review into departmental practices throughout the review process.

1.2 Timeframe of the review

The initial ToR called for the Panel to review incidents occurring between 1 January 2008 and 1 April 2015. In later versions, this was amended to 'since 1 January 2008'.

On the advice of the Department's Child Protection Panel Secretariat (the Secretariat), the Panel took a position that there needed to be an end date to matters referred for review, to avoid the Panel being used in a de facto investigative function. This was an important distinction, because the

[2] When reviewing incidents, the Panel opted to omit the term 'alleged' from descriptions. It is important to note that, in the majority of cases, the person of interest is 'alleged', as no conviction was recorded.

Panel's primary purpose was to review the Department's and service providers' responses to incidents. If the Panel became part of that response (in an operational sense), then a conflict between the operational and assurance roles could emerge.

Subsequently, it was agreed with the Department that the Panel's review should cover the period 1 January 2008 to 30 June 2015.

1.3 Child Protection Panel Secretariat

The Secretariat was established during April–June of 2015 in the Detention Assurance Branch of the Department. Specific skillsets were targeted in staffing the Secretariat: assurance and risk management, experience in reviews and other inquiries, administration and writing, and knowledge of law enforcement practices. The Secretariat was six officers at full strength.

The role of the Secretariat has been to support the Panel by working closely with other areas within the Department, most often the detention operations functions, child protection and service delivery areas.

1.4 Issues Paper

The Panel sought support for, and action on, its findings and conclusions as these emerged, rather than waiting for all issues to be documented in a formal set of recommendations at the completion of its work. To advance this objective, the Panel released a preliminary discussion of its observations on, and suggested actions for, immigration detention facilities and RPCs in an Issues Paper in December 2015 (Appendix 4). This identified 20 priority issues for the Department to address to ensure the wellbeing and protection of children in held detention[3] and RPCs.

The Panel acknowledges that several of these findings have been, or are being, addressed by the Department already:

- The Child Safeguarding Framework (Section 8.2) has been finalised and agreed to, and addresses many of the areas for improvement that the Panel had identified. Importantly, it adopts the 'triple track' approach developed by the Panel for responding to incidents of child abuse, and establishes the accountability of specific senior departmental staff in advancing the wellbeing and protection of children.
- The Department is beginning to identify and respond to individuals within the detention network who are a risk to children (see Section 8.9).
- The Department is now including more information about the previous behaviour of individuals in its submissions to the Minister when considering a person's relocation into community detention.

Some of the Panel's earlier observations are no longer as directly relevant, as there are now very few children in held detention. Instead, children are currently prioritised for community detention. However, the Panel considers that these initial findings and the recommendations of this report

[3] Refer to Appendix 1 for a definition.

should not be lost, because they will become relevant again if circumstances change. Further, many of these findings and recommendations have wider application beyond the Panel's ToR.

1.5 Consultation

To enhance its understanding of issues around the Department's response to, and management of, incidents of child abuse, the Panel met with multiple internal and external stakeholders, including:

- departmental executives who manage policy development and operations
- service providers
- authorities responsible for law enforcement, education and children's wellbeing in some states and territories
- officials responsible for child-related issues in Nauru RPC
- organisations with an interest in the wellbeing and protection of children.

The Panel acknowledges that it has only engaged some individuals and organisations that may have an interest in this area.

Members of the Panel also visited all held detention facilities that held children during the tenure of the Panel, some on more than one occasion, as well as Nauru RPC on two occasions. Consultations and visits are listed at Appendix 5.

2 A history of relevant policy 2008–15

Australia's ***Migration Act 1958*** requires people who are not Australian citizens and do not hold a valid visa to be detained.[4] Unlawful non-citizens[5] must remain in detention until they are granted a visa or are removed from Australia.[6,7]

A series of significant decisions in the past decade have changed the way unlawful non-citizens, including children, are managed by the Australian Government. In July 2008, the Government introduced a new immigration detention policy, which stated that 'children, including juvenile foreign fishers, and, where possible, their families, will not be detained in an immigration detention centre' (Phillips & Spinks 2013).

The fulfilment of this policy was significantly affected by the arrival of increasing numbers of unauthorised vessels at Christmas Island between late 2007 and 2013. In line with Australian Government policy at the time, children and their families arriving at Christmas Island were initially accommodated in community detention facilities or alternative places of detention (APODs) on Christmas Island. When these facilities were no longer sufficient for the numbers of arrivals, some people were transferred to new and existing mainland held detention facilities.

From October 2010, the Australian Government increased efforts to move children out of held detention and into community-based accommodation. This saw the number of children and families accommodated in community detention settings increase. By September 2013, there were 6403 people in various forms of held detention, including 1078 children. In addition, there were 3241 people in community detention, including 1760 children (DIBP 2013).

The number of children in held detention facilities had started to decline in 2014; by this time, 424 children remained in detention on Christmas Island and 582 in mainland facilities. By February 2015, there were 133 children in mainland held detention and 1544 in community detention (DIBP 2015b).

Figure 2.1 demonstrates the substantial reduction in the number of children in held detention since a peak in mid-2013 through to February 2016 – attributable to changes in immigration policy and settings, as well as the reduced numbers of maritime arrivals.

Housing and other services for children, parents and families in each environment are provided through a combination of staff of the Australian Government Department of Immigration and Border Protection (the Department) and service providers engaged by the Department. This mix of staff and contractors, and the roles they play, varies between held detention, community detention and Nauru Regional Processing Centre (RPC). In all three environments, the primary providers of day-to-day services are contracted organisations.

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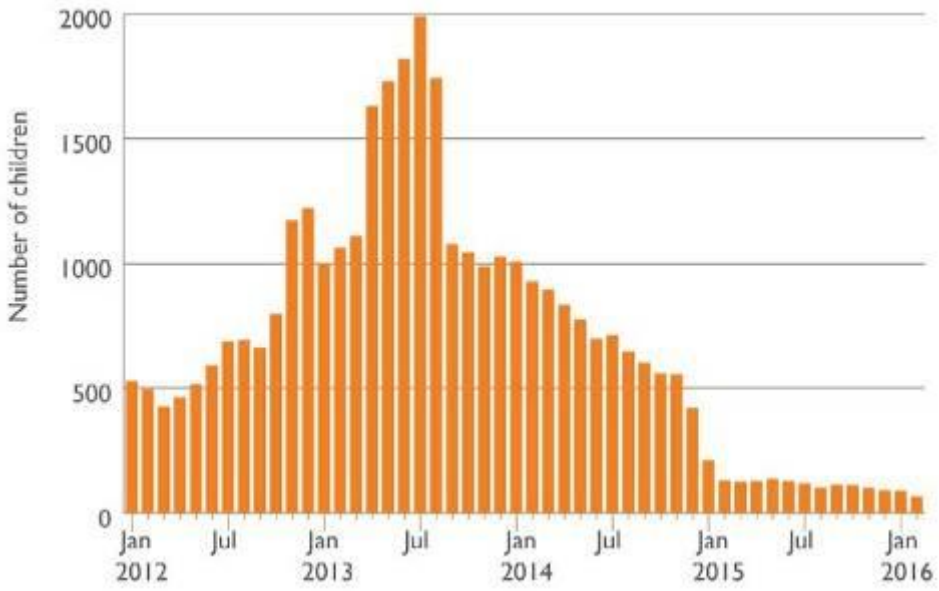
4 *Migration Act 1958* (Cwlth), s. 189

5 *Migration Act 1958* (Cwlth), s. 14

6 *Migration Act 1958* (Cwlth), s. 196

7 *Migration Act 1958* (Cwlth), s. 198



Source: DIBP 2016

Figure 2.1 Children in immigration detention residential housing, immigration transit accommodation and alternative places of detention, January 2012 to February 2016

2.1 Held detention

Held detention services in Australia are under the direct control of the Department. They include immigration detention centres,[8] immigration residential housing, immigration transit accommodation and APODs. In most locations, a Detention Superintendent controls the operation of an immigration detention facility, and departmental staff provide associated administrative support. Departmental Case Managers work with persons to assist them in resolving their immigration status. Garrison (including security), welfare and medical services[9] are provided by departmental service providers.

Detention Superintendents have specific accountabilities for the wellbeing and protection of children in their facilities, and service providers are responsible for delivering wellbeing programmes and immediate responses to any reports of child abuse. Detention Superintendents work with state and territory child protection authorities and police to ensure an appropriate, coordinated, effective and timely response to any incident.

2.2 Regional processing centres

Two RPCs were established to accommodate people affected by regional processing arrangements: Manus RPC, Los Negros Island, Manus Province, Papua New Guinea; and Nauru RPC, Republic of Nauru. Children currently reside in Nauru RPC only; Manus RPC ceased to accommodate children in early July 2013. Within Nauru RPC, there are currently three centres, referred to as RPC1, RPC2 and RPC3. It is noted that children do not reside in RPC2, and will only reside at RPC1 (in the accommodation areas) in special circumstances.

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8 Note that children are only held at low-security facilities, not at immigration detention centres.

9 Medical services are also supported by the public health system, as required.

The Government of Nauru controls and operates Nauru RPC. To assist the Government of Nauru, the Australian Government (via the Department) funds and manages contracted service providers for the delivery of facility infrastructure, operations, and medical and welfare services – some of which are, in turn, delivered through subcontracts with local organisations.

The Operational Manager (appointed by the Government of Nauru) is responsible for the day-to-day management of the RPC under administrative arrangements. The Operational Manager is responsible for monitoring the welfare, conduct and safety of transferees. Garrison (including security), welfare and medical services are provided by departmental service providers.

The Australian Government also supports the Government of Nauru through capacity building in a range of areas such as child protection, policing and education. The protection of children on Nauru is the responsibility of the Government of Nauru under the Nauru Child Protection Policy, Practice and Reporting Procedures, supported at the RPC by the policies and procedures of the Department and its service providers.

2.3 Community detention

Generally, community detention – via a residence determination[10] – enables unlawful non-citizens to live in the Australian community while they await resolution of their immigration status. People in community detention have a higher degree of independence in managing their daily living than in held detention or at an RPC. Therefore, the Department and its service providers give less direct oversight to these people.

Families with children, unaccompanied minors (UAMs) and vulnerable adults are prioritised for community detention. People in community detention are allocated housing and must observe a number of conditions, including not undertaking paid work and residing at the nominated residence. Their health care is provided by general practitioners and other health professionals in the community. These services are coordinated by the Department's contracted detention health services provider.

Community detention provides a level of support to community detainees to enable a modest lifestyle while their immigration status is resolved.

In community detention, people receive the support of a departmental Case Manager to resolve immigration status issues and a contracted case worker to address welfare issues.

UAMs have the above services and rostered in-house support workers on a 24/7 basis.

Field Compliance Operations Superintendents have specific accountabilities for the wellbeing and protection of children in community detention, including when there have been incidents of child abuse.

Services to children in community detention are governed by departmental policies and standard operating procedures, contract provisions and service provider child protection policies. State and

[10] *Migration Act 1958* (Cwlth), s. 197AB

territory child protection authorities and police may provide services[11] when matters are referred to them. Incidents involving children are reported to the Department's Incident Reporting Hotline.

2.4 Mandatory reporting of incidents of child abuse

In Australia, each state and territory government has enacted mandatory reporting laws to impose a legislative requirement on selected classes of people to report suspected cases of child abuse and neglect. The mandatory reporting laws differ across jurisdictions in relation to terminology, the scope and timeframes of a report, and the prescribed class of mandated reporters. Subject to the child protection legislation of the relevant jurisdiction, departmental staff and contractors may be mandated to report suspected incidents of child abuse and neglect.

Generally, all contractors providing health services (such as registered health practitioners) will fall within the class of mandated reporters across all jurisdictions. Departmental staff and contractors providing non-health related services will ordinarily not fall within the class of mandated reporters, unless they satisfy the following criteria:

- are working in the Northern Territory
- are engaged to provide or manage welfare or residential services to children in South Australia
- are engaged to provide or manage health-care, welfare or residential services to children in New South Wales.

Departmental staff and service providers are required to report possible incidents of child abuse to the Department under the Reporting Child-related Incidents Policy.

[11] Such as education or investigative services.

3 Review methodology

The Child Protection Panel (the Panel) examined a substantial sample of incidents involving reported child abuse in accordance with its terms of reference (ToR). In accordance with the parameters outlined in the ToR, the Australian Government Department of Immigration and Border Protection (the Department) applied an algorithm that was developed to ensure all incidents involving children in held and community detention were identified. From that process, the departmental Secretariat selected the most serious incidents for review.

3.1 Incident review and policy

As part of its assessment of the departmental response to the management of incidents of child abuse, the Panel reviewed the Department's and service providers' effectiveness in applying the policies, procedures and legal advices in place at the time. In the course of this assessment, the Panel analysed the adequacy of existing policy and practices, and identified systemic risks and opportunities for improvement.

In addition, on request from policy and operational areas, the Panel provided occasional policy guidance around managing individual cases and responding to emergent issues involving children. The Panel also engaged extensively throughout its tenure on the development and refinement of the Department's Child Safeguarding Framework.

3.2 Incident selection

A total of 242 incidents were referred to the Panel for in-depth review. After the removal of duplicate incidents and those out of scope,[12] the total number of incidents used by the Panel for statistical analysis was 214.

In selecting reported incidents for in-depth review, the Secretariat aimed to capture those of most concern – namely, serious or complex instances of abuse of children. The Panel also sought to incorporate the full range of child abuse incidents that occur within immigration detention settings and at regional processing centres (RPCs), including reported incidents that vary in severity, and the age of the child and of the person of interest.

The initial focus of the Panel's review work was on all incidents identified through the Australian Human Rights Commission's (AHRC's) *The forgotten children: National Inquiry into Children in Immigration Detention 2014* (AHRC 2014) and Mr Philip Moss's *Review into recent allegations relating to conditions and circumstance at the Regional Processing Centre in Nauru* (DIBP 2015a).

3.2.1 Held detention in Australia

An Incident Taskforce was established within the Department in early 2015 to draw a sample of incidents from immigration detention facilities.

[12] An example of an out-of-scope matter is one where the harm was not to a child.

The primary role of the Taskforce was to extract all relevant incidents of child abuse from the Department's reporting databases: the Compliance, Case Management, Detention and Settlement (CCMDS) portal; and the Immigration Services Information System (ISIS). CCMDS holds all departmental records for all people in all types of detention. These records include incident detail reports, which departmental service providers are required to enter following an incident.

CCMDS was implemented in May 2009 and replaced ISIS. Accordingly, incident records from January 2008 to May 2009 were drawn from this former system.

The total number of possible incidents of child abuse from both systems was 1211 (1207 from CCMDS and 4 from ISIS) from 1 January 2008 to 30 June 2015.

From this pool, 170 were selected for in-depth review by the Panel on the following grounds:

- 36 incidents previously of interest to the AHRC inquiry
- 61 incidents identified as falling within the scope of Notices to Produce issued by the Royal Commission into Institutional Responses to Child Sexual Abuse
- 6 incidents provided as an early sample for review by the Incident Taskforce
- 67 incidents selected by the Secretariat on the basis that they were of most concern (rated as 'critical' or 'major').

The size of the final sample selection was determined by the available time for the Panel to conduct its reviews, using past completion rates as a guide.

The process for incident selection is represented in Figure 3.1.

ISIS – 1 January 2008 to May 2009

From the ISIS data, 2536 incidents were identified. An exclusion process removed those incidents that only involved adults, resulting in the identification of 65 incidents involving minors in held facilities for assessment. The content of these 65 incident reports was then scrutinised by Taskforce members, with the goal of identifying incidents that met the definitions of abuse, neglect and exploitation. This resulted in the identification of four incidents involving possible child abuse.

CCMDS – 1 May 2009 to 31 March 2015

The initial search of CCMDS returned 73,414 incidents (records within the database). An exclusion process was then carried out to avoid overlooking any incident reports involving children who may have been abused, neglected or exploited. This process was conservative in that it focused on *excluding* reports that did not describe incidents of child abuse or neglect, rather than beginning a search for these incidents themselves.

Initially, reports were excluded if they originated in detention facilities that did not house children during the review period, or reported incidents that did not involve a child or children. Next, the content of the incident description in the remaining 10,637 reports was examined by Taskforce members. Using consistent and accepted definitions of sexual and physical child abuse (see Appendix 1), reports that referred to incidents other than these focal incidents were excluded (e.g. incidents that required medical attention, or involved theft or power failure).

The content of the remaining 7401 reports was then scrutinised by Taskforce members with the goal of identifying incidents that met the definitions of abuse, neglect and exploitation. Members consulted within the Taskforce when incidents were ambiguous – always erring on the side of inclusion when the nature of the incident remained unclear. This resulted in 1198 incidents involving possible child abuse.

CCMDS – 1 April 2015 to 30 June 2015

In October 2015, a further 4744 incidents from 1 April to 30 June 2015 were added to the data following a decision to extend the Panel's ToR. Using a similar method to that described above, 474 incidents were identified as potentially involving a child. Of these, 125 were excluded on the basis that the incidents occurred in the community. Of the remaining 328, nine incidents were identified involving possible child abuse.

Selection for in-depth review

Of the available pool of 1211 incidents, the four from ISIS were excluded from selection on the basis that a subjective review conducted by the Taskforce determined three to be minor in nature, and one to be outside the Panel's ToR on the basis that the incident occurred while in transit to Australia.

The effect of that exclusion was to remove cases that occurred before June 2009 from the set of cases reviewed by the Panel.

Of the 1207 CCMDS incidents, an initial sample of six incidents identified and packaged[13] by the Taskforce were referred to the Panel for review.

Additionally, analysis of the dataset indicated that 48 per cent of the 1207 were categorised as 'major' and 14 per cent as 'critical'. A further selection of 67 incidents was then prioritised for review by the Panel from these categories, representing incidents of most concern to the Department.

Major and critical incidents

The definition of major and critical incidents (as opposed to minor) is provided to all persons who make reports for CCMDS and ISIS. These incidents refer to those requiring expedited reporting, and having the potential to affect the safety or security of the facility or welfare of detainees and transferees, rather than the nature of the incident (although these are inextricably linked in most instances).

In one service provider's guidelines, critical incidents refer to incidents that seriously affect the security or safety of the facility, or where there is a serious injury or threat to life. These incidents must be verbally reported to the Department within 30 minutes of occurring and reported in writing within four hours of this verbal report.

Major incidents refer to an incident that seriously affects, or has the potential to threaten or harm, the security and safety of the facility, the welfare of detainees, or the success of activities involving

[13] Packaging of incidents included collation of relevant documentary material and pre-population of known data into incident review templates.

escort, transfer or removal. Such incidents must be verbally reported to the Department within one hour of the incident occurring and reported in writing within 6 hours of this verbal report.

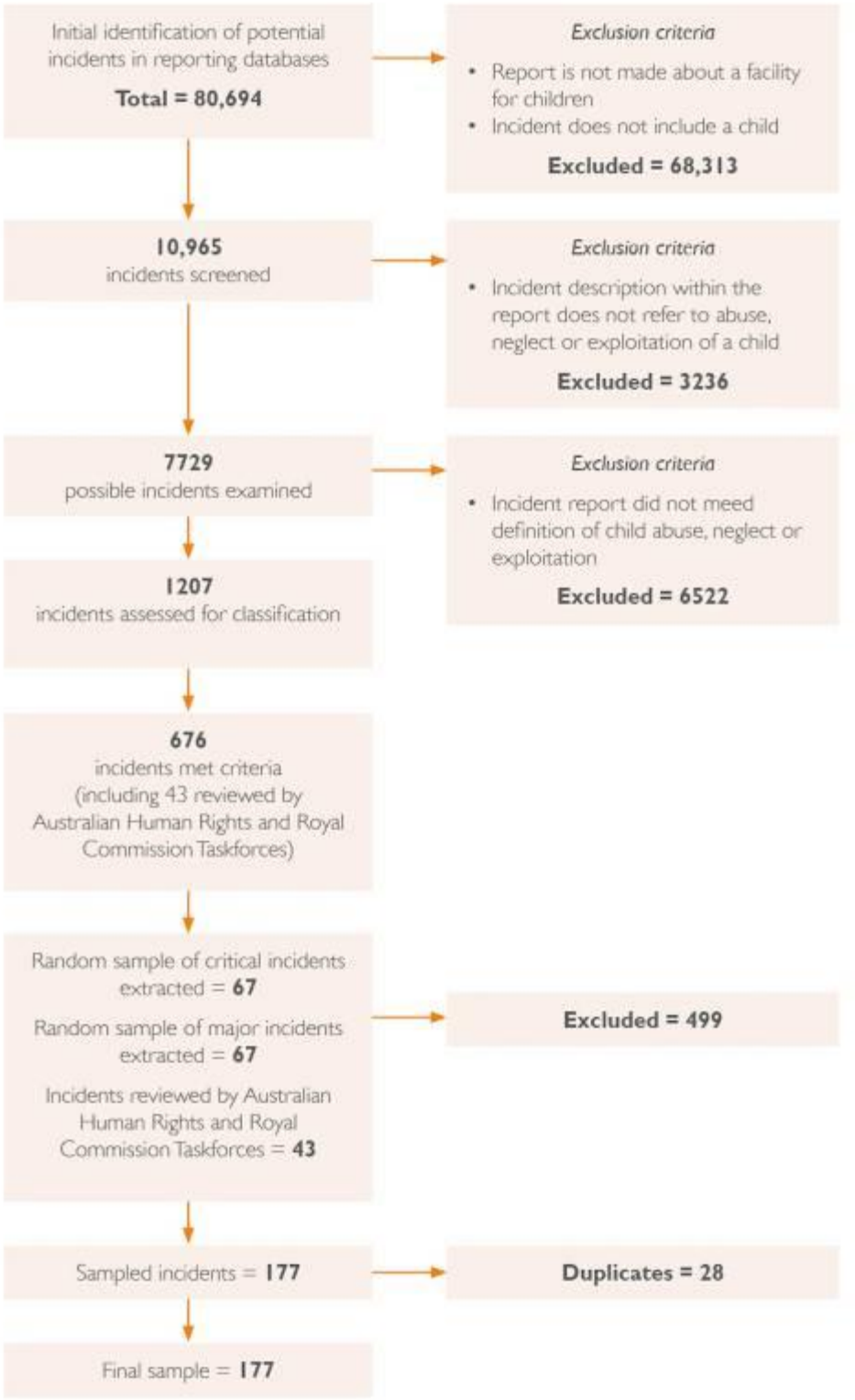

Figure 3.1 Held detention incident selection process for the Child Protection Panel review

3.2.2 Incidents from other facilities

The process for identifying incidents at RPCs and in onshore community detention differed from the process adopted for held detention.

Regional processing centres

Children were accommodated at Manus RPC for a limited time – from November 2012 to July 2013. The Department's Manus Coordination Section identified eight incidents within the scope of the Panel's ToR (see Appendix 2). Of the eight, five were referred to the Panel by the Secretariat. The Panel reviewed four of the five after determining one was out of scope.

In relation to Nauru RPC, the Panel was referred 18 reported incidents of child abuse that had been identified by Mr Moss. In addition, following discussions with senior departmental staff, the Panel was made aware of a further 76 cases that had occurred at Nauru RPC. Of these 76 cases, 18 of the most serious were subsequently referred to the Panel for review. The Panel reviewed 32 of the 36 incidents after determining one to be out of scope, one to be a duplicate of a previously reviewed incident, and two to have insufficient information to assess.

Combining the two RPC environments, a total of 41 matters were referred to the Panel, 36 of which were subsequently subjected to in-depth review.

Community detention

The primary data source used to identify incidents for the Panel's review was the CCMDS portal. There are, however, gaps in the information recorded in the portal.

Before July 2011, the Department maintained a variety of site- and client-based records. Incidents recorded in CCMDS were likely to have been entered under the name of the primary family member, or with no participants entered in relation to the incident. Therefore, not all incidents involving children have been captured accurately for this period.

Even with CCMDS in place, incidents that occurred between July 2011 and February 2013 in community detention were not consistently recorded. This has improved and, since March 2013, incident records in the CCMDS portal have been created by the Department's community detention contracted service providers. These service providers are required to record all incidents that occur to a detainee who is in community detention. Service providers record incidents against a predefined set of categories: critical, major and minor.

A dataset, limited to incidents that occurred in community detention, was extracted from the CCMDS portal.

The initial search of CCMDS returned 3181 incident reports involving a child in community detention. These reports were then filtered by incident type to include only incidents that the Secretariat determined to be most likely within scope for the Panel.[14]

[14] These include assault (various), death and notification by a welfare authority.

This reduced the number of incidents to 385. Of these, the Secretariat packaged 31 incidents from within a targeted selection of the most severe incidents (see the section on assessment of severity, below). One incident was later determined by the Panel to be out of scope.

This process is represented in Figure 3.2.

Secretariat assessment of severity

To refine the identification of incidents for review, the Secretariat undertook an assessment of severity in relation to incidents from Nauru RPC and in community detention. This process was overseen by a staff member in the Secretariat with a law enforcement background, including both intelligence and investigations roles, with a particular career emphasis on child abuse.

Based on the available information for each incident, they were rated as:

- Category 1 – incidents of most concern
- Category 2 – incidents of moderate concern
- Category 3 – incidents of least concern.

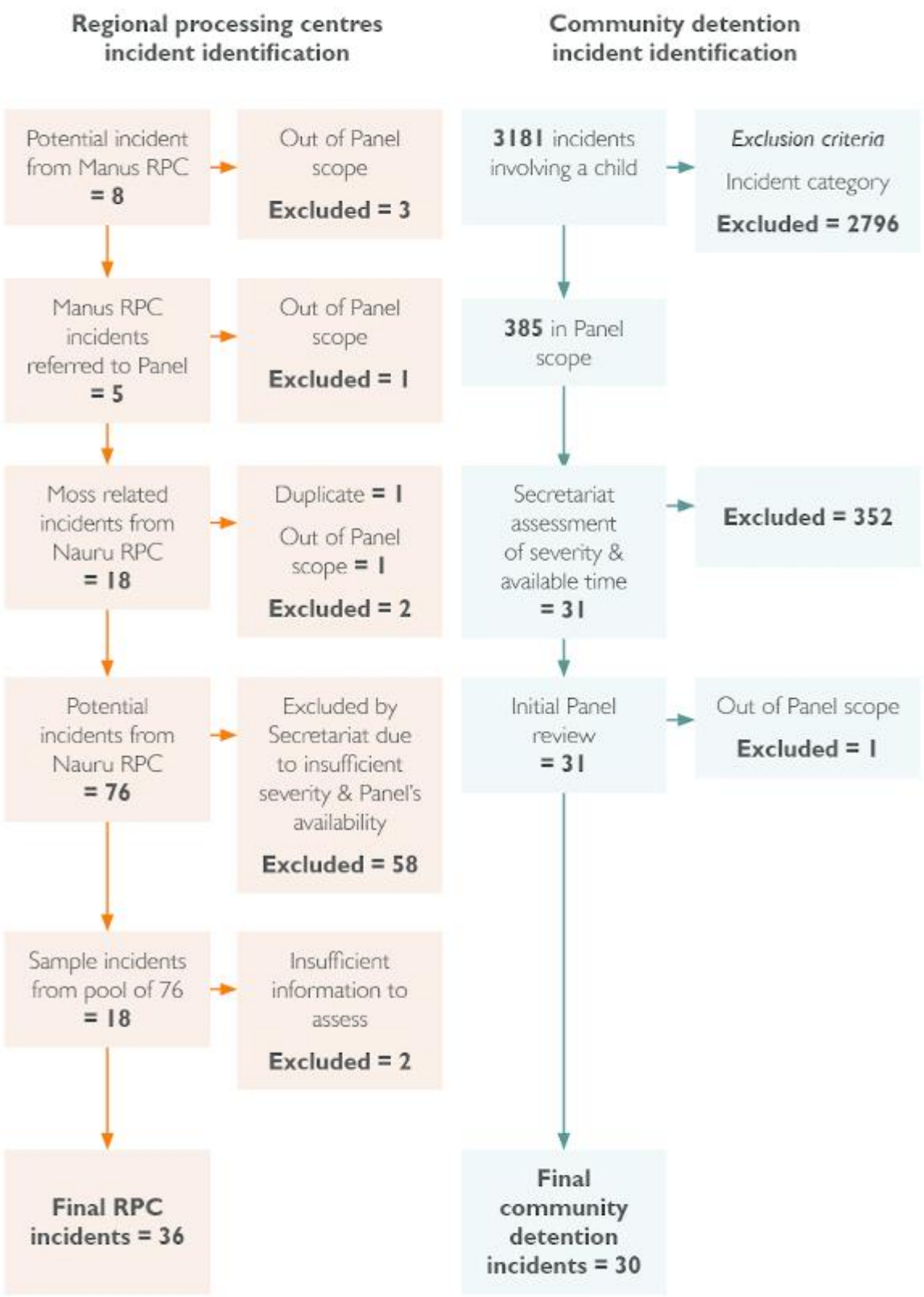

Figure 3.2 Regional processing centre and community detention incident selection process for the Child Protection Panel review

4 Held detention – observations through incident analysis

Key messages

- The response to incidents of child abuse in held detention was assessed by the Child Protection Panel (the Panel) as being adequate or good in 57.4 per cent of the cases reviewed.
- The categorisation of incidents needs to be strengthened so that the Department of Immigration and Border Protection (the Department) is aware of the accurate number, nature and seriousness of reported incidents.
- There is room for improvement in the areas of report quality, incident description, complaint closure and withdrawal, feedback to complainants, and follow-up with external agencies where involved.

4.1 Held detention environment

Held detention facilities in Australia include immigration detention centres, immigration residential housing, immigration transit accommodation and alternative places of detention (APODs). These facilities are located across Australia.

Detention Superintendents manage the operation of most held detention facilities. Garrison (including security) and welfare services are provided by service providers. Detention Superintendents are accountable for child wellbeing and protection in their facilities, including children as visitors. The service providers are responsible for delivering wellbeing programmes and the immediate response to incidents of child abuse.

Detention Superintendents work with state and territory child protection authorities, police and schools to ensure an appropriate, coordinated, effective and timely response to incidents. Case Managers from the Department are responsible for managing the 'immigration pathway' of each person.

As a result of several Australian Government policies, including the prioritisation of children for community detention and the policies of enhanced border protection, there has been a significant reduction in the number of child abuse incidents.[15]

4.2 Held incidents reviewed

The Panel reviewed 170 incidents that occurred in held detention, of which 148 were used for analytical purposes.

Overall, the response by the Department and service providers to these incidents was assessed as adequate or good in nearly 60 per cent of cases.[16] Within these cases, the response to victims re-

[15] This reduction directly correlates with the numbers of children in held detention, as shown in Figure 2.1.

ceived an even higher rating, with 67 per cent assessed as adequate or good, and for the responses to persons of interest (POIs), just over 50 per cent were assessed as adequate or good.

4.3 The Panel's observations

Some of the Panel's earlier observations are no longer as directly relevant, as there are now very few children in held detention. However, there is inherent value in identifying some of the lessons learned from this period, particularly given that short-term held detention in appropriate facilities remains an option for the management of unlawful non-citizens, including, at times, families or children.

4.3.1 Inadequate reporting of incidents

The Panel observed that garrison service providers sometimes prioritised the actual process of reporting an incident more than ensuring accuracy of the incident details or quality of the report itself.[17] This seemed to be motivated by service providers' desire to meet the reporting requirements of their service provider contract. However, reports often failed to detail the incident in such a way that it could then be dealt with appropriately. Moreover, once an incident was reported to police or child protection authorities, it was often closed by the service provider because 'it was a police matter'. This meant that the Department lost visibility of the status of the incident and, in some cases, did not undertake follow-up action.

More often than not, the reports themselves lacked the required detail and chronology to fully describe exactly what had taken place.[18] This was particularly true when describing the detailed specifics of the abuse, with often generalised, nonspecific descriptions being used and an apparent reluctance to describe exactly what happened. The worst examples of such reports were seen in the held detention environment; community detention reports often contained extremely detailed information.

An example of a report lacking detail is the term 'rubbing against', which was used throughout a particular incident report.[19] As the report did not reveal what the POI was rubbing with and where on the victim the rubbing took place, it was difficult to assess the seriousness of the incident. These variables can make a significant difference to how the incident should be assessed and responded to.

Further recommendations regarding incident reporting and accuracy are made in Section 8.4.

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16 The Panel used a four-tier scale of 'Good', 'Adequate', 'Poor' and 'Cannot be assessed' to assess the adequacy and effectiveness of the Department's and service providers' responses to incidents of child abuse. The Panel made this assessment separately in relation to the responses to victims, persons of interest and the incident overall.

17 Incidents CPP0093, CPP097, CPP0104, CPP0106, CPP0108, CPP0109, CPP0110, CPP0111, CPP0112, CPP0113, CPP0114, CPP0124, CPP0125, CPP0129, CPP0139, CPP0150, CPP0151, CPP0156, CPP0181, CPP0182, CPP0195 and CPP0205.

18 Incident CPP0093.

19 Incident CPP0063.

4.3.2 Categorisation of incidents

The Department's ability to quickly produce accurate information on the number, nature and seriousness of incidents of reported child abuse occurring in the held detention environment, over a given period of time, is paramount. The Minister for Immigration and Border Protection, and departmental executives and other officers rely on this information for decision making and strategic response. There is also significant public and political interest in this area. The Panel considers that the Department cannot be assured on either the number, nature or severity of the reported incidents of child abuse.[20]

The number and categorisation (i.e. seriousness) of held detention incidents has been inflated.

The Panel's review shows that just less than 50 per cent of the cases have been overcategorised. Further, there appeared to be a reluctance on the part of the service provider and the Department to change the category, even if subsequent inquiry showed the original categorisation to be inaccurate. This came about as a result of process design, which meant that an incident is duplicated in the system if the categorisation is changed.[21] For example, in one case, there was one incident but three records created, which also led to overreporting.[22]

Further recommendations about the categorisation of incidents in reporting systems are in Section 8.4.

4.3.3 Building confidence in the reporting and complaint management system

The Panel learned of concerns about a lack of confidence by detainees in the integrity and efficacy of complaint management.[23] Detainees gave examples of where they had submitted complaint forms and made oral complaints about incidents on which they wanted action taken, including those of child abuse, but heard nothing further from the service provider or the Department.

This lack of confidence has potentially led to some underreporting of incidents, as well as to some complaint withdrawals. Further reasons for this lack of confidence may include:[24]

- that families had a close relationship or had to live side by side with the POI, and they did not want to adversely impact their own or another person's immigration pathway
- a lack of understanding of what constitutes acceptable behaviour under Australian law
- victim lethargy, caused by fatigue, and physical and mental illness
- the view that incidents have been reported in the past and not investigated.

The Panel found that, generally, service providers did take the complaint process seriously and did take action, which may have involved referring the matter to police or to child protection authorities. However, weaknesses in processes following that referral and closure of the cases by the ser-

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20 For example, incidents CPP0153, CPP0158, CPP0159, CPP0181, CPP0183, CPP0187, CPP0188 and CPP0203.

21 Incident CPP0194.

22 Incident CPP0181.

23 Incidents CPP0047 and CPP0189.

24 Incidents CPP030, CPP0033, CPP0034, CPP0046 and CPP0062.

vice providers meant that visibility on the progress of the complaint resolution (by the detainees involved) was more often than not lost.

Analysis of data collected on behalf of the Panel indicates that two groups – staff, and the victim(s) or their family – reported almost 80 per cent of the incidents reviewed. These figures would support a general view that there was no reluctance on the part of staff to report matters to authorities.

Typically, complainants did not receive any updates about the progress of the inquiries[25] into their complaints, nor the outcome of the finalised investigation.[26] Complainants therefore believed, often inaccurately, that nothing had been done.

4.3.4 Lack of timely feedback from external authorities

When the police and other authorities (e.g. child protection) were involved in some cases (and these were not closed),[27] there were often long delays in the resolution of these incidents.[28] These authorities rarely advised the Department or its service providers of the outcome of their investigations (see Case example 4.1); the Panel did not see any finalised police reports among their review documents. Anecdotally, departmental and contracted staff explained that the authorities' reports detailing the incident were not supplied to the Department because the reports were 'sensitive' or otherwise subject to statutory confidentiality requirements. This makes it very difficult to properly manage serious cases of child abuse, and can prevent the Department from adequately managing risks within the held detention environment.

One state and territory child protection authority advised the Panel that there is no formal process to ensure feedback to the Department following a report of child abuse. In some instances, welfare authorities and police made a distinction between the Department and its service providers as to whether they would provide them with any information on the child abuse referrals, because of their understanding of privacy considerations.

Further recommendations regarding the proper follow-up of inquiries and improving information flow between the Department and external authorities can be found in Section 8.3.

Case example 4.1 Lack of timely feedback from external authorities

The Child Protection Panel reviewed a report about ongoing concerns of neglect of a young child by their parents. Service providers had found the child unsupervised in a sink full of water with hot tap water dripping, and an electrical appliance plugged in and within reach of the child. A few months later, the same parents left another child alone in the doorway of a housing unit for about an hour. These and other matters relating to lack of supervision were regularly reported to welfare authori-

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25 The terms 'investigation' and 'inquiry' are occasionally used synonymously. The Panel accepts that the Department has a view that investigation has law enforcement connotations. The Panel notes that connotation, but uses investigation in the plain-English sense.

26 Incident CPP0189.

27 Incidents CPP0021 and CPP0022.

28 Incident CPP0055.

ties, who did not respond to the incidents or provide advice to the service provider on any required action.[29]

4.3.5 Inadequate supervision of children

The Panel regularly observed a lack of child supervision by parents and service provider staff in the held detention environments in the cases they reviewed.[30] However, although parents are the primary protectors of their children, it is not uncommon in institutionalised settings to see a decline in parental capability. Consequently, service provider staff should assist parents to fulfil their roles, and not let children roam around the facilities unsupervised, particularly late in the evening.[31] Case example 4.2 demonstrates this.

Case example 4.2 Consequences of unsupervised children

Two boys assaulted two younger girls in an outside area of a facility. The incident took place during late evening. The persons of interest gave the victims chocolates in return for pulling down their pants and then hitting them in the buttocks.[32] The boys had previously come to attention for displaying sexualised behaviours and because of ineffective supervision by their single parent.

In addition, service providers play a primary role in ensuring children's activities are being supervised properly and making sure that there is close staff supervision in high-risk areas, including recreational facilities, internet rooms and dining facilities.

The Panel reviewed a number of incidents of child abuse that arose from ineffective supervision of children during sporting and recreational activities (see Case example 4.3), many of which were preventable through proper management and effective oversight.[33]

Case example 4.3 Consequences of unsupervised recreation

A teenage male with a serious medical issue was playing sport with a number of young children. Some of the children began to act in an inappropriate sexual manner. The personal of interest (POI) then grabbed one of the young boys by the throat and lifted him off the ground for a period of a few seconds. During this incident, he also touched a female child on the buttocks.[34] The incident caused serious anger and distress within the detention facility. The POI had previously been involved in numerous incidents of inappropriate behaviour towards staff and other children. This incident was entirely preventable because the POI should have been more closely supervised, and not allowed to participate in activities with much younger children.

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29 Incidents CPP0021 and CPP0022.

30 Incidents CPP0019, CPP0036, CPP058, CPP0087, CPP0119, CPP0139, CPP0151, CPP0157, CPP0164, CPP0174, CPP0175, CPP0183, CPP0186, CPP0188, CPP0195 and CPP0207.

31 Incidents CPP0128, CPP0150, CPP0173 and CPP0175.

32 Incident CPP0157.

33 Incidents CPP0050, CPP0128 and CPP0141.

34 Incident CPP0036.

4.3.6 Communication of case information

People are regularly[35] moved within the detention network for a variety of reasons, including to overcome placement difficulties (e.g. to access necessary health and medical services), as a result of alleged child abuse, or because the person was difficult to manage and presented a risk.

A comprehensive case history (including status resolution progress, personal and family welfare issues, and service requirements) was rarely forwarded with the detainee to the receiving facility or relevant service provider. This appeared to be the result of several factors, including the difficulty in establishing a comprehensive case history of an individual because of weaknesses in case management systems, difficulties with staff access to systems containing important information, lack of training and a lack of intelligence capability.

The Panel noticed that, in a limited number of cases, the seriousness of the incident and history of the detainee appeared to be downplayed, possibly so the receiving facility would not reject the transfer. Similarly, submissions about the transfer of a detainee from held detention to community detention often did not accurately reflect the complete behavioural history of the detainee. Further, concern was expressed that important medical history was generally not provided when someone was moved from held detention to community detention. Privacy concerns were suggested as the reason for this not being done.

The Panel considers that this can be overcome by requesting that the person (or, in the case of a child, their parent or guardian) sign a consent form allowing important medical history information to be provided. This consent would be limited to information on any medical issues that are relevant to the support of the person in the new environment (e.g. if the parent has depression, or if a child has a developmental delay or disability). In one case of reported child abuse, it is clear that the Department responded to the incident without the necessary background on the POI. If they had accurate information, the response may have been different and more robust.[36]

Further recommendations about case management are in Section 8.13.

4.3.7 Internet use and external storage devices

At the time of the Panel's first visit to a held detention facility, it observed issues with internet use and supervision. The internet room was unstaffed and unmonitored, and there did not seem to be robust security protocols for access and use. These are locations frequented by adults and children who are normally in close proximity to one another. The Panel reviewed a number of reported incidents that occurred in or near the internet access areas.[37] Although the Panel was advised that the system blocked access to unsuitable sites, concern remained about the potential misuse of the internet for child exploitation or radicalisation purposes, and the inability to link the use of a terminal to a particular individual at a particular time, as would routinely be the case in most public internet access facilities.

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35 Incidents CPP0049, CPP0090, CPP0135, CPP0136, CPP0162, CPP0201 and CPP0203.

36 Incident CPP0055.

37 Incidents CPP0094 and CPP0143.

As a result, the Panel relayed its concerns to the Department's Detention Assurance Team, which undertook an assurance review. This review found that current controls were inadequate and made a number of recommendations.

During case reviews, the Panel saw an associated problem with detainees inappropriately using universal serial buses (USBs) to download, store and share pornographic material. A number of cases involved pornographic material on USBs being used during serious child abuse offending or to groom children within the facility.[38]

There are also no systems in place to ensure that children can access only material that is age appropriate, in line with age-related classification restrictions. There was an example where very young children were exposed to material that was rated MA15+.[39]

4.3.8 Use of closed circuit television

In cities and towns across Australia, closed circuit television (CCTV) is widely used, and seen as a standard and necessary tool in the fight against crime and public disorder. It is particularly important in providing clear and compelling evidence of offences. It is therefore valuable in the detention environment.

The Panel observed a number of cases where, in common areas of held detention, including recreational facilities, CCTV could be used better. A number of cases have been conclusively resolved given the availability of CCTV. It is important to note that the use of CCTV can be both inculpatory and exculpatory. Proper management and record retention of CCTV footage by the Department and its service providers are equally important (see Case example 4.4).

Case example 4.4 Use of CCTV as exculpatory evidence

Parents reported to service providers that another detainee had touched their young child on the genitals while in a dining area. The person of interest (POI) was promptly spoken to by staff. The POI denied assaulting the child, and stated that he had only moved the child and other children away from a hazard. The CCTV footage showed that the contact with the child was indeed an attempt to deter children from playing in the vicinity of a hazard, and that the contact appeared innocent and incidental.[40]

[38] Incidents CPP0155, CPP0172 and CPP0200.

[39] Incidents CPP0183 and CPP0188.

[40] Incident CPP0047.

5 Regional processing centres – observations through incident analysis

Key messages

- The response to incidents of child abuse at Nauru Regional Processing Centre (RPC) was assessed by the Child Protection Panel (the Panel) as being adequate or better in 30.5 per cent of the cases reviewed. More than 20 per cent of all incidents could not be assessed because of the lack of data available to the Panel.
- The professional conduct of subcontractor staff was of concern to the Panel.
- There is value in the Australian Government in general, and the Department of Immigration and Border Protection (the Department) specifically, continuing to support the Government of Nauru in capacity building with respect to child protection, policing and education.

5.1 Regional processing centre environment

There have been a number of improvements at Nauru RPC during the past 18 months. These include the gradual transition to an 'open centre', where residents can come and go freely from the centre. Also, the Government of Nauru has taken positive action in settling an increased number of refugee claims, including those made by children and families. Although there has been a large number of refugee visas being granted, this, in turn, has put pressure on the availability of suitable accommodation in Nauru.

The move to an open centre environment has had a clear positive impact on children and families. On the Panel's most recent visit, stakeholders largely agreed that this openness played a major role in the reduction in reported incidents of child abuse at Nauru RPC. Although the adoption of more generally accepted criteria for the reporting of child abuse incidents should lead to more accurate data on the nature, seriousness and number of incidents, the Panel received three differing accounts of numbers of incidents of child abuse that had occurred between July 2015 and March 2016.

When the Panel members visited Nauru in March 2016, they were advised of plans to move families and children from RPC3 to RPC2. The Panel members had significant concerns about these plans from a child wellbeing and protection perspective. The Panel understands that these plans are no longer active.

The Government of Nauru has taken on a much more active role in responding to child abuse and family issues, both in the RPCs and in the broader Nauruan community.

The Panel received a number of separate comments that indicated a marked improvement in the response by the Nauru Police Force, the Child Protection Coordinator and Government of Nauru departments.

5.2 RPC cases reviewed

The Panel reviewed 36 incidents that occurred in RPCs: 32 occurred at Nauru RPC and 4 at Manus RPC. The Panel notes that there are no children currently at Manus RPC. These 36 incidents were a subset of the original 41 matters referred to the Panel before data cleansing to remove duplicates and those out of scope.

The incidents at Nauru RPC included:

- 17 that were reported during the Moss Review in October and November 2014, but that had occurred at earlier dates
- 15 other incidents that had been reported to the Department.

Some 20 per cent of incidents could not be assessed by the Panel because of a lack of information (including, in some matters, the inability to identify individuals). Those cases that could be reviewed resulted in an assessment of a poor response to persons of interest (POIs) in 50 per cent of the cases.[41]

5.3 Observations from the Panel

The Panel has identified a number of systemic improvements that can be made to protect children at Nauru RPC. The Panel comments in detail on, but purposely has not made recommendations in relation to, Nauru RPC, as this facility is operated by the Government of Nauru.

5.3.1 Staff involvement in assaults on children

A distinguishing feature of the incidents of child abuse reported to the Moss Review was the involvement of subcontractor staff as the POI (see Case example 5.1). The Panel notes that just over 20 per cent of these incidents were among those that could not be assessed because of a lack of information.

Case example 5.1 Service provider staff as the person of interest

In 2014, an employee was driving a group of school-aged children. The driver pulled over and pointed a cricket bat at close range at a teenage boy, and shouted at him to get off the bus and to 'shut up'. Other staff on board witnessed the event, and physically intervened to escort the driver off the bus and take the bat from him.[42] In this case, the officer was suspended on the day of the incident and dismissed several days later.

The Panel, through its own work and that of the Moss Review, identified several areas of concern in relation to the involvement of staff in incidents:

- opportunistic assaults on children, particularly at night in poorly lit areas[43]
- failure by staff to maintain appropriate professional boundaries in their dealings with child transferees; this manifested through a range of behaviours, from exchanging personal details

[41] Note that the small sample size means that only general conclusions can be drawn.

[42] Incident CPP0009.

[43] Incidents CPP0002 and CPP0013.

and attempting to 'friend' children on social media, to making explicit and unwelcome sexual overtures[44]

- difficulties in identifying staff inappropriately using force against children, particularly in response to 'cheeky' or provocative behaviour (see Case examples 5.1 and 5.2)
- staff reported to be under the influence of alcohol or other drugs.[45]

Case example 5.2 Overreactions to children's behaviour

A young child was running through a playground area. They were asked to leave the area, but responded by throwing stones and saying 'fuck you' to the officers involved. Some of the stones hit the officers. A security guard grabbed the child by the hair and collar, and dragged them for about 20 metres. There were a number of witnesses to the incident, including the child's parent. The child was listed as the offender and the officer as the victim. The incident was originally categorised as 'assault – major' before being downgraded to 'assault – minor'.[46]

During a site visit in March 2016, the Panel discussed with departmental and service provider management the issue of investigation and, where appropriate, disciplinary action against staff who are alleged to have assaulted a child.

The Department and service providers stated that such action is the responsibility of the local subcontractor who employs the POI. Staff said that action by the local subcontractor should be visible to the Department and the primary service provider through incident management meetings and contract assurance processes; however, the Panel was not convinced that effective controls were in place.

From the incidents reviewed, the Panel could identify only two instances where any form of disciplinary action was taken against a staff member.[47]

The Panel's view is that, to reinforce expectations of professional conduct, officers should be required to wear a form of identification on the front of their uniforms. This identification should include an employee number as well as a first name, to allow identification of officers by people who may be functionally illiterate or cannot read English.

The Panel also considers that standard operating procedures should be developed for situations in which more than one officer may be required. Such situations included the induction of new officers through 'buddy' arrangements, provision of any kind of personal assistance to children where other adults are not present, and high-risk situations where there are aggressive or self-harming behaviours, or imminent risk of these. A further consideration is the need for gender to be taken into account in assigning officers to certain tasks (e.g. security of areas in proximity to ablution blocks).

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44 Incident CPP0004.

45 Incident CPP0005.

46 Incident CPP0001.

47 Incidents CPP0007 and CPP0009.

5.3.2 Alcohol testing of staff

The Moss Review revealed complaints that some staff appeared to be regularly affected by alcohol and/or other drugs while on duty (DIBP 2015a). The Panel considers that this contributed to a sense of disinhibition and the commission of inappropriate, or even criminal, acts. The Panel notes that service providers have now introduced random alcohol testing of all onsite staff.

5.3.3 Supervision of children

The Panel reviewed a significant number of incidents of reported child abuse that arose from ineffective supervision of children during sporting and recreational activities (see also Section 4.3.5), many of which were preventable through proper management and effective supervision.[48]

During its initial visit to Nauru RPC in July 2015, the Panel noted a very high level of nocturnal activity, with residents (including children) wandering around, engaging in social activities, or undertaking personal tasks such as bathing or laundry. This is partly because of climate and the cooler night-time conditions, and residents making phone or online contact with family members in other countries.

Night-time can be risky for children (see Case example 5.3). The Panel noted that a number of serious incidents occurred at night, up to about 11.30 pm. Some involved the abuse of young children who were unaccompanied by their parents at the time.

Case example 5.3 Increased risks to children at night

It was reported to the Moss Review that a security guard attempted to sexually assault a teenage girl one night. The girl revealed that she had been using the telephone with a family member, but the latter had returned to the family's tent and the girl was left alone. As she was walking back to the tent, an employee took her by the hand and attempted to drag her to a dark area of the park. The girl escaped and returned to her tent.[49]

There are other problems associated with a child being up late at night, such as the child getting sufficient sleep and waking up in the morning for school, and parents ensuring children are ready for school, having their lunch packed and so on.

The Panel considered that there should be procedures that require parents to accompany their children outside the family dwelling area beyond a certain hour at night. This is both a response to the inherent vulnerability of unaccompanied children roaming alone at night, as well as a prompt about the need for adequate sleep to get the most out of school the next day. Just as it is in many families, a more relaxed approach could be in place on the weekends.

[48] Incidents CPP0050, CPP0128 and CPP0141.

[49] Incident CPP0013.

During its visit to Nauru RPC in March 2016, the Panel observed that the service provider had introduced a strategy that reinforced parental authority and responsibility for their children. Service providers reported a significant improvement in the behaviour of children since the introduction of this initiative.

5.3.4 School attendance

Service providers told the Panel that transferee children's school attendance had increased from 11 per cent in late 2015 to 40 per cent in March 2016. Service providers were working to increase attendance further; however, some parents were withholding children from school. Reasons for this included the cleanliness of some school facilities and the behaviour of some local children. The Panel learned that there had been three reports of inappropriate sexual behaviour (i.e. touching) towards children living at the RPC during the previous two weeks.

The Panel also considers that centre-based performance measures in service provider contracts regarding levels of school attendance and participation in school activities could help boost school attendance.

5.3.5 Information flow between service providers

When the Panel visited Nauru RPC in July 2015, it was concerned that the wellbeing and safety of children was being compromised by inadequate transfer of information when a family with children was granted refugee status and moved to live in the community. The community settlement service provider was given inadequate information on each family – including those where there might be a child at risk.

On the Panel's second visit to Nauru, this situation had not improved. In discussions with relevant staff from medical and community settlement service providers and the Department, it became clear that all parties saw benefit in better sharing of information. The Department moved quickly to rectify this situation. The Panel notes that the arrangements do not yet include the provision of relevant health information to the community settlement service provider.

The need for better flows of information is also discussed in Section 8.13.

5.3.6 Coordination of responses to child abuse

The Panel's review of incidents at Nauru RPC demonstrated that the reporting and investigation of incidents, and the coordination of responses to them, were of poor quality overall. There was also no agreement on what the response to an incident should be. An important element of this was the absence of a forum to coordinate the actions of the various respondents to an incident (e.g. the Operations Manager [RPC3], the Nauru Police Force, the Nauru Child Protection Unit, service providers and the Department). There was no person clearly accountable for coordinating such a forum and ensuring a suitable outcome was achieved.

Before the Panel's second visit, the Children and Families Committee was established as the vehicle to coordinate appropriate responses to incidents of child abuse. The Panel is not convinced that this Committee is yet structured and operating in a way to achieve the required level of coordination.

5.3.7 Investigations

The Panel reviewed many cases that lacked a timely, robust and comprehensive investigation. As a direct result, the Department and its service providers did not know the details of what had taken place. In addition, the Department and service providers responded – albeit with good intentions – without having a solid basis for their response.

The Panel observed only one case of child abuse at Nauru RPC that was referred to the Nauru Public Prosecutor; this prosecution did not proceed.[50] Given this observation, the use of investigative outcomes to manage risks and inform decisions is more critical than ever.

The initiation, conduct, coordination, review and conclusion of investigations to ensure that they are timely, comprehensive and transparent to all stakeholders needs to be substantially improved.

Another feature of investigations into incidents was the unsatisfactory manner in which complaints were withdrawn, often without documentation, and then subsequently closed. As this issue was also common to Australian held detention, it is dealt with in detail in Section 8.4.4.

5.4 Supporting Nauru Regional Processing Centre

The Panel notes that Nauru RPC is under the control of the Government of Nauru, and has made no recommendations as a result. However, the Panel considers that the Department can leverage contract provisions to improve child wellbeing and protection delivery through service providers.

Specifically, the Panel considers that there is a need to strengthen the professional standards requirements of contracts and the processes to enforce these – to address the pattern of behaviour by subcontractor staff and to ensure that contract provisions require comprehensive responses to incidents of child abuse.

The Panel considers that it is important that the Department, and the Australian Government more generally, continue to work with the Government of Nauru to support the interests of children and families.

[50] Incident CPP0015.

6 Community detention – observations through incident analysis

Key messages

- The response to incidents of child abuse in community detention was assessed by the Child Protection Panel (the Panel) as being adequate or better in 46.7 per cent of the cases reviewed.
- When serious incidents occur, there is a need for more immediate action, including revocation of community detention.
- There are significant weaknesses in some service provider and subcontractor capacity and structures; these are demonstrated in responses to complex child protection incidents.
- The level of services provided to families and children in community detention should be tailored to their vulnerabilities.

6.1 Community detention environment

Of all the detention environments, community detention is where the Australian Government Department of Immigration and Border Protection (the Department) has the least direct oversight of day-to-day activities of detainees. To all intents and purposes, detainees carry on their lives in the Australian community as an Australian child or family would – albeit with restrictions around working and movement. The Department relies extensively on community detention service providers to report any incidents of child abuse in a timely fashion.

The Panel had 31 community detention incidents referred to it for review, one of which was discarded as out of scope.[51] These were the most serious matters of which the Department was aware. The Panel notes that there is a substantial cohort of children in the community on a variety of visas where similar risks may be present. The Panel has not considered the circumstances of these children, as these matters fall outside its terms of reference (ToR).

Finally, because of process, the Department might not have become aware of incidents of child abuse in community detention if the incident was first reported to the police or the relevant child welfare authority. This also extends to incidents where the person of interest (POI) and victims are detainees, visa holders or Australian citizens – in other words, where one (POI or victim) is in community detention and the other party is not.

Recommendation 1

That the Department review its operational framework for community detention to ensure that the:

a. current and emerging risks to children and families in the changing community detention environment are fully understood and acted upon

[51] Note that the small sample size means that only general conclusions can be drawn.

b. services available to detainees are tailored to their needs, including enhanced support and transitional arrangements.

6.2 Community detention incidents reviewed

The Panel critically reviewed 30 incidents that occurred in community detention. These incidents included families with children living independently and unaccompanied minors (UAMs) living in group houses.

These 30 incidents were approximately 8 per cent of the total number of incident reports within the Panel's ToR. This sample also represents the more serious incidents. The Panel specifically requested that some incidents be included, because of the behaviour of particular individuals in held detention before being moved into community detention.

Although the most serious community detention incidents were identified for the Panel's review, these were assessed as having the lowest adequacy of response when compared with other environments. The Panel noted that the response by the Department and its service providers was assessed as poor in 53 per cent of the incidents; in relation to UAMs, the response was similarly rated as poor in 62.5 per cent of the incidents.

The particular issues with UAMs suggest a need for greater contractor expertise in the provision of out-of-home care services for young people. Also, there is a need for clear and expeditious reporting and support arrangements for after-hours incidents, under the leadership of the Field Compliance Operations Superintendents.

6.3 Observations from the Panel

The Panel has identified a range of improvements that can be made to protect children in community detention.

6.3.1 Placement in community detention

The Panel reviewed a number of community detention cases involving POIs who had exhibited a range of challenging behaviours while in held detention that represented a risk to children. These behaviours included physical and sexual assaults, standover and intimidation, threats, verbal abuse, and an inability to control anger. Where the Department is aware of these behaviours before placement in the community, it is incumbent on it to recognise and manage the risks represented by that person, including (but not limited to) the risks to children.

A number of the incidents reviewed by the Panel could be attributed to detainees being placed into community detention perhaps without sufficient understanding of their background or the development of mitigation strategies to address any risk factors. These detainees often had significant histories of violence and aggression in held detention (see Case example 6.1).

Generally, submissions proposing placement in community detention included only risk factors that concerned matters before the criminal justice system. As most child abuse incidents that occur in held detention do not result in criminal proceedings, this means that a complete picture of a detainee's history and risk is not properly conveyed.

Case example 6.1 Placement in community detention

In 2015,[52] a man assaulted an unaccompanied minor residing at the same house.[53] The person of interest (POI) punched and bit the victim, resulting in cuts and abrasions that later required medical attention. When staff intervened and separated the two by taking the victim into the staff room and locking the door, the POI proceeded to punch and kick a hole in the door in an attempt to continue the assault. Police were called, and when they arrived they handcuffed the POI until he calmed down. Both persons were interviewed separately, and neither wanted to press charges. The POI made multiple threats of violence against teachers, carers and other residents of his house following this incident.

The initial submission to the Minister for Immigration and Border Protection, which recommended his release into community detention, disclosed that he had been involved in multiple significant behavioural incidents in held detention, including abusive and aggressive behaviour, assault, threatened sexual assault and self-harm. The submission went on to say that the Department had no information to suggest that his behaviour would pose a threat to the Australian community if he were placed in community detention.

The POI's community detention was revoked in 2015.

In Case example 6.2, two high-risk UAMs were placed in a house together, with only one staff member allocated. An effective risk analysis would likely have resulted in these two UAMs not being placed together and would have highlighted that one staff member would not suffice.

Case example 6.2 Consideration of risk factors

Two unaccompanied minors (UAMs) physically assaulted a sole staff member on several occasions over the course of a night.[54] The carer injured his knee attempting to escape after he had been choked by one of the UAMs, and ended up pounding on a neighbour's door in fear for his life. The history of both these UAMs was concerning; one in particular had an extensive history of being the aggressor in many physical assaults, in held detention and community detention, and had engaged in intimidating behaviour towards staff and carers, damaged the community detention property (punching holes in the wall), self-harmed and stolen property.

6.3.2 Revocation of community detention

The Panel reviewed a number of community detention cases where serious misconduct led to the revocation of community detention, and the person being placed back in held detention. In some of these cases, conduct was of a criminal nature (e.g. serious assaults, child abuse), but not necessarily of the seriousness that would see a court remand the person in custody if the person was charged.

In one case,[55] a father was charged with offences related to the physical abuse of his son. He was initially remanded in custody, and placed in the local remand and reception prison. Even when he

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52 Incident CPP0239.

53 The Panel observed situations where UAMs who had turned 18 often remained in their accommodation for a range of reasons (e.g. completion of schooling, transition to suitable adult accommodation).

54 Incident CPP0224.

55 Incident CPP0245.

was subsequently granted bail by the court, he was returned to held detention until the matter was dealt with by the court. Following specialised counselling and, in light of all family members' extreme distress at being separated, the father returned to his family at the conclusion of the court proceedings.

The Panel has reviewed a number of cases where violent and aggressive behaviour has warranted a return to held detention to protect the safety of children or the community (see Case example 6.3). In several instances, these decisions took weeks or months to finalise, and the Panel considers that a more immediate response is required so that children and the community are not exposed to unacceptable risk.

Case example 6.3 Delayed response to serious incidents

In 2014, a teenager picked up a younger teenage female student and carried her over his shoulder from one end of the school to the other against her will. The school advised the boy's Case Manager that he was to be suspended for five days and possibly expelled. The female student also disclosed numerous threats of violence and intimidation the boy had made towards her. The boy was convicted of two counts of unlawful assault and was returned to held detention two months later.[56]

The Panel's view is that there is a need for a streamlined process that enables immediate movement of a detainee, which may include return to held detention when there is a high risk to the wellbeing or protection of children.

6.3.3 Needs-based support

Service providers complete an Initial Needs Assessment (DIBP 2014) when people move into community detention and subsequently prepare a case plan that is intended to meet the individual needs of the person. Many elements of the case plan are standard services that are available to all detainees (e.g. access to school uniforms and equipment for children). The Department can approve other services based on individual needs. The Initial Needs Assessment states:

> Service Providers should consider the previous life experiences of the community detainee and determine whether the community detainee has any interests that can be continued in the community (for example, interests in soccer, learning English, or farming can all be furthered in community detention through activities, English lessons and volunteering). (DIBP 2014)

The Panel assessed a number of incidents where support services could have been better tailored to the needs of individuals, families and households. The Panel observed that there would have been a better tailoring of these services if a full risk assessment had been completed when the person entered community detention. The Panel observed several cases where additional services were provided, but these did not address the actual risk involved.[57]

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[56] Incident CPP0240.

[57] Incidents CPP0219 and CPP0220.

The Panel learned, from service providers, that they would like to have better transfer of information when a detainee is placed into community detention, including relevant medical summaries.[58]

The Panel notes that the guidance to service provider Case Managers does not include reviewing a person's held detention history. This information, at least in summary form, should be made available, because a person's held detention history can provide useful insights into likely family or household dynamics and risks, including risks of domestic violence.[59]

6.3.4 Service provider capacity and structure

Typically, support arrangements for people in community detention involve a contracted service provider responsible for obtaining and managing accommodation and overseeing casework services. These service providers engage subcontractors, who provide day-to-day support to the household. In the case of a UAM household, rostered support workers are provided on a 24/7 basis.

The Panel has four areas of concern in relation to the capacity of service provider staff and the structures within which they operate.

The first concern is the inability of some front-line support staff to respond adequately to critical incidents, including self-harm and attacks on others. In one incident, where a detainee had self-harmed and needed immediate medical attention, the support worker rang a supervisor before calling the ambulance.[60] Many front-line support staff are recruited for their language and cultural skills rather than their ability to manage critical situations.[61] Front-line support staff require specific training on how to manage critical incidents that involve children in community detention.

The second concern is the layered reporting structures that exist in the Department– service provider–subcontractor chain of command. The Panel reviewed some serious incidents where front-line workers engaged with two levels of managers within their organisation, and an additional two levels of managers within the service provider organisation. In addition, the worker had to report to the Department, and to state or territory child protection authorities. This resulted in delays in reporting incidents to the Department or child protection authorities, and delays in seeking police assistance.[62]

In one instance, the need to receive approval from the Department in Canberra for a child to be examined by a forensic paediatric specialist resulted in this not occurring – contrary to the advice of the relevant state child protection authority.[63]

The third area of concern is the failure of service provider staff to identify and act on emerging risks – for example, failing to:

- recognise and respond to peer bullying and sexual assault that occurred in a UAM household for a month[64]

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58 The sharing of such information is also referenced in Chapters 4, 5 and 8 of this report.

59 Incident CPP0230.

60 Incident CPP0226.

61 Incident CPP0234.

62 Incidents CPP0226 and CPP0234.

63 Incident CPP0243.

- discern the pattern of behaviour in a series of six assaults and neglect of a child with a disability[65]
- act on the malnutrition of siblings with a disability[66]
- identify a suspected attempt at child grooming and take preventative action[67]
- prevent a series of assaults by a father on his daughters.[68]

The fourth area of concern relates to UAM households. In several of Australia's larger jurisdictions, standards exist for out-of-home care, and the provision of those services is regulated. However, many of the current service providers are from a migrant and refugee resettlement professional background, and do not have experience in providing out-of-home care services to young people. This could account for some of the poor judgement that seems to have been exercised in terms of behaviour management, regulation of activities and visitors, household routines, rostering and critical incident management (see Case example 6.4).

The Department might wish to consider how it can ensure that this expertise in out-of-home care is guaranteed in its providers, through its contracts. The out-of-home care sector is very used to dealing with young people who have traumatic backgrounds and challenging behaviours.

Case example 6.4 Unaccompanied minors in community detention

A male unaccompanied minor (UAM) disclosed to a youth worker that he had been sexually assaulted at a community detention property by two other UAMs. The two persons of interest (POIs) were removed to another property and suspended from the school that they attended with the victim. There is no evidence that the matter was referred to police (as it should have been, given the very serious nature of the sexual offending) or that the allegations were put to the POIs in any context.[69]

6.3.5 Timely intervention by service providers with persons of interest

When the Panel met with departmental staff who are responsible for community detention operations, one of the issues raised by staff was that of a potential dilemma for service providers. On the one hand, service providers need to form trusting relationships with the individuals and families they are required to support. On the other hand, service providers have reporting obligations to the Department (and potentially mandatory reporting obligations).

It was suggested that this role dilemma could lead to a reluctance to report incidents, because doing so might adversely affect the immigration status of the person involved. Although the Panel has no knowledge of incidents that have not been reported, in the review of some incidents, the Panel observed a reluctance by service providers to confront the POI in an incident, or to confront the behaviours that ultimately led to an incident of child abuse (see Case example 6.5).

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64 Incident CPP0231.

65 Incidents CPP0219 and CPP0220.

66 Incident CPP0221.

67 Incident CPP0223.

68 Incidents CPP0227 and CPP0230.

69 Incident CPP0222.

Case example 6.5 Reluctance of service providers to report incidents

A male unaccompanied minor (UAM) told his Case Manager that he felt unsafe and in danger at his community detention property. He disclosed that he had been touched inappropriately about four weeks earlier by one of the other UAMs in the house and, since then, had been subjected to ongoing verbal harassment in a sexually explicit way by all other residents at home and at school. He confirmed the details of the assault in a police interview, but signed a statement of no further police action. The victim was moved to another property, but the provider decided not to talk to the other residents of the household because of the 'delicate nature of the situation'. The POIs had access to the property to which the victim was relocated.[70]

6.3.6 Police liaison and coordination

Occasionally, POIs were taken into custody by police and then released. When POIs were released from police custody, there was often poor coordination between the police and the service providers about their return to an appropriate community detention property. In one instance, a POI was released from police custody and the provider was not advised until several hours later.[71] In another incident, a parent who had physically assaulted their child was released subject to a Family Violence Safety Notice that precluded them from returning to the community detention property where their family lived. They arranged their own accommodation that evening, and the service provider was not aware of what had happened until the following morning.[72]

6.3.7 Flow of information

The flow of information between the Department and service providers is addressed in Sections 4.3.6 and 8.13. It is sufficient to note here that this flow of information was a concern also for community detention service providers.

6.3.8 Service provider child protection policies

The Panel reviewed a sample of service provider policies. These policies varied significantly in quality and focus, and there were several areas of concern:

- The policies have a general lack of focus on child wellbeing.
- The policies generally do not identify the actual risks to which children in community detention are exposed (e.g. domestic violence or violence from other UAMs). Rather, the policies focus on risks from employees.
- The policies lack a common code of conduct that would apply to all people providing community detention services.
- The impact of some policies detracts from the capacity of front-line staff to manage critical incidents effectively. Some policies were so brief that they did not provide sufficient guidance to staff.

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70 Incident CPP0232.

71 Incident CPP0238.

72 Incident CPP0243.

- Not all policies authorise front-line staff to make mandatory reports.

The introduction of the Department's Child Safeguarding Framework provides opportunities for the Department to work with service providers to upgrade these policies and align them with the Framework and its supporting policies.

Child protection policies are also discussed in Section 8.2.

Recommendation 2

That the Department work with community detention service providers to strengthen performance around:

a. the capability of service provider and subcontractor staff to identify and act upon emerging risks to the safety of children

b. the capability of front-line support staff to respond to critical incidents

c. rationalising reporting arrangements between the Department, service providers and sub-contractors.

7 Vulnerable populations

Key messages

- The cohort most likely to be recorded as the victim of child abuse is children less than six years of age. This group requires priority responses.
- The families of children with a disability require earlier engagement with specialist disability services.
- Services to unaccompanied minor (UAM) households require expertise in out-of-home care as well as in settlement services.

The Child Protection Panel (the Panel) considers that the needs of particular groups of children and families within detention environments and at regional processing centres (RPCs) require specific consideration, including specialist service provision.

7.1 Children under six years of age

The Panel's data analysis shows that the cohort most likely to be recorded as the victim of child abuse is children less than six years of age. These children represented 40 per cent of all child victims. Within this group of children under six years, boys represented 70 per cent of the victims.

Infants and young children are clearly the most vulnerable to harm. They are more likely to be harmed as a result of lack of supervision, are less able to tolerate any failure to address their nutritional needs, and are more at risk of developmental delays if they do not have close parental bonds and an enriching environment. They are also often unable to articulate harm that has been caused to them.

It is for these reasons that, in statutory child protection practice, priority of response is given to very young children, and incidents are responded to with the highest level of urgency. A similar level of priority needs to be given to reports involving children under six, with matters involving infants (under one year of age) regarded as urgent for inquiries to be undertaken.

Given these findings, the Australian Government Department of Immigration and Border Protection (the Department) and its service providers should consider providing an enhanced level of services and support to children up to six years of age, to better ensure their safety and wellbeing.

7.2 Unaccompanied minors

UAMs are one of the most vulnerable groups, as they lack the guidance and support of their own parents during their developing years, and the protection of their parents during the difficult experiences of leaving their country of origin and entering detention.

UAMs are less likely to be victims of serious incidents of child abuse than other people in held and community detention in Australia. Although UAMs comprise 35 per cent of the population of chil-

dren in detention or at RPCs, they were involved in only 15 per cent of incidents reviewed by the Panel. Further work is required to understand the drivers for these results.

In the held detention environment, UAMs are quite properly housed separately from the adult males, but often fit uneasily into the areas where families are held, as they have little in common with younger children or those whose lives are managed more stringently by their parents. It is also a challenge to manage such young people if they are a person of interest (POI) in a child abuse matter, and require separation from one or more people residing in the same area.

There is a gap in services for UAMs in the held detention environment. Because of their age and lack of a primary caregiver, these young people need more consistent supervision by staff who have skills and training with young people. This may facilitate the development of trusting relationships with those adult staff and 'quasi-parental' guidance. All young people need direction about their behaviour, support to develop life skills such as cooking and laundry, and prompting to complete daily activities such as showering and getting to bed at a reasonable time (see Case example 7.1).

In the community detention environment, the Panel was of the view that service models need to incorporate a similar level of guidance and direction. Careful consideration needs to be given to household numbers and composition, especially where children are of quite different ages in the house. Consideration also needs to be given to the youngest age at which children could be placed in a UAM house, rather than in a foster care arrangement or similar.

Case example 7.1 Guidance and direction for unaccompanied minors

In one case, a young girl was placed in an unaccompanied minor household when her relationship with her mother broke down.[73] It was reported that she missed school on a number of occasions because she was on her phone until very late, and then could not get up the next day. However, the staff held the view that they could not intervene by removing her phone from her during the night – as might be done by parents in similar circumstances – because this constituted a 'restrictive practice' under state legislation, and statutory approval would be required.

Community detention services providers raised the need for a gradual transition process from the more supported UAM environment to adult services where the young person might only have contact by telephone on a monthly basis. This was seen to be of particular importance when the young person was part way through a school year. The Panel was made aware of a number of instances where young people in school were transitioned quite abruptly from a supported share-house arrangement to one where they might receive a phone call every few weeks.

In most statutory child protection jurisdictions in Australia, there is legislative or administrative provision – called 'transition from care' programmes – that offer the continued delivery of services to young people, beyond the expiration of any care orders to which they have been subject. These programmes recognise that the development of the ability to independently manage one's life affairs does not automatically come with being 18 years old. They also recognise the greater vulnerability of young people who do not have family to 'fall back on' in times of crisis.

[73] Incident CPP0217.

Transition from care services can extend until the young person is 21 years of age, although, in some states and territories, young adults can be supported until the age of 25 years. Such services can include access to counselling or other necessary allied health services, some financial support to set up a household or contribute to the costs of further study, and the provision of a case worker who can keep in touch with them as required. Community detention service providers support the introduction of a similar scheme for UAMs that goes beyond current departmental arrangements.

Recommendation 3

That the Department review the management of unaccompanied minors (UAMs) in community detention, to ensure that:

a. contractual arrangements for the provision of day-to-day care of UAMs include expertise in out-of-home care, as well as settlement services

b. a 'transition from care' scheme is established that extends current levels of support to UAMs beyond their 18th birthday where this is required, especially for the purpose of completing school.

7.3 Parental care of infants

The importance of a child's experience in his or her first year of life is critical in developmental terms. For these reasons, the Panel has paid particular attention to cases involving very young children.

In the community generally, most new parents and their babies receive a high level of follow-up by midwives or other specialist care nurses in the first four weeks after birth. Often, this will be provided through a mix of home visits and child health centre visits, with ongoing services (e.g. management of vaccination schedules) provided for the first year of life (albeit at a lesser intensity than the first four weeks). These services also provide a referral point for other services, such as playgroups (which provide social support for the mother, in particular, as well as developmental opportunities for the baby) and early intervention services where there might be concerns about developmental milestones not being met.

In the held detention and Nauru RPC environments, a number of staff expressed concern about the frequency of very young infants being left unattended. In some cases, this was attributed to the cultural expectation that another person would be around to help manage the care of that infant, based on extended family living arrangements. It is also noted that particular equipment may be necessary to ensure the safety of the child (e.g. cot, change table). In one case reviewed by the Panel, an infant rolled off the bed where he was being changed when his mother turned away to get a nappy.[74] Although this is a relatively common occurrence (in Australia, most presentations to hospital emergency departments involving children under one year of age are for this reason), it is entirely preventable.

As children get a little bit older, the chance for mothers to get together through playgroups is important for the child's social and physical development, and for the mother's mental health. Consid-

[74] Incident CPP0085.

eration could also be given to formalising some limited respite for parents who are severely stressed.

While acknowledging the complexity of cases of suspected abuse involving very young children, the Panel reviewed a number of cases where the Department or service provider was too slow to respond to situations of high risk. These cases included ones where nourishment had been deliberately withheld[75] from children (including babies so young that they were entirely breastfed[76]), ongoing physical abuse involving repeated assaults to the head[77] and leaving babies for extended periods without supervision.[78] Although it is a significant decision to separate a baby from his or her primary caregiver, it can be necessary (even for a limited period) to properly assess the situation and ensure the safety of the child. Departmental procedures need to reflect the need for urgency in responding to matters involving young children, particularly those under one year.

7.4 Specialised services for persons with a disability

The Panel reviewed a number of cases involving people with a disability, either intellectual[79] or physical.

In the cases involving an intellectual disability, the person with a disability was the POI in a number of incidents involving physical and/or sexual assaults. What is evident from a review of these cases is the need for specialist disability advice on the support required by these individuals in their daily lives, and the reduction of the risks they might represent to others or a particular group, such as children.

It was noted that there was a tendency to excuse the actions of those people with an intellectual disability on the basis that they did not know what they were doing or the impact of their actions on others. For this reason, it seems that some matters were not actively followed up with the police, or a view was formed that there was no benefit in bringing criminal charges as a successful prosecution would be unlikely to occur.

However, even when a court ultimately forms the view that a person lacks the mental capacity to be tried, a referral to the forensic mental health system can be highly useful in suggesting strategies to address the behaviour of the person. Such strategies can include, in very serious matters, a period of removal from the community under the provisions of mental health legislation.

The Panel also examined a few cases involving children with a physical disability. Again, the need for disability-specific intervention was evident (see Case example 7.2).

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75 Incident CPP0129.

76 Incident CPP0085.

77 Incidents CPP0103 and CPP0121.

78 Incidents CPP0021 and CPP0246.

79 Incidents CPP0179 and CPP0190.

Case example 7.2 Children with physical disabilities

A teenager with high support needs, requiring assistance with all activities of daily life (e.g. feeding, bathing, toileting), had been assaulted by a family member on a number of occasions. The family member also forced the teenager's head back to put food in their mouth. This presented a risk of choking and of aspirating food into the lungs.

Various family interventions were tried, including a referral to a course designed to improve family communication. The teenager was expressing a desire to be placed away from their family in a disability-specific setting. A disability service specialising in transitioning young people with a disability to independence was eventually engaged, which is commendable. Earlier engagement of a speech and language pathologist with expertise in swallowing disorders and feeding techniques may have been of assistance, and reduced the tensions that contributed to the assaults.

7.5 Promoting the mental health and wellbeing of children and their carers

The effects of people's previous experiences – in their home country or in transit to Australia – may compound the effects of detention on individual and family functioning. For a significant number of people in held detention, this will result in some mental health issues. However, it might be assumed that these issues will be alleviated when the person or family is placed in the community. In fact, although this action might be welcomed by the person or family, it can potentially give rise to a fresh range of concerns that might trigger the need for mental health support. For example, in held detention, programmes are provided to develop skills, offer meaningful activity and alleviate boredom. No such equivalent exists in a community setting, and this could increase a vulnerable person's sense of isolation, as well as anxiety about their future prospects.

The secondary impact of parents' mental illness on their children can also be profound. The symptoms of these illnesses means that parents may be unable to meet children's needs for bonding, nutrition or safety – which, in turn, can have immediate and long-term consequences for the child's mental and physical health.

8 Departmental and service provider policy and practice

Key messages

- Completing and implementing the policies and procedures that support the Child Safeguarding Framework (the Framework), and aligning service provider policies and key roles of the Australian Government Department of Immigration and Border Protection (the Department) is a critical priority.
- There is an imperative to improve the reporting, documentation and investigation of incidents of child abuse.
- There is a need to amend departmental and service provider risk assessment protocols to specifically address risks to children.
- There is a requirement to upgrade the flow of information within and between all detention environments, and to use that information more effectively.
- Relationships with state and territory authorities need to be strengthened at the national and, more importantly, local operational level.

8.1 Proposals for reform

In December 2015, the Child Protection Panel (the Panel) released an Issues Paper for discussion within the Department. This paper identified a range of actions that the Department could take to improve the wellbeing and protection of children in detention. Key issues included the adoption of the 'triple track' approach to responding to incidents of child abuse, and the need to make senior local departmental staff accountable for child wellbeing and protection outcomes.

The Panel has worked closely with the Department to ensure that these findings are progressively adopted, and is pleased to note that many of the actions it proposed are given effect to in the Department's Child Safeguarding Framework. The Panel also notes that the Child Protection and Wellbeing Branch will coordinate and track the implementation of these action items.

8.2 Child Safeguarding Framework

A new Framework was endorsed by the Department in March 2016. The Framework explicitly establishes principles to protect the safety and wellbeing of children in the care of the Department and its service providers. This integrated policy focus on children in detention has previously been lacking and will consolidate many of the recommendations made by the Panel.

This endorsement followed extensive work by the Panel to ensure that its findings and advice were incorporated in the Framework. This advisory process took place throughout the Panel's tenure.

Taking such a long-term advisory role also reflected the request of the Department's Secretary that the Panel 'infuse' its findings into departmental policies and processes.

A key element of the Panel's terms of reference (ToR) was to 'ensure that a comprehensive and contemporary framework for the Department relating to the protection of children is in place'. The Panel can provide such assurance on the Framework and notes that it is in the process of being implemented.

A number of the key features of the Framework that are relevant to the current review are outlined below.

8.2.1 The 'triple track' approach

A holistic response to a reported incident of child abuse has several components that must be managed simultaneously. The Framework adopts the Panel's clear, practical 'triple track' approach for the investigation and management of incidents of suspected child abuse within detention or at regional processing centres (RPCs):

1. Take immediate action to ensure the child (and any other child at risk) is protected from further harm, and has access to the necessary medical, therapeutic or other support services to address their current and ongoing needs.

2. Make an effective response in relation to the person of interest (POI). Where the POI is another detainee, or transferee in an RPC, consideration needs to be given to ensuring that a suitable management regime is implemented immediately to safeguard the child and other children.[80] This might range from an operational directive to provide more frequent monitoring of a situation involving parental neglect, to the physical separation of the child and POI.

3. Ensure that the incident is reviewed, and any lessons learned are incorporated into future management and prevention strategies.

This triple track approach will be further integrated into departmental policies and procedures related to responses to child abuse incidents in held detention, RPCs and community detention, and in the training curricula for departmental and contracted staff.

8.2.2 New role of the Child Protection and Wellbeing Branch

The Framework creates a new role for the Department's Child Protection and Wellbeing Branch that includes the:

- development, implementation and review of child safeguarding policies and procedures
- establishment and monitoring of standards for the effective documentation of individual case notes and transfer reports
- development of professional training and development for officers required to deal with child protection and wellbeing matters, delivered in collaboration with the Australian Border Force College and the Learning and Development Branch

[80] Where the POI is an employee, immediate and appropriate management action must be initiated.

- provision of expert support and advice on child safeguarding matters to departmental officers and service providers, including Detention Superintendents and Field Compliance Operations Superintendents responsible for those in the Status Resolution Support Services programme
- development of positive working relationships with operational and line areas within the Department responsible for working directly with children and their families
- development and implementation of a quality assurance and reporting process that will provide a 'whole of Department' perspective on its effectiveness in protecting children.

8.2.3 Establishing accountabilities

A key weakness in the Department's past responses to incidents was the lack of staff members with clear authority to respond to the incident. At best, the authority was diffuse and often characterised by a lack of urgency, even when it was probable that harm to a child was continuing. This particularly applied to matters where a decision might be incongruent with other general policy positions of the Department, in complex cases involving parental abuse of a child, or where there is a need to remove a POI who is also a child from their current environment.

The new Framework has addressed this weakness, and establishes new roles for Detention Superintendents, Field Compliance Operations Superintendents and the Assistant Secretary of the Child Protection and Wellbeing Branch. These roles are described in Section 8.6.

8.2.4 Incident management

The Framework provides a basis to ensure that responsible departmental officers fully investigate incidents of child abuse, and the facts of what occurred are accurately known and recorded. In addition to supporting any investigation by police and child protection authorities, the Framework establishes clear authority for conducting internal inquiries to establish the facts of the matter and, in particular, working with service providers to 'seek the response of the person of interest to any allegations that have been made'.[81]

8.2.5 Implementing the Framework

The Framework is dependent on a large range of child protection–related policies and other documents. It is essential that the Department maintain momentum on the concurrent delivery and application of these policies and other supporting structures.

Many service providers will need to review their policies, such as the following, to align them with, and give effect to, the Framework:

- child protection policies
- incident reporting policies
- risk assessment and management policies
- incident classification policies

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[81] Child Safeguarding Framework, p. 26.

- incident investigation policies
- professional standards policies
- critical incident management policies.

Recommendation 4

That the Department give effect to the Child Safeguarding Framework (the Framework), by:

a. finalising the stated policies, procedural instructions, operating procedures and supporting material that underpin the Framework

b. ensuring that service provider and subcontractor policies that support child wellbeing and protection are amended to align with the Framework

c. ensuring that Detention Superintendents and Field Compliance Operations Superintendents have the necessary authority and knowledge to fulfil their accountabilities under the Framework.

Recommendation 5

That the Department complete a review of the implementation and effectiveness of the Framework within 18 months of its endorsement, with particular focus on the:

a. effective exercise of accountability and control by Detention Superintendents and Field Compliance Operations Superintendents

b. quality assurance and policy roles of the Child Protection and Wellbeing Branch

c. use of the 'triple track' approach to incident response.

8.3 State, territory and Australian Government relationships

The Department needs to develop more effective relationships with state and territory police and welfare authorities so that all parties are working towards the common purpose of protecting children, while understanding each other's roles. In the first instance, this can involve developing protocols[82] about information transfer between Department networks and external authorities and stakeholders.

In accordance with the triple track approach, the Department needs to be aware of the local state or territory investigation responses and work with them to ensure that the child's protective needs are met. This will also result in investigations maintaining momentum and not succumbing to undue delay.[83]

[82] In line with relevant legislative provisions.

[83] Incidents CPP0065 and CPP0138.

The most urgent needs for information sharing between the Department and other authorities relate to:

- child abuse matters where a child or children need to be removed from their parents, at least for a period. For example, if a parent is ill and cannot currently care for their child (and there is potential for neglect), lawful arrangements for the alternative care of the child may need to be made
- serious offences against children, where there is an urgency to arrange forensic medical examination of the child and specialist interviewing of the child.

To achieve this, the Department should put in place arrangements for regular meetings between Detention Superintendents and Field Compliance Operations Superintendents with their counterparts in state and territory authorities. In relation to community detention, it is particularly important that there are effective relationships with police, and the state or territory child protection authorities, to ensure a coordinated response to domestic violence issues.

8.3.1 Use of state and territory facilities

The Panel is of the view that much greater use could be made of state and territory facilities for detainees charged with criminal offences, or that some detainees could be dealt with under mental health legislation. The number of individuals in these categories is not high, so there is limited consequent risk of 'swamping' state and territory facilities with demand for services.

This proposal is likely to require considerable discussion and negotiation with state and territory authorities, including the briefing of police services, Director of Public Prosecution offices, mental health authorities and judicial officers about the role and limits of immigration detention facilities and services.

It may also be valuable to consider appropriate mechanisms that would enable the Department to seek the leave of the relevant court or tribunal to appear and make submissions relating to a held or community detention issue.

Recommendation 6

That the Department continue to build sound working relations with state and territory authorities on child protection matters, to:

a. ensure the reciprocal flow of information about child protection matters
b. establish a common understanding of the processes followed by each party so that complex cases can be effectively resolved
c. seek to brief law enforcement, judicial and mental health authorities to enhance their understanding of Australian Government immigration detention arrangements
d. seek the leave of the relevant court or tribunal to appear and make submissions relating to a held or community detention issue.

8.4 Improving incident reporting

The Department cannot have full confidence in the data that identify the number and type of incidents relating to child abuse in held detention, in community detention or at an RPC.

The Panel identified a number of areas where departmental policies and processes require strengthening so that the reporting of, and response to, incidents is adequate, correct and effective.

Poor reporting was an issue in many incidents reviewed by the Panel. This includes the:

- willingness of detainees, transferees and service providers to report an incident
- accuracy of incident categorisation in reports
- inadequate detail and clarity in the incident report on which to base an investigation.

8.4.1 Reluctance to report

The Panel considered the need for strategies that will encourage people to bring matters (not just complaints) forward to facility management for further action, including the promotion of existing strategies such as suggestion boxes and resident committees. Given the experience of Mr Moss receiving many 'first time' complaints during the Moss Review, a possible option for consideration is the development of an 'official visitor' type scheme in addition to the role played by the Ministerial Council on Asylum Seekers and Detention. Such schemes are used in psychiatric or correctional environments in other jurisdictions.

The Panel also considered that it was critical to improve confidence in the complaints system. In a number of reviewed incidents, no feedback was provided to the child (depending on age) or to the child's family about action taken or progress made on investigating or addressing the complaint. As a result, they formed the (often incorrect) view that nothing was happening, which discouraged further disclosures. These feedback processes need to be formalised, and undertaken with transparency and integrity to protect the interests of all stakeholders.

8.4.2 Incident categorisation

To respond effectively to incidents of child abuse in detention, the Department, service providers and external authorities (e.g. police) must have reliable information about what happened, who was involved and the seriousness of the incident. This information will help the Department to take appropriate action to protect children, manage children and people who are at further risk, and make the detention environment safer in the future.

The Panel determined that a little over 40 per cent of cases it reviewed were accurately categorised. A further 40 per cent overstated the seriousness of the incident (see Table 8.1).

Table 8.1 Accuracy of incident categorisations

Panel assessment	Regional processing centres	Held detention	Community detention	Total
Accurately categorised	26	47	15	88
Overcategorised	9	76	1	86
Undercategorised	1	25	14	40
Total	**36**	**148**	**30**	**214**

The Panel noted several problems with the categorisation of incidents of abuse:

- The Department and service providers use separate incident classification systems, and these are not sufficiently aligned (i.e. these systems can use different categories of classification and/or have different interpretations of these categories).
- In both departmental and service provider reporting requirements, the incident classification does not require a detailed description of the event or behaviour.
- Current incident classification systems overstate the number of reported incidents because, from the Panel's observations, change of classification appears to duplicate the incident report.
- Because of inadequate or unclear categorisations, current systems overstate the severity of some incidents and understate the severity of others, with the result that some less serious incidents (that would not normally attract the attention of Australian child protection authorities) are overreported and more serious offences are not responded to effectively.
- Reasonable parental discipline was reported as abuse.
- Accidents that do not involve neglect or other low-level incidents can be reported as child abuse.

There is a need for much greater granularity in incident categorisation systems to ensure a more accurate characterisation of the incident and therefore more reliable information about what has occurred. In the absence of an intelligence system to analyse and use information in relation to child wellbeing and protection, incident reports are the only pathway for information to reach decision-making systems. The existing incident categorisation system does not produce useful information. The Department should consider the best way to advance these desired outcomes.

8.4.3 Incident record keeping

The Panel experienced considerable challenges in reviewing some of the cases presented by the Secretariat because of poor record keeping by the Department and some service providers. These

problems were common to incident reports, and included illegibility, factual inaccuracies, spelling mistakes and gaps in the chronology of the incident.

Over time, the seriousness of some incidents was 'lost' to the Department because the key facts were not reported or wrongly reported in the original source documents. The Department would have had great difficulty in accurately reporting on these matters. The Secretariat had to undertake extensive searches to identify documents that, collectively, provided the full details of an incident.

Service providers must upgrade the skill of their staff in incident description. This should be done in tandem with the implementation of a revised incident classification system by the Department.

Report writing is a critical skill for security and welfare staff who have direct contact with detainees and transferees. They are likely to be the people who directly witness or initially intervene in incidents, to whom complaints are first made, or who are monitoring children at risk. Reports need to include clear, behaviourally based descriptions of what is alleged to have happened or what they have witnessed (e.g. there were matters characterised as attempted rape, but with no descriptions of the behaviours alleged to have occurred[84]). Reports should be written in electronic format (not handwritten), signed and dated.

In addition, the Panel considered that the post-incident review forms completed by the service providers often served little purpose beyond contract compliance. It is important to note, however, that the post-incident reviews play an important role in the implementation of the triple track approach. They could be the vehicle for implementing the third 'track' – identifying what can be learned from the incident to make children safer in the future.

8.4.4 Complaint withdrawal

Reasons for the withdrawal of a complaint about child abuse must be carefully and sensitively investigated to ensure the complaint is not withdrawn because of external pressures, or misconceptions about the investigative process and outcomes.

Withdrawal of a complaint must be done in an informed and transparent way. Records noting a verbal request for withdrawal of complaints are not transparent and leave the withdrawal process open to challenge. At a minimum, the complaint withdrawal process must be in writing and signed by the victim or complainant. Interpreters should be used, and an independent person should be present. An audio or video recording of the complaint withdrawal would be optimal, leaving no opportunity for confusion or doubt as to the integrity of the withdrawal process.

8.4.5 Responsibility for inquiries

There is a need to clearly establish who is responsible for internal inquiries into incidents of child abuse, and to coordinate these with any external investigation by police or child protection authorities to achieve effective child protection outcomes in both the immediate and the longer term.

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[84] Incident CPP0016.

In many cases reviewed by the Panel, there was confusion between criminal investigation processes, and administrative inquiries or operational responses. The Panel observed incidents where a police referral had been made, and subsequently no further action was taken as it was believed that to do so might impede any criminal proceedings.

As previously observed, the rate of criminal conviction arising from such incidents is very small, and taking such a passive response does not address the immediate child protection concerns that are present. This led to perverse outcomes where POIs and victims were not separated, and other reasonable measures to prevent further harm were not taken.

This is particularly concerning given that, in many incidents reviewed, service providers' existing policies and processes for investigating and responding to incidents of child abuse were assessed by the Panel to be inadequate. The result was an ineffective response to the incident of child abuse. This observation applies to all detention environments and at RPCs. The Panel notes that the work to implement the Framework includes the review of service provider policies and processes, and the creation of protocols for child safeguarding inquiries.

During the Panel's work, there was regular uncertainty about, and disagreement regarding, the term 'investigation', including who had responsibility for ensuring that a comprehensive inquiry into a reported incident of child abuse had occurred.

This confusion led, in some instances, to no inquiry or investigations taking place at all.[85] In addition, well-intentioned responses (to victims) were sometimes initiated without a basic understanding of what had occurred, or what the existing risks around further harm might be.

There seemed to be little appreciation of the need for the Department to determine, to the fullest extent possible, what had transpired or 'what the truth of the matter was', so that risks to children could be mitigated.

Under new arrangements, Detention Superintendents and Field Compliance Operations Superintendents are best placed to ensure that timely and comprehensive inquiries and coordinated responses to incidents, in line with the triple track approach, are carried out. This activity should not compromise either police or child protection agency investigations. However, to achieve this objective, these officers need the necessary authority and specialist support to engage with external stakeholders, such as police and child protection authorities.

A broad multi-agency response capacity needs to be established to coordinate child abuse and other related investigations. Regular forums need to be held, under the leadership of the Superintendents, to facilitate the outcomes of external child protection investigations and ensure subsequent stakeholder-integrated responses, in line with the triple track approach.

8.4.6 Medical examinations

An issue of concern to the Panel in reviewing cases was the failure to have children medically examined following reports of child abuse. This included cases where sexual abuse reports had been made involving young children.

[85] Incident CPP0182.

These cases were often of the slapping and hitting category, where untrained service provider staff, often security staff, conducted an external visual examination of the child who had been the victim of the reported abuse. This level of observation is both appropriate and necessary to provide an accurate account of any observed injuries to the child. However, the Panel also considers it important to require, as a standard practice, the medical examination of children in all cases where child abuse reports are made.

However, on occasion, staff formed a view, when there were no visible injuries apparent, that a medical examination was not required, a judgement they were not trained to make. This is inappropriate because the injury may not be visible (such as a concussion in cases where repeated or severe blows to the head had occurred). In addition, a professional medical examination may well discover other injuries consistent with child abuse.

8.4.7 Premature closing of incidents

The formal police investigation was often seen to be the main response to reported incidents of child abuse. Many service providers held the view that no other inquiry of any kind should take place until a police investigation was complete.[86] This view does not take into account the possible need to take immediate actions following an incident of child abuse, such as responding to and separating victims and POIs, or securing possible evidence (noting the importance of not impeding any police investigation).

The Panel observed many cases that were closed by the Department's service provider before any police investigation was complete or had even started.[87] On other occasions, the initial investigation was well done and the facts were established in a timely fashion.[88]

The Panel also uncovered instances where police had concluded their investigation and closed their case file without advising the Department or its service providers.[89] The Department believed that matters were under active investigation when they were not and, as a result, valuable time was lost.[90] As a result, there was no attempt to establish an accurate account of the incident, witnesses were not interviewed, and the POI, if necessary, was not held accountable for their actions.[91] In some cases, police claimed that cases had not been referred to them, whereas the service provider said that they had.[92] As a result, no remedial action was taken.

The Panel notes that a referral to police should not preclude other safeguarding inquiry–related activity, nor the conduct of remedial action to secure the child from further harm.

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86 Incident CPP0182.

87 Incidents CPP0029 and CPP0038.

88 Incidents CPP0094, CPP0137 and CPP0185.

89 Incident CPP0093.

90 Incidents CPP0097, CPP0100, CPP0104, CPP0106, CPP0108, CPP0111, CPP0112, CPP0113, CPP0114, CPP0120, CPP0122, CPP0125, CPP0135, CPP0139, CPP0151, CPP0155, CPP0161, CPP0165, CPP0168, CPP0182, CPP0186, CPP0188, CPP0192, CPP0198, CPP0205, CPP0206 and CPP0207.

91 Incident CPP0087.

92 Incidents CPP0039 and CPP0046.

State and territory child protection agencies can and should be involved in inquiries into child abuse. These agencies prioritise the protection of the child and respond to the underlying causes of the abuse. Child protection agencies have a variety of powers to ensure the child's interests are safeguarded, which do not necessarily involve police. They may, however, lead to a court order to remove the child from the parents.

Welfare agencies are in a good position to deal with incidents where the POI and victim are both children, since the police are unlikely, in some instances, to pursue a criminal investigation (e.g. where those involved are under the age of criminal responsibility). However, as with police, Detention Superintendents or Field Compliance Operations Superintendents must maintain awareness of incidents even after referral to child protection agencies. The Panel reviewed incidents that had been responded to by child protection agencies, but the Department was not made aware of the outcome.[93,94]

Immediate protective action is required to support the victim and other children in reported cases of abuse. However, it is clear that more action must occur, including (at minimum) interviewing all those involved.

Regardless of who makes the inquiry or investigation, the Department should take responsibility for understanding the facts of a reported incident. The Department could rely on the police or child protection authority investigations, or initiate its own inquiry process, either in tandem or subsequently. This is particularly necessary where the reported POI is a departmental officer or service provider staff member.[95]

The Department has a number of important roles to perform in the process of inquiry:

- Incident response – the Department must take on a more active role in the management of incidents, whether they are being investigated by the state and territory authorities or not. The Department's service providers will normally be the first to receive a complaint of child abuse. They need to respond by keeping the victim safe in the first instance, managing the POI, preserving the scene of the incident and gathering the basic facts to establish what happened. The incident then needs to be reported promptly to the relevant authorities, where it is appropriate to do so.
- Coordinating and actioning a broad multi-agency response in conjunction with a range of both external and internal stakeholders – this can be achieved through regular meetings, chaired by the relevant Detention Superintendent or Field Compliance Operations Superintendent, where updated advice is provided on the incident response and necessary ongoing actions agreed to. This forum should be the entity where the investigative response is assessed and finalised with the agreement of all. Similar arrangements would be relevant to Nauru RPC.

93 Incidents CPP0110, CPP0124, CPP0134, CPP0158, CPP0183 and CPP0187.

94 Incident CPP0129.

95 Incidents CPP0097 and CPP0106.

8.4.8 Monitoring the outcomes of inquiries

The Department relies upon a range of information in making decisions about character for immigration status and placement purposes. The Panel observed an overreliance by the Department on criminal convictions in settling issues of a detainee's character or behaviour.

Analysis of the 242 cases reviewed by the Panel shows that only one resulted in a criminal conviction.[96] Since so few cases lead to a conviction, it is unsatisfactory as the basis on which to make these placement decisions. An individual may have a substantial history of poor behaviour, including a reasonable suspicion that the POI has committed child abuse, even where they have never been convicted.

Without a proper intelligence function underpinning detention operations, an alternative process using intelligence assessments may be difficult to establish. The Department should move to using all the information relating to a person's behaviour in detention in its decision-making processes. Section 8.14 discusses using intelligence to resolve these types of issues.

Where the facts of an incident have been established, the Department should ensure its records accurately reflect this. For example, in a number of cases, the POI was still recorded in departmental systems as having been responsible for a child abuse incident even though a subsequent investigation had cleared them of these allegations. Untrue adverse references to POIs need to be corrected.[97]

Service providers need to understand that investigations can be carried out for different, but equally legitimate, purposes, with very different outcomes. Ultimately, the outcome that must be achieved, if at all possible, is to establish the truth of a matter, be it inculpatory or exculpatory.[98] Where matters cannot be resolved conclusively where there are two different versions of events, then an equally legitimate response is to record the incident in detail for intelligence purposes.

The Department's Child Protection and Wellbeing Branch, and Contract Managers have a critical quality assurance role in regularly auditing the management and outcome of complaints and investigations, including oversight of service providers regarding their systems and responses, and ensuring that there is clear evidence of actions undertaken. In addition, the quality of safeguarding inquiry responses by Detention Superintendents and Field Compliance Operations Superintendents need to be subject to clear performance measures within their roles.

Recommendation 7

That the Department develop an enhanced incident categorisation system, in conjunction with service providers, that accurately identifies the number, nature and seriousness of incidents, including child abuse.

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96 Incident CPP0100.

97 Incident CPP0180.

98 Incident CPP0038.

Recommendation 8

That the Department strengthen its capacity to conduct child safeguarding inquiries by:

a. ensuring effective leadership and management of inquiries by Detention Superintendents and Field Compliance Operations Superintendents

b. requiring service providers to deliver accurate and complete incident reporting

c. establishing regular multi-agency forums to coordinate and facilitate the outcomes of child protection investigations

d. ensuring that inquiries are not finalised until all available facts are established and effectively responded to

e. ensuring that any complaint withdrawals are fully documented and transparent.

8.5 Increased capability to deal with highly complex matters

The Panel concluded, in relation to the cases reviewed, that the Department did not, at the time, have the capability to effectively manage complex cases of child abuse. In particular, the most poorly handled cases related to situations where:

- the child in question was very young (often an infant)
- there was a history of serious domestic violence
- the matter involved abuse by a parent that persisted over time and did not respond to intervention
- the POI was a person with an intellectual disability.

In the most complex cases, where there is a high level of concern for the immediate wellbeing of the child involved and supportive interventions have not resulted in improved care of the child, it is essential for the Department to engage effectively with state and territory child protection authorities. With respect to management of the most complex case matters, the Panel notes and supports the recent employment of a senior executive–level child protection expert to provide case consultancy and advice to departmental decision makers. The Panel also notes that the Framework specifically addresses engagement with state and territory authorities.

Recommendation 9

That the Department develop, in conjunction with relevant service providers, case management standards for children in immigration detention. Further, the Department should design a complex-case management protocol, in consultation with Detention Superintendents and Field Compliance Operations Superintendents, within the ambit of the Child Safeguarding Framework.

8.6 Strengthening key departmental roles

The Panel has identified several key roles that are accountable for child wellbeing and protection outcomes. These roles are identified in the Framework. The Panel wants to emphasise the action required to build the capability of the occupants of these roles.

8.6.1 Detention Superintendents and Field Compliance Operations Superintendents

Detention Superintendents and Field Compliance Operations Superintendents are accountable for ensuring there is an appropriate response to incidents that occur in held detention and community detention. They must also develop a range of ways to encourage reporting of incidents, focus on the risks to children, and share relevant information and intelligence within the Department and with its service providers.

The job descriptions of these roles should be reviewed to ensure that their key accountabilities in relation to child wellbeing and protection are described. Further training to fulfil these roles should be provided, if necessary (e.g. understanding child protection principles, the obligations placed on them by the Framework, working with state and territory authorities, incident management, investigation oversight and coordination, and access to professional services). In addition, operating procedures need to be amended to reflect these new accountabilities and to ensure that there is an agreed response to incidents.

8.6.2 Child Protection and Wellbeing Branch

The Child Protection and Wellbeing Branch is responsible for ensuring the development and review of child safeguarding policies, and for ensuring that staff have the resources and access to expertise to perform their roles, and to provide quality assurance as per Section 8.2.2.

The Child Protection and Wellbeing Branch will need to strengthen its cohort of professionally qualified staff with practical experience in child protection practice and systems. This expertise is required to support Detention Superintendents, Field Compliance Operations Superintendents and Contract Managers.

8.6.3 Contract Managers

Contract Managers have a dual accountability.

Firstly, Contract Managers must ensure that amended or renegotiated contracts clearly spell out service provider accountabilities for a consistent, cooperative approach to wellbeing programmes, and for the response to, and investigation of, incidents. Similarly, the contracts must be consistent and fit for purpose, and include child protection policies, a common code of conduct and child safety–specific risk assessments, and incident description and categorisation processes.

It is essential that contracts contain effective mechanisms for the Department to be assured that service providers (and their subcontractors) are applying appropriate professional standards and taking action when these standards are breached by staff. Contract Managers must work closely with the Child Protection and Wellbeing Branch, the Health Service Branch, and the Detention Operations area, to ensure that contracts reflect all requirements of the Framework. In relation to Nauru RPC, the Regional Processing and Settlement Branch is also an important stakeholder.

Secondly, Contract Managers must ensure that service providers meet their contract obligations in terms of ensuring that wellbeing programmes are delivered, that incidents involving children are responded to and managed effectively, and that breaches of professional standards by service providers and subcontractor staff are managed appropriately. This will require Contractor Managers to

actively participate in quality assurance programmes conducted by the Child Protection and Wellbeing Branch, and to work closely with Detention Superintendents and Field Compliance Operations Superintendents.

Recommendation 10

That the Department ensure that Detention Superintendents and Field Compliance Operations Superintendents, service providers and subcontractors are aware of, and have access to, appropriate professional services that are required in complex child wellbeing and protection cases.

8.7 Improving risk management

Although it is important that the Department develop strong and effective responses to incidents of child abuse, it is also critical that the Department acts in ways that better identify risk to children and seeks to prevent the occurrence of incidents in the first place.

The Department's and service providers' existing individual planning processes – such as the Security Risk Assessment (SRA) process, which focuses on the risk to facilities – do not consider the safety and wellbeing of children. In addition, the SRA process is overseen by staff who focus on facility security – not child safety.

Similarly, the information gathered about potential risks during the development of Individual Management Plans (IMPs) is not always integrated into day-to-day supervision of the child involved. This can have extremely poor outcomes for the child if, for example, IMPs identify problematic parenting or incidents of abuse.[99]

It is clear to the Panel that abuse can occur over a lengthy period in more than one facility, and for staff not to be aware of this pattern of events.[100]

It is not apparent that a risk assessment is done when a child moves into community detention. It would enhance the safety and wellbeing of children if service providers conducted such a risk assessment of children and their families (or, in the case of unaccompanied minors (UAMs), assessed the UAM household) when children first move into community detention, and repeated this risk assessment at regular intervals.

8.8 Prioritising children most at risk

The cases reviewed by the Panel show that nearly 25 per cent of cases included children who had previously been the victim of child abuse. These children have an increased, ongoing risk of harm.

Of the incidents examined by the Panel, 70 per cent involved an adult POI and a child victim, leaving 30 per cent where a child had been identified as a POI.

[99] Incident CPP0013.

[100] Incident CPP0024.

Of the victims identified, just over 40 per cent were under the age of six years, with a disproportionate number of those (70 per cent) being boys. The next most vulnerable group were aged 6–11 years, making up 32 per cent of the total incidents.

Of the POIs, 77 per cent were adults, with males represented twice as often as females.

Case example 8.1 Repeat victimisation

Over a period of nearly 12 months, a toddler and their sibling were subjected to child abuse at the hands of their parents. The numerous reported child abuse incidents included sexual and physical harm against a child, threats of harm, aggressive behaviour and repeated failure to supervise.[101]

To protect these child victims and others like them in the future, the Panel considers that the Department should develop an intelligence-based method of identifying them, and making sure that they receive the support and services they need to prevent future incidents.

The implementation of the Framework will enhance protection of this group. The Framework includes two new mechanisms. Child Protection Assessments will help to identify the ongoing risk to a child who may have been the victim of abuse or inappropriate behaviour. On a more proactive basis, Wellbeing Assessments will provide the opportunity for all information regarding a child to be collated and assessed when they enter a facility or transfer between facilities.

Using this information, Detention Superintendents and Field Compliance Operations Superintendents should identify those children who are at risk of abuse and put in place arrangements to ensure their protection. This information could be aggregated nationally and flagged when a child at risk is moved from one environment to another. To support this, the Department and its service providers should revise the scope of the SRA process used in facilities and community detention to include risks to the wellbeing of children.

The Panel was advised of earlier plans around the introduction of a specialised facility for families and children, and introducing child protection staff in that facility, which would help focus on children who are at risk. At this stage, the progression of those plans is unclear, given changes to the number of children in held detention.

8.9 Managing recidivists

During its review of incidents, the Panel was struck by the number of POIs who were identified in multiple incidents involving children. Of the cases reviewed, 22 POIs came to notice in 53 cases.

This trend was evident in all three environments. Recidivists included parents, UAMs and adults with an intellectual disability. Although it is beyond the Panel's ToR, the Panel notes that some people who were recidivists in the abuse of children had a similar history in matters not involving children. For example, one adult POI who was involved in 41 child abuse matters was involved in 175 incidents overall.[102]

[101] Incidents CPP0071 and CPP0079.

[102] Incident CPP0032.

Case example 8.2 Recidivist persons of interest

One person of interest (POI) is linked to dozens of incidents of concern. These incidents included a critical sexual assault, several major incidents of assault, and several incidents in which force was used to restrain them from harming themselves and/or others.[103] This POI was also involved in numerous incidents of abusive/aggressive behaviour, predominantly directed at service provider staff. In addition, according to the same reporting, this individual is recorded as being a victim in relation to more than 10 incidents.

It is clear that the risks associated with this population are not being well managed, despite it comprising a relatively small number of people.

For each of these POIs, an IMP should be developed to manage the particular risks associated with the person, and to prevent or reduce future opportunities to harm children. It is noted that similar strategies have yielded very positive results for law enforcement agencies and child protection authorities. This approach to risk would be a significant change for the Department and its service providers. Until now, risk assessment has focused on the physical security of a facility only.

This strategy would yield significant benefits in terms of improved safety of children, prevention of incidents that would otherwise require reporting and responses, and reduced administrative burden for the Department. In combination with suggested strategies to reduce incident overclassification (Section 8.4.2), the Panel is of the view that the action proposed will free up resources to improve responses to the most serious and complex cases.

This targeting role is probably best performed by trained and experienced intelligence officers, most likely attached to the Intelligence Division. Their work will require them to engage with a wide range of stakeholders both within and outside the Department, including Detention Superintendents, other relevant departmental officers (including those who decide on people's immigration pathway and movement), state and federal police, and child protection agencies. The lists will need to be comprehensive and contemporary, so that the POIs who pose the highest risk to children are the focus of necessary attention.

The Panel notes that the Department is acting on this issue.

Recommendation 11

That the Department:

a. extend its risk assessment mechanisms to ensure that they specifically address the safety of children in immigration detention, including:
    i. children under the age of six years and others known to be at high risk of abuse
    ii. recidivist persons of interest
b. introduce a risk assessment process around the movement of children and their families
c. extend the National Detention Placement Model to include the needs of, and mitigation of the risks faced by, children and families in immigration detention.

[103] Incidents CPP0033, CPP01814 and CPP0224.

Recommendation 12

That the Department identify, assess and effectively respond to:

a. children who have been the victims of abuse on multiple occasions

b. persons of interest who have been involved in multiple child abuse incidents.

8.10 Internet and digital safeguards

The Panel supports the findings of the Detention Assurance Team's review (see Section 4.3.7). The Panel also suggests that the data-transfer capability on computers in internet rooms at immigration facilities be disabled. It is understood that residents often have copies of their official documents and correspondence on universal serial buses (USBs), so there may be a need to provide a terminal with data-transfer capability in a supervised administration area for this purpose only. Generally, the free circulation of USB devices represents an unacceptable risk, as evidenced by the number of cases where they were used to store and share pornographic material.

The Department should progress the implementation of the report of the Detention Assurance Team, and further consider the issues and risks associated with data-transfer capability on computer terminals in held detention and RPCs, as well as the use and exchange of USBs.

The issue of age-related classification restrictions is a slightly broader one, as it relates not only to internet use but to the screening of DVDs and the like for children, as part of their recreational activities. The Panel considered that this issue needs to be addressed in relevant protocols. The Department may wish to develop procedures for facilities to ensure that children are limited to viewing only material that is age appropriate, whether online or on DVDs.

Recommendation 13

That the Department continue to implement the findings of the review of internet safeguards conducted by the Detention Assurance Team, including:

a. the restriction of data-transfer capability

b. the capacity to identify users of departmental computers in immigration detention facilities

c. a regular review of data access records to identify unlawful and inappropriate access

d. age-appropriate access to online and other digital media.

8.11 Improving facility infrastructure

Two areas that featured prominently in reviewing cases concerned the application of closed circuit television (CCTV) and appropriate lighting.

The Panel considers that the use of CCTV should be expanded in the detention and RPC environments, to assist with investigating child abuse incidents and, more broadly, to assist detention operations. Proper management and record retention of CCTV footage by the Department and its service providers is equally important.

The Panel observed that some of the most serious incidents occurred during the hours of darkness and in areas that were not well lit. The Panel is of the view that enhancements to facility lighting will act as a deterrent to opportunistic offending.

8.12 Improving and enforcing professional behaviour among staff

The Panel reviewed a number of incidents – approximately 8 per cent of all reviewed incidents – in which an employee had caused harm to a child. The Panel reviewed 10 such incidents that occurred at Nauru RPC[104] and three that occurred in held detention in Australia.[105] In two instances, staff involved in the Nauru RPC incidents were dismissed. There was no evidence of internal professional standards or employment review, or any evidence of action taken in any of the other cases. There may be value in improving monitoring (through contractual arrangements) in this regard.

Current service provider policies prevent local managers from initiating inquiries. At Nauru RPC, the view of the primary service providers is that such investigations are a matter for the Nauru-based subcontractor.

The Panel requested the Department to review its records to identify any incidents of child abuse by its staff. This research identified no instances of child abuse–related behaviour by departmental staff.

The Panel also requested the held detention service provider to review its records to identify any further incidents of child abuse by its staff. The response identified only one incident where a staff member had been investigated for child abuse. It is essential that service providers introduce appropriate professional standards investigations in such cases, including when subcontractor staff are involved.

8.12.1 Pre-employment screening and training of service provider staff

A number of incidents indicated that some security staff did not have an awareness of normal behaviours exhibited by children of particular ages, or the ways in which children may use behaviour to attract adult attention or express their feelings.

The Panel considers that the emotional maturity of staff applicants should be assessed before confirmation of employment and, more specifically, how the applicant deals with provocation, and their ability to defuse and de-escalate tense situations. Although this ability can be enhanced by training in the use of specific techniques and strategies, employees need to display a level of maturity and understanding of children if they are to be assigned to work in areas where children and their families are located.

In relation to Nauru RPC, the Panel has been advised that, since its first visit in July 2015, all security staff employed by local subcontractors have completed a relevant Certificate II qualification.

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[104] Incidents CPP0001, CPP0003, CPP0004, CPP0005, CPP0006, CPP0007, CPP0008, CPP0010 and CPP0013.

[105] Incidents CPP0093, CPP0097 and CPP0106.

The Panel noted the importance of staff being culturally aware. Service providers need to be trained and supported to accurately assess whether the behaviour of children or their parents reflects cultural beliefs and standards, or if the behaviour warrants further attention.

8.13 Improving flow of information

Aspects of the Department's service delivery have been evolving quite quickly while the Panel has been in operation. There is better coordination of detention and RPC information sharing through the new accountability arrangements of departmental Detention Superintendents.

Greater efforts can be made to actively transfer important child protection information:

- within the Department
- between held detention and community detention
- at RPCs
- between detention environments and RPCs
- between service providers and the Department
- among service providers
- between detention and RPC environments, and external authorities.

8.13.1 Case management systems

In each incident that the Panel reviewed, every effort was made to locate and collate all relevant records in each case, to allow a thorough assessment of all documentary evidence available. The Panel's efforts in this regard were supported by the Secretary of the Department and the Australian Border Force Commissioner, who issued a directive to staff to locate and provide any relevant material in their possession. Despite these efforts, document discovery was a slow and iterative process that continued up to the completion of this report.

Data holdings are currently fragmented, and access to them depends on an in-depth knowledge of the systems – knowledge that is not held by all staff. Panel members experienced these problems themselves in accessing complete and reliable information regarding incidents relating to children in detention or at RPCs. Data are held in different departmental databases and onsite spreadsheets.

There is not a clear record of the nature and severity of incidents available in departmental information and intelligence systems, which lessens the Department's ability to manage children who are at risk and those people who are a threat to children in detention or at RPCs. This information is particularly important when someone moves between facilities – it is not appropriate for a person who has assaulted a child in one facility to be moved to another where there are children.

The Panel reviewed a number of cases[106] where it was clear that information available to the Department and service providers had not been collected, collated, analysed, assessed and disseminated. A key causal factor was the lack of a comprehensive case management system.

[106] Incidents CPP0032, CPP0033 and CPP0189.

The Panel sees a need to integrate and enable authorised access to the full case-related information holdings within the Department. The quality of case reporting varies quite markedly across and within the different detention and RPC environments.

Immigration systems are not structured around linking and understanding family groups. There are IMPs for every person, but no planning mechanisms for families. It can even be challenging to know who is regarded as being part of the family, especially as members may well have different surnames. Unless there are some unusual circumstances (e.g. a couple has agreed to marital separation, or to be considered separately where one has an adverse security assessment), reporting should reflect the family as a unit.

8.13.2 Communication of case information

People are regularly moved within the held and community detention network for a variety of reasons, including to overcome placement difficulties (e.g. to access necessary health and medical services), as a result of alleged child abuse, or because the person was difficult to manage and presented a risk.

As discussed in Section 8.13.1, weaknesses in the case management systems and difficulties with staff access to systems meant that comprehensive histories of people were not easily accessible to the Panel. As a result, a person's comprehensive case history was rarely forwarded to the receiving facility or relevant service provider.

It is important that all relevant information about an individual be actively conveyed to the service providers who will manage the person in the part of the system to which they are being transferred.

There must also be clear criteria for movement of individuals and families, such as considering access to specialist medical treatment (e.g. obstetrics) or other services (e.g. disability services, torture and trauma counselling), and the proximity to other family members.

Recommendation 14

That the Department improve its management of case-related information, including by:

a. developing a mechanism to ensure that officers who need this information know where it is and how to access it

b. integrating the currently fragmented information holdings relating to children and their families in immigration detention.

Recommendation 15

That the Department:

a. ensure that all relevant information on the history and background of the child and the person of interest is communicated to all relevant stakeholders (including state and territory authorities) when the child or person of interest is moved within or outside the immigration detention network

b. seek consent, where necessary, from the detainee concerned to authorise the sharing of information to enhance the services to be provided – or consider if there are other grounds to lawfully disclose the information.

8.14 Use of intelligence

The Department has intelligence capability in place that serves different purposes; however, none of it is directed to the protection of children in detention or at the RPCs.

The Department's security service providers in held detention have some intelligence functionality in place; however, it is directed to the physical security and good order of the facilities. It does not help key decision makers to understand the threats to children that some people pose or to identify children most at risk of abuse. Having robust and refined intelligence assessments available to decision makers, at the right time, is pivotal in reducing the risk of harm of persons in detention or at the RPCs, including children.

There is broad support in the Intelligence Division of the Department to focus intelligence resources on the protection of children. Recently, the Department reviewed its intelligence capability and endorsed this position. The Panel notes that the Department is considering the development of a new intelligence capability to support detention operations, with a number of funding models under consideration.

Intelligence assessments relating to the character or behaviour of people, particularly the risk posed by people who have abused children, should be considered by key departmental decision makers in matters such as detention placement, transfer or movement decisions, and, ultimately, the Minister for Immigration and Border Protection when making status determination decisions.[107]

Recommendation 16

That the Department develop its intelligence capability in the immigration detention network to address child abuse risks, in line with the findings of the Integrated Intelligence Capability Review, so that:

a. the incidence of child abuse is reduced

b. intelligence products are used to inform decision making.

8.15 Mandatory reporting

Integral to the Panel's ToR was the requirement to determine if the Department had complied with the relevant state and territory mandatory reporting laws. The Department and its service providers were highly compliant overall with mandatory reporting requirements in held and community detention, notwithstanding some confusion in some cases.[108]

[107] Incident CPP0038.

[108] Incident CPP0168.

The assessment of the Panel is that there has been a very high level of compliance by the Department and its service providers, achieving 95.3 per cent compliance against the mandatory reporting requirements in each relevant state and territory jurisdiction. In addition, the Department reported 41 incidents that the Panel determined did not require reporting (i.e. were overreported).

Given that incidents reviewed by the Panel were the most serious reported to the Department, it is a little surprising that the Panel assessed only 50 per cent of such incidents as requiring mandatory reporting under the relevant state and territory legislation.

In some of the compliant 4.7 per cent of cases, it is unclear if the matter was reported and follow-up inquiries are ongoing. Only two cases have been confirmed as not being reported at the time of the incident, with remedial action by the Department subsequently undertaken.

Although it is clear that many of these other matters were reported with the best of intentions when there was no legal requirement to do so, it is possible that this overreporting may have the undesirable effect of state and territory authorities becoming complacent with departmental reports, masking the more serious legitimate reports when made. The settings and practice in the recently endorsed Child Safeguarding Framework may assist in this regard.

However, the review has revealed some underlying issues about the complexity and inconsistency of various pieces of legislation. There were incidents that were reported, which did not accord with jurisdictional requirements, and, as a result, jurisdictions did not respond. This can cause risk and tension between the Department, and state and territory agencies.

The complexity and legislative inconsistency in mandatory reporting requirements across jurisdictions have much wider application across the Australian community. They allow for information loopholes to be exploited by POIs. Behaviour that was identified under mandatory reporting regimes in one jurisdiction may not be reportable in another.

Although these broader mandatory reporting issues are outside the Panel's ToR, the Panel's concerns arise from its observations that the current mandatory reporting arrangements provide varying levels of protection to children under the Department's care in both community and held detention.

The Panel, therefore, formed the view that the issue of a consistent national mandatory reporting arrangement should be brought to the attention of the Royal Commission into Institutional Responses to Child Sexual Abuse, which has already expressed a similar interest in other cross-jurisdictional issues.

Recommendation 17

That the Department consider providing a copy of this report to the Royal Commission into Institutional Responses to Child Sexual Abuse, drawing its attention to the enhancements that could be made to Australia's mandatory reporting arrangements.

9 Future directions

This report identifies action that the Australian Government Department of Immigration and Border Protection (the Department) can take to improve the wellbeing and protection of children in detention and at Nauru Regional Processing Centre (RPC). The issues identified are supported by substantial evidence derived from the review of a large number of reported cases of child abuse, observations made during visits to facilities, discussions with departmental officers and service providers, and review of contemporary practice.

The Child Protection Panel (the Panel) notes that the broader environment is one characterised by unpredictability and constant change. For example, during the course of the Panel's work, the number of children in held detention and at Nauru RPC has reduced significantly.

In this context, it is important that the Panel's embedded observations, which might now appear to have less immediate relevance, are not lost. For example, the Panel concluded early in its work that the establishment of a specialised facility for families and children would have many benefits in terms of child wellbeing and protection – a requirement that might not currently be relevant given the reduced numbers.

The Panel notes that, as at 31 March 2016, there were some 600 children in community detention (with their families or as unaccompanied minors) and a much larger number residing in the Australian community on temporary visa arrangements. Some of the Panel's observations would likely be relevant to this broader cohort of children.

Some of the changes arising from the Panel's recommendations are significant for both the Department and its service providers. They go to policy, practice, operating procedures, roles and accountabilities. Some deeply embedded cultures (such as incident investigation) will require purposeful and sustained effort to address.

There are a number of recommendations that will be challenging to implement, particularly those that relate to developing an effective intelligence capability, addressing the fragmentation of data holdings and improving the case management capability.

The Panel has also made a number of observations relating to operations at Nauru RPC. Some aspects of service delivery at Nauru RPC, including the professional conduct of some staff, arise from, and can be influenced through, the management of contracts.

There are several quality assurance processes that support the protection of children in detention and at Nauru RPC:

- The Child Safeguarding Framework gives a quality assurance role to the Child Protection and Wellbeing Branch.
- The Detention Assurance Branch reviews high-priority incidents that occur in detention.
- The Detention Services Division monitors quality of contractual arrangements.

- The Community Operations and Community Support branches carry out process-based quality assurance of providers in the community detention programme.

It is suggested that the Department expand its quality assurance processes to ensure that all incidents involving child abuse that occur in detention are reviewed, with a particular focus on the three dimensions of the 'triple track' approach developed by the Panel. The outcomes of these quality assurance processes should be reported to the Executive.

Beyond this, there is an opportunity to focus more generally on the prevention of harm to children and the promotion of their wellbeing, rather than merely improving responses to incidents.

Margaret Allison, Dominic Downie and John Lawler AM, APM

11 May 2016

Appendix 1 Glossary

Child abuse – All forms of abuse, including: (AIFS 2014)

- **Physical abuse** – the use of physical force against a child that results in harm to the child. Physically abusive behaviour includes shoving, hitting, slapping, shaking, throwing, punching, kicking, biting, burning, strangling and poisoning. It is important to consider, however, behaviour that constitutes reasonable parental discipline, in line with current legislation.
- **Emotional abuse** – inappropriate verbal or symbolic acts towards a child, or a pattern of behaviour over time that fails to provide a child with adequate nurture and emotional availability.
- **Sexual abuse** – 'the use of a child for sexual gratification by an adult or significantly older child/adolescent' (Tomison 1995) or 'any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards' (Broadbent & Bentley 1997). Sexually abusive behaviours can include the fondling of genitals; masturbation; oral sex; vaginal or anal penetration by a penis, finger or any other object; fondling of breasts; voyeurism; exhibitionism; and exposing the child to, or involving the child in, pornography (Bromfield 2005).
- **Neglect** – the failure to provide a child (where the carer is in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing.
- **Exploitation** – child exploitation is the use of a child (usually by an adult or significantly older person) for their own personal benefit or interest. Behaviours indicative of child exploitation include the:
  - possession, control and distribution of child pornography material
  - coercion of a child to perform an inappropriate act
  - commission of abuse against a child
  - grooming of a child for future abuse
  - trafficking of a child for the purposes of slavery or prostitution.
- **Witnessing family violence** – this term has been broadly defined as 'a child being present (hearing or seeing) while a parent or sibling is subjected to physical abuse, sexual abuse or psychological maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behaviour' (Higgins 1998).

Held detention – For the purposes of this report, held detention refers to any designated immigration detention facility in Australia that is authorised to hold children. These include alternative places of detention, immigration residential housing and immigration transit accommodation. All such facilities are low security in nature.

Person of interest – The person – adult or child – reported to have performed the act of abuse or neglect.

Victim – The child reported to have been abused or neglected.

Acronyms and abbreviations

ACBPS	Australian Customs and Border Protection Service
APOD	alternative place of detention
CCMDS	Compliance, Case Management, Detention and Settlement
CCTV	closed circuit television
the Department	the Australian Government Department of Immigration and Border Protection
the Framework	the Child Protection and Wellbeing Framework
IMP	Individual Management Plan
ISIS	Immigration Services Information System
Manus RPC	Manus Regional Processing Centre
the Minister	the Minister for Immigration and Border Protection
the Panel	the Child Protection Panel
POI	person of interest
Nauru RPC	Nauru Regional Processing Centre
RPC	regional processing centre
SOP	standard operating procedure
SRA	Security Risk Assessment
ToR	terms of reference
UAM	unaccompanied minor
USB	universal serial bus

Appendix 2 Terms of reference

Evolution of the terms of reference

The Panel's terms of reference (ToR) were announced in April 2015 and made available online on the Department's website (DIBP 2015c). These called the Panel to critically review reported incidents of abuse, neglect or exploitation involving children that occurred between 1 January 2008 and 1 April 2015 within that domain.

The Panel's ToR subsequently evolved to include a broader range of issues that reflected Panel members' early review activities. On 16 April 2015, revised ToR were provided to the Panel, which introduced an expectation that the Panel would now provide advice on departmental and service provider policy and procedure around the management of, response to, and reporting of, incidents involving children in both the held domain and the regional processing centres (RPCs).

On 3 May 2015, the Panel's ToR were again amended to consider the passage of individuals through the immigration detention pathway – for example, an individual detainee going through held detention, to Nauru RPC and into community detention at differing points of their engagement with the Department. Similarly, the advice on policy and procedure was no longer constrained by geographic location.

As the Panel was working through incident reviews in held detention and at RPCs, it became apparent that the Panel would not have an opportunity to consider a sufficient number of incidents in the community detention space (such that reasonable comments could be made) in advance of the initial date for a preliminary report (December 2015). Consequently, the Panel sought to amend the ToR such that an initial Issues Paper would be produced by the end of the calendar year 2015, with the full report due for delivery by mid-2016. This amendment was made on 7 October 2015.

The Panel's final ToR are provided below.

Final terms of reference

The Department takes very seriously its role in protecting children who are in immigration detention from abuse, neglect or exploitation, as well as its role in assisting the Government of Nauru to do the same in the Nauruan Regional Processing Centre. The Department seeks to identify opportunities for improvement to processes, practice, policy and cultural norms around its responses to such incidents involving children.

To that end, the Secretary of the Department of Immigration and Border Protection has established a Child Protection Panel (the Panel) to provide independent advice on child protection in immigration detention and regional processing centres. The establishment of the Panel is partly in response to the recent Moss Review into allegations at the Nauru RPC.

The purpose of this Panel is to ensure that a comprehensive and contemporary framework for the Department relating to the protection of children is in place. This will be done by assessing the adequacy of departmental and service provider policy and practice around the management of incidents

of abuse, neglect or exploitation involving children. Based on this assessment, the Panel will provide recommendations for ongoing improvement.

In relation to incidents of abuse, neglect or exploitation involving children the Panel will:

- critically review responses by the Department and its service providers in onshore detention environments, including community held detention, and at RPCs, to reported incidents which occurred since 1 January 2008
- provide independent advice to the Secretary in relation to the effectiveness and correctness of departmental and service provider policy and procedure around the management, response, and reporting of incidents involving children, and
- make recommendations to strengthen arrangements around the management, response, and reporting of incidents involving children.

Any material obtained by the Panel that might be of assistance in relation to criminal charges or investigation activity will be made available to relevant authorities.

The Panel will provide an Issues Paper to the Secretary outlining indicative findings from the targeted reviews by the end of the calendar year 2015. A final report will be provided to the Secretary by mid-2016 covering both better practice and a comprehensive sample of reviews.

Appendix 3 Panel members' biographies

John Lawler AM APM

Mr John Lawler AM APM is a 34-year career law enforcement officer who served from 2009 to 2013 as the Chief Executive Officer of the Australian Crime Commission (ACC) before retiring in October 2013.

He previously served for 29 years with the Australian Federal Police (AFP).

Mr Lawler has extensive experience in a wide range of law enforcement disciplines, performing roles at the local, national and international levels, including community policing, investigations, protection, intelligence, international operations and executive services.

He was Director of Internal Security and Audit, performing the critical oversight role of the AFP's internal security activities.

As Chief Executive Officer of the ACC and a member of the ACC Board, Mr Lawler has strong relationships with state and territory police commissioners, state police ministers, and key state and territory departments, including the Commissioners of Corrections.

Since retiring, Mr Lawler has established a consultancy conducting investigations, reviews, assessments and assurance for government and the private sector. In addition, he provides mentoring to senior law enforcement executives.

Margaret Allison BSocWk, MPubAd, FIPAA

Margaret Allison was previously the Director-General of the Department of Communities, Child Safety and Disability Services in Queensland, and the Chief Executive of the Public Service Commission in Queensland. She currently sits on the Queensland Police Service Board of Management. She has had a diverse career spanning more than 35 years in the public sector in Queensland and New South Wales, and in local and state government. With a professional background in human services, she has led services and reforms in areas including youth justice, child protection, disability, legal aid, domestic and family violence, child care and customer services.

Since retiring from the public service in 2014, Ms Allison has established a consultancy specialising in organisational strategy and leadership of change, strategic organisational reviews, executive team performance and performance management.

She brought to the Panel extensive legal, change management and leadership experience, shown during her last major review, *Independent review of an incident involving Queensland Fire and Rescue Service employees*, completed in December 2014.

Dominic Downie

Dominic Downie has a 35-year career in the Australian Public Service (APS) and associated authorities, and has had significant roles, including being involved in the design of the APS capability framework.

He was a Senior Executive for 16 years: six years at the SES Band 2 level.

During his career, he has worked in both service delivery and central policy agencies. Key roles included Assistant Commissioner in the Australian Public Service Commission and Head of the Corporate Development Division of the Health Insurance Commission.

Mr Downie now specialises in the development of capability frameworks, business planning, evaluations and performance audits, functional reviews, the development of governance structures and workforce planning, development and innovation.

He is the Director and Board Chair of a not-for-profit organisation working in the disability services sector.

Appendix 4 Issues Paper

Initial Priorities for reform
Child Protection Panel – Issues Paper

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Part 1 - Executive Summary

The Child Protection Panel (the Panel) was established in March 2015 to review the Department's responses to reported child protection matters in detention over a period of seven years, in both onshore and offshore environments and to recommend improvements to the Department's approaches to child wellbeing and protection.

The Panel has now completed the first stage of its work. It has reviewed a sample of more than 150 incidents that occurred in held detention. These desktop reviews have been supplemented by a series of meetings with departmental officers, contract service providers and other stakeholders and visits to all detention centres where children are, or could be, located. After a review of the cases, the Panel has requested additional inquiries be undertaken in a number of matters, where the matter had been serious and the outcome was unclear. Further, in accordance with the Secretary's wishes, the Panel has escalated a small number of cases and issues that required immediate management attention to reduce risk to a child.

Although further work is yet to be undertaken on child protection matters in community detention, the Panel is now in a position to suggest some initial priority areas for the Department's consideration. These priorities have been generated directly from our case reviews, conversations and observations. Some of those areas for consideration have a broader application beyond child protection.

The priorities are grouped into four themes:

1. Focusing on the wellbeing of children

Underlying this theme is the recognition that contemporary frameworks for the protection of children focus not only on effective responses to abuse or neglect, but also the strengthening of those systems and services that support the well-being of children. This includes recognition of the important role parents play as the primary protectors of their own children, and the critical contribution of universal services such as health and education.

A number of the priorities identified under this theme are about prevention of child abuse, as well as harm minimisation strategies that can be readily implemented, including the establishment of specialist centres for children and families. The completion of the Department's Child Protection and Wellbeing Framework is also critical.

2. Strengthening the response to incidents

The priorities identified within this theme reflect the importance of responding to incidents promptly and comprehensively when they occur or are alleged. The central proposal of the Panel is the adoption of a 'triple track' response to incidents - the immediate protection of the child (and other children) from further harm, an appropriate response to the person who has caused the harm, and learning from the incident to improve systems. An effective response starts with an accurate categorisation of the incident when it is reported, so that the urgency and extent of the response is commensurate with its seriousness. The Panel observed that some incidents were over-classified and duplicated, thus inflating the number of matters which were serious. In fact, an initial assessment would indicate that roughly a third of cases referred for Panel consideration would not meet the threshold for child abuse reporting.

The Panel also identified the same names coming to notice in the incident reports, both as persons of interest and as children subject to abuse. This reflects trends in the broader community, and highlights the importance of closer management strategies and protocols for some individuals.

3. Improving centre management

This theme relates to those matters under the control of the Superintendent in charge of a centre. With

the new centre structures and reporting lines in place, there is an ideal opportunity for Superintendents to realign centres to ensure the highest standards of professional operation. The authority of Superintendents to make operational decisions about case matters – including those that relate to children – is critical to the success of this realignment.

It is also expected that Superintendents will develop a range of ways to encourage reporting of incidents, focus on the risks to children and to share relevant information and intelligence within the Department and with its contractors. This theme also deals with the professional conduct of all staff employed in centres.

4. Enhancing stakeholder and system responses

The matters incorporated within this theme largely relate to systemic issues that may take some time to resolve. For example, it deals with the relationships between the Department and State and Territory authorities (principally police and welfare authorities), and the Government of Nauru. In the Australian context, these relationships are made more complex by the different statutory requirements and reporting regimes in each jurisdiction.

Other matters raised under this theme are more within the Department's control, including the operation of the detention network as a single entity. This will allow more rational use of the Department's detention resources, and the placement decisions that must be made. Critically, this part of the report also deals with the use of intelligence in the making of key decisions, so that child protection reports become an integral part of the intelligence holdings of the Department. It also highlights the fragmentation of information holdings within the Department. Issues of data access and quality are also highlighted in this part of the report.

The work undertaken by the Panel to date provides a unique window to the work of the Department, its service providers and the external stakeholder agencies with which they deal, over an extended period. No other piece of work has examined the breadth of departmental cases through a child protection lens.

In many ways, the Department can be reassured by some of the Panel's findings and observations. For example, there is a high level of compliance with mandatory reporting obligations across State and Territory jurisdictions in Australia. (Mandatory reporting will be dealt with in detail in the next report.) Similarly, a significant proportion of matters have been reported as being more serious than they actually were, mostly due to the limitations of the incident classification system.

As requested by the Secretary, the Panel has sought to progressively discuss the issues it has identified and its proposals for improvements with senior staff and contractors. In most instances, the Panel has found that there is agreement with its conclusions on how the issues identified can be addressed and in some cases, such as the 'triple track' approach and the strengthening of internet safeguards, these are being incorporated into operating procedures.

Nevertheless, there remains some important work to be done. Perhaps the most important work is that being undertaken by the Department to ensure that, wherever practical and possible, all children will be placed in community settings, as well as the movement towards a specialist centre for children and families. This commitment is strongly supported. Further aspects of the work will be achieved through the opportunities presented by the Department's structural re-alignment, and the focused reviews of detention capability and intelligence systems.

Part 2 - Introduction

In March 2015, the Secretary, Department of Immigration and Border Protection (the Department), determined that a review should be undertaken of reported matters involving children in onshore held detention, to ensure that the policies and procedures of the Department and its contractors reflected best practice in the protection of children, and compliance with the relevant laws of the State and Territory jurisdictions in which the centres are located.

The review was to examine matters over a seven year period from 1 July 2008 to 30 June 2015. Later, the scope of the work was extended to include regional processing centres, and community detention.

The Secretary commissioned a three person Child Protection Panel (the Panel) to undertake the above work. Each Panel member was appointed on the basis of particular expertise:

- Significant law enforcement experience – Mr John Lawler AM APM
- Significant child protection administration experience – Ms Margaret Allison BSocWk MPubAd FIPAA
- Significant public administration experience – Mr Dominic Downie BA GAICD.

The Panel was also asked to provide their views on systemic improvements that could be made to support the well-being of children in detention generally. The work of the Panel is supported by a small Secretariat located in the Department's Integrity, Security and Assurance Division.

The Panel and Secretariat worked collaboratively (and iteratively) to develop a template that would assist not only in the review of individual cases, but also provide the potential for a search capability that would allow common themes to be considered. The template included both factual (e.g. summation of the reported incident) and evaluative (e.g. assessment of the adequacy of the response) components.

Every effort was made to locate and collate all relevant records in each case, to allow a thorough assessment of all documentary evidence available. The Panel's efforts in this regard were supported by the Secretary and the Commissioner, Australian Border Force, who issued a directive to staff to locate and provide all relevant material in their possession.

To date, the Panel has reviewed 152 matters, representing 41 offshore and 111 onshore cases. These represent a significant sample of matters identified by the Department and are, on subjective analysis, the most serious matters. They do not include matters related to community detention, as this aspect of the Panel's work has not yet commenced. The Panel's work has incorporated the Nauruan matters identified by Mr Philip Moss and those onshore matters examined by the Australian Human Rights Commission.

In the final report, which will be delivered in the first half of 2016, the Panel will explore its observations on issues regarding children in held detention in greater detail, and include its review of community detention. More detailed analysis of the available data will be included in the final report.

The primary purpose of this issues paper is to highlight some initial priority areas for suggested action for the Department and its contractors. The Panel will continue working collaboratively with the Department on the implementation of those matters agreed.

The matters highlighted as priorities are based on the Panel's review of cases, discussions with departmental officers and external contractors and stakeholders, as well as direct observations made from the Panel's visits to centres. A schedule of the visits undertaken by Panel members is provided in Appendix 1.

Part 3 - Focusing on the wellbeing of children

3.1 Child Protection and Wellbeing Framework

Issues

The Department has a duty of care to children in the immigration detention system, whether those children are in the care of their parents or guardians, or are unaccompanied minors. A duty of care is also owed to children who attend detention centres as a visitor. To assist departmental officers to exercise their responsibilities in relation to children, the Department has a range of policy and procedural documents which are available on the departmental intranet. These documents are generally grouped in the Detention Services Manual Chapter 2 – Detainee Placement – Minors in Detention or the Procedures Advice Manual – Minors in Detention, and include:

- Education of minors residing in immigration detention facilities
- Minors in immigration detention – Health Screening Policy, and
- Mental Health policies – application to minors in detention

Currently, the Department's contractors in the delivery of detention related services have their own child protection policies and procedures. This creates complexity and potential lack of consistency in an environment where alignment of strategic purpose and operational activity between the Department and its contractors is necessary to ensure good outcomes. This is particularly important given the different mandatory reporting regimes in Australian States and Territories.

As awareness of child protection issues in a detention context has increased, the Department has acknowledged the need for a comprehensive, overarching framework that reflects a contemporary approach, guides the development of relevant policies and procedures, and applies to both the Department and its contractors.

Panel view

A framework for improving the Department's response to children in detention is currently being developed, and this will provide a basis to rationalise and link the policies and procedures of the new integrated Department. The Panel has provided input to the development of the Child Protection and Wellbeing Framework.

There is an urgent need to finalise the framework, and the policies and procedures associated with it, as it has now been in development for over a year. The framework should be widely circulated, easily understood, and integrated into other policies. Caution also needs to be taken that associated policies and procedures are not so prescriptive that they might limit the authority and discretion of Superintendents to make urgent operational decisions regarding children.

Suggested actions

It is a matter of some urgency for the Child Protection and Wellbeing Framework to be finalised, published and widely promulgated. The current review of policies and procedures associated with children in all forms of immigration detention needs to be completed, having regard to consistency, clarity and redundancy.

3.2 Daily routines in detention centres

Issues

During visits to a number of detention centres, the Panel noted a very high level of nocturnal activity with residents (including children) wandering around, engaged in social activities or undertaking personal tasks such as bathing or laundry. This was attributed in part to climate and the pleasance of the cooler conditions at night, and partly due to residents mak-

ing phone or online contact with family members in other countries.

Unfortunately, this can create a climate of risk for children. The Panel noted that a number of serious incidents occurred very late at night, up to about 11.30pm, and involved the abuse of quite young children who were unaccompanied by parents at the time[109]. It also leads to practical problems associated with children being able to get sufficient sleep at night, getting up in the morning for school and parents ensuring children are ready for school, have their lunch etc.

Panel view

The Panel is of the view that there is merit in establishing a daily routine in centres that better reflects the activities and events that would occur in a community setting at different times of the day. The sense of predictability that a routine creates can contribute to children's perceptions of security. It also helps to convey expectations of the tasks that need to be undertaken at various stages during the day, like preparing children for school in the morning, completing homework in the afternoon and ensuring that children are in bed at a time that allows for reasonable sleep before school the next day. School attendance should be monitored given its fundamental importance to the wellbeing and future prospects of children, and this rate incorporated into performance measures for Superintendents.

The Panel considered that there should be centre procedures that require parents to accompany their children outside the family dwelling area beyond a certain hour at night. This is both a response to the inherent vulnerability of unaccompanied children roaming alone at night, as well as a prompt about the need for adequate sleep in order to get the most out of school the next day. Just as it is in many families, a more relaxed approach could be in place on the weekends.

Further, the establishment of a program schedule within centres, which is well publicised internally, allows for families to plan and balance the activities of their children, and for centre management to provide program responses to any pattern of events occurring at a particular time of the day or week, or during school holidays.

Suggested actions

There is a need to develop protocols and procedures consistent with the issues outlined above, and oversee implementation of these by Superintendents. It might also be useful to implement centre based performance measures regarding levels of school attendance and participation in school activities.

3.3 Specialist centres for children

Issues

Given the Department's strong commitment to reducing the number of children in held detention, the issue of the nature and amenity of facilities where children reside will become less pressing over time. This commitment is lauded and supported. Given complex family circumstances and constructs, it is likely that there may continue to be a small number of children who continue to reside with their parents in detention.

Currently, there is great difference between the standard and amenity of the facilities where children reside, onshore and offshore. In the offshore environment, children are housed with their families in tent accommodation, following the burning of hard walled accommodation in 2013. In the case of families with younger children (i.e. under four years), the accommodation is air-conditioned. Other accommodation is ventilated with fans.

In the onshore environment, accommodation ranges from centres originally designed for adult males (Wickham Point) to the much more homelike environment of Immigration Residential Housing (IRH). Even within the Immigration Transit Accommodation centres, there are observable differences in amenity

[109] CPP0002, CPP0175

(such as outdoor meeting spaces, shade, gardens and play equipment) and the range and quality of programs provided. In any event, the needs of families with children are not currently included in the criteria for determining centre placement.

Serco are of the view that a single, fit for purpose centre, would enable them to concentrate the staff expertise required to provide an environment that is better suited to the well-being and protection of children.

Panel view

The Panel supports the intention of the Department to move as many children as possible to community settings; but it is acknowledged that this may not always be possible, mainly because of circumstances that relate to the security clearances of one or both parents. In this light, the Panel is of the view that there is merit in rationalising the use of current facilities by establishing a particular centre or centres as those most suitable for placing families. Further, the Department needs to retain a contingency capacity to respond to a range of future scenarios.

The IRH model has much to commend it, especially for families who will possibly be placed in the community as their next move. The homelike environment allows for a high degree of family autonomy, with food purchased and prepared by parents for their children. It allows for parents to be gainfully occupied with household work, as well as the other programs they may attend. The facilities also allow for good supervision of children's play areas. The Panel found it surprising that relatively few children are placed in the various IRHs in Sydney, Adelaide and Perth.

The nature of the physical facilities alone is not the only consideration. For example, the Panel was impressed with the operation of the Brisbane Immigration Transit Accommodation centre, in terms of its individualised responses to infants, its support of a large volunteer network that allowed a very rich range of programs to be offered in the centre, and the level of commitment to children's school attendance and participation.

The greater specialisation of centres where children are accommodated would also allow for some different security arrangements that might not be so visually confronting for children, and allow for greater use of safety features such as CCTV. The Panel has discussed these proposed actions with the Detention Review Taskforce, Serco and the contract manager. There is support for them.

Specialist centres would also reduce risk to children. The Panel was concerned about the placement of some long term adult male detainees in the Sydney IRH, especially as one of them was involved in an incident of indecent exposure to a child who was resident in the centre[110].

Suggested actions

The Panel is aware of the work of the Detention Capability Review Taskforce, and considers this planning should incorporate the concept of one or more specialist centres where children and their families can be accommodated.

3.4 Staff supervision of child activities

Issues

In a considerable number of cases reviewed by the Panel, incidents involving the physical or sexual abuse of young children had occurred in areas of detention centres set aside for sport or recreation. Many of these matters involved either coercion of younger children by older children, or sexualised behaviour involving children of a similar age. Children involved were as young as three years of age, although children aged five to seven years were more commonly involved[111].

What the matters have in common is the lack of any staff attendance or supervision. From a review of the

110 CPP0168

111 CPP0002, CPP0164, CPP0184

cases, it seems that there is an assumption that, where children have expressed their intention to play sport or other outdoor games, they can manage the activity entirely independently.

In visiting Regional Processing Centre 3 on Nauru, Panel members observed that a static guard post is located only a short distance from the popular playing field, but its orientation faces away from the field.

Panel view

The Panel is of the view that these matters could have been prevented had there been a mandatory requirement for staff to supervise all sporting and recreational activities in which children participate. This would apply to less formal play as well. Clearly, the closeness of the supervision would vary with the age of the children concerned, and the lateness of the hour. Particular focus should be given to activities undertaken at night, given the environment created for opportunistic offending.

It is not intended that the supervision be undertaken in a restrictive way that would discourage children from undertaking physical activity and playing together. It can be done quite discreetly, and would be triggered by one or more children requesting access to the soccer balls or similar.

Suggested actions

It would be beneficial to develop protocols and procedures consistent with the issues outlined above, to oversight implementation of these by Superintendents, and monitor incidence over time.

3.5 Case management capability

Issues

There are a number of dimensions to this issue. The first is about basic skills in the writing of incident reports. Although these are not case management records as such, they are important inputs to those records, and provide important information about the management of that person in the centre.

In many cases reviewed by the Panel, the information contained in incident reports was very brief and so general that it was hard to determine what had actually occurred. In some cases, officers had submitted handwritten notes that were virtually illegible.

The second issue is formal case management processes and records. In reviewing 152 of the more serious cases identified by the Department, the Panel noted that it was often difficult to piece together a narrative about what had occurred, what management responses were being put in place, and how the situation was being monitored over time, including the basis for significant decisions that were made.

The third issue is about the management of the most complex and contentious cases. The Panel assessment is that there are a relatively small number of cases in this category (although they are often associated with a high number of incidents)[112]. These have tended to be cases that are about serious and sustained parental abuse of a child[113], or where the Person of Interest (POI) has a significant intellectual disability[114]. There are also a number where the POI is an unaccompanied minor[115].

Regrettably, it appears that the Department does not have the capability at this stage to deal effectively with these admittedly challenging and complex matters. The two main issues are delays in determining a course of action with consequent adverse impacts on the safety of children, and transferring the POI to another centre for reasons that are not always clear, and with the information about the seriousness of their prior behaviour not identified or underplayed.

Panel view

The Panel supports the Department's commitment to place expert child protection advisors in centres

112 CPP0073

113 CPP0073, CPP0077, CPP0079, CPP0080, CPP0081

114 CPP0179, CPP0190

115 CPP0055, CPP0154, CPP0162, CPP0170

where there are a reasonable number of resident children. This will assist in a number of ways, including the development of early intervention strategies for matters that do not yet reach the threshold of child abuse but require some response, and the provision of some clinical governance to support Superintendents in relation to child protection intervention

Report writing is a critical skill for security and welfare staff who have direct contact with residents. They are likely to be the people who directly witness or initially intervene in incidents, or to whom complaints are first made. Reports need to have clear, behaviourally based descriptions of what is alleged to have happened or what they have witnessed (e.g. there were several matters characterised as attempted rape, but with no descriptions of the behaviours alleged to have occurred[116]). Reports should be written in electronic format (not handwritten), signed and dated.

The implementation of improved case management processes is of critical importance to the Department in ensuring that:

- staff and contractors have complete and accurate records on children in detention and any matters affecting them
- situations of concern are being regularly monitored and reviewed
- case plans are understood and implemented, and
- case transfer notes are detailed and accurate.

With respect to management of the most complex case matters, the recent employment of a senior child protection expert to provide case consultancy and advice to Superintendents is noted and supported. The development of a complex case protocol could support Superintendents in the timely and effective management of these matters, which are often dogged by delay and indecision.

Suggested actions

Under the ambit of the Child Protection and Wellbeing Framework, there is a need to develop case management standards and protocols for children in detention, and to design a complex case management protocol, in consultation with Superintendents, for management of more difficult matters.

3.6 Availability of expert advice

Issue

During their review of cases presented by the Department, the Panel noted that there were a number of reported incidents that did not meet the threshold of being considered as child abuse, but were nevertheless matters of concern that required an organisational response. A further part of this report deals with the consequences of 'over-classifying' such matters.

An example of this is the frequently reported behaviour of young children (often less than six years) pulling each other's pants down[117]. Although this is clearly inappropriate behaviour, it does not warrant a full child protection investigation and response. However, the organisation does need to respond because of the potential for escalation to more sexualised behaviours, or the involvement of older children or adults.

A further example is the rough play among male UAMs that sometimes escalates to more serious threats and physical aggression. It is considered that some expert advice on development of adolescent boys, and programs to manage their behaviour would assist centre staff.

Other examples include organisational responses to domestic violence matters, or dealing with parents whose use of discipline is excessive or increasing in severity.

[116] CPP0016

[117] CPP0031, CPP0175, CPP0193

Panel view

The Panel is of the view that Superintendents and other senior centre staff need to have access to some specialist advice to help them develop a suitable response to behavioural issues that might arise from time to time, that do not require a child protection response. The kinds of expertise required could include child psychology, intellectual disability, domestic violence specialists or early childhood educators. Services could be provided on a fee for service basis.

In the example of young children pulling pants down, an experienced child psychologist could give practical advice and strategies to frontline staff most likely to encounter such behaviours. Strategies could include reinforcing positive behaviour, distracting and diverting the child from the undesired behaviour or limiting access to areas where the behaviours tend to occur, such as the sports oval.

Suggested actions

The Department should consider issuing an Expression of Interest for suitable professionals to provide specialist advice on behavioural matters of concern, on a fee for service basis.

Part 4 - Strengthening the response to incidents

4.1 Triple track approach

Issues

A holistic response to a reported incident of child abuse has several components, which must be managed simultaneously. The first of these requires immediate action to protect the child (or other children) from further harm. At the same time, there must be a focus on the person alleged to have caused harm to the child. (The Panel has used the descriptor 'POI' [person of interest] to describe this person, as other options such as 'offender' or 'perpetrator' did not fit well with a range of the circumstances in which these matters can occur.)

For example, it needs to be determined what risk the person continues to represent to the child or other children, what immediate actions need to be put in place (e.g. movement to another part of the centre), and whether the matter is one that requires reporting to an external agency. Finally, there is the need to review action taken during the course of an event to find opportunities for process improvements or implement other changes suggested by the circumstances of the event.

In the cases reviewed by the Panel, there were some excellent examples of immediate protective action towards the child following a reported incident. This included medical assessment of the child, which the Panel considered should be standard in response to any child abuse allegation.

More commonly, the organisational response focused solely on the POI, often with a view to formal reporting to police. Once that external referral has been made, there is a prevalent tendency to 'close the incident', regardless of whether there is an active police investigation. In these circumstances, there tends to be a lack of ongoing focus on the victim (including the provision of any support or services they might need to deal with the impacts of the incident), management of the POI and responding to other issues related to the incident. Generally, the incident is 'forgotten' on the system, and staff and contractors tend to view the responsibility for action as someone else's job.

In the onshore detention environment, current post-incident review processes are to be completed within seven days of an incident being first reported. As a consequence, these reviews tend to be perfunctory, and have a compliance focus (i.e. was the incident reported to the Department on time?). Thus, even in cases where environmental factors (such as poor lighting) contributed to the occurrence of the incident, there did not seem to be a focus on remedying these problems as a risk reduction strategy for the future.

Panel view

Although managing the three different streams of activity outlined is nothing new in the context of a comprehensive child protection strategy, the Panel observed very few cases where it could be said that each of the streams was actively managed at the same time. For that reason, the Panel considered there was merit in formalising the streams of activity by referring to them as a 'triple track' approach, incorporating:

- immediate action to ensure the child (and any other child at risk) is protected from further harm, and further action to ensure access to any required medical, therapeutic or other support services
- action to ensure there is an effective response to the POI that is proportional to the seriousness of the incident, and
- actions that need to be taken to ensure the response to the incident is comprehensive, addressing not only the issues for the child victim and POI, but incorporating any organisational learning identified through the management and review of the process.

Where the POI is another detainee (which is the most common scenario), consideration needs to be given to ensuring that a suitable management regime is implemented immediately to safeguard the child and other children. This might range from an operational directive to provide more frequent monitoring of a situation involving parental neglect, or the physical separation of the child and POI within the centre.

Where the person alleged to have caused the harm to the child is an employee or contractor working within the centre, consideration needs to be given to the action that needs to be taken in relation to that employee, even when an investigation has not been completed. In one case considered a good example by the Panel, an employee was moved to a different part of the centre where he would not have contact with the child complainant, or access to any other child, while the matter was being investigated[118].

Suggested actions

The elements of the 'triple track' approach could be incorporated into the Child Protection and Wellbeing Framework, departmental policies and procedures related to responses to child abuse incidents in detention centres, and in the training curriculum for departmental and contracted centre staff.

4.2 Improved incident classification system

Issues

To respond effectively to Incidents of child abuse and neglect in detention, the Department must have reliable information about what happened and how serious it was. This information will help the Department to take appropriate action to protect children, manage people who are a risk to the well-being and safety of children and make the detention system safer in the future.

At present there are separate incident classification systems in use by the Department and contractors, and these are not well aligned. In departmental and contractor reporting requirements, the incident classification does not require a detailed description of the event or behaviour that has occurred.

The current incident classification systems overstate the number of matters, as any change of classification duplicates the case. The systems also overstate the severity of some incidents and understate the severity of others, with the result that some less serious incidents (that would not attract the attention of Australian child protection authorities) are over reported and more serious offences are not responded to effectively. For example:

- Behaviour between young children which might be inappropriate but causes no harm to a child is regularly reported as abuse
- The incident classification system potentially allows reasonable parental discipline to be reported as abuse (this further disempowers parents in the detention environment and leads to them relinquishing the control and supervision of children to staff)
- Accidents that do not involve neglect can be reported as a child abuse matter, and
- Where assaults are serious, the level of seriousness may not be conveyed by the classification, and this can lead to a limited response in the short term.

Just as importantly, the fact that there is not a clear record of the nature and severity of incidents available in departmental information and intelligence systems lessens the Department's ability to manage children who are at risk and those people who are a threat to children in detention. This information is particularly important when detainees move between facilities - it is not appropriate for a detainee who has assaulted a child in one centre to be moved to another centre where there are children.

Panel view

The Panel considers that there is a need for much greater granularity in incident classification systems to ensure more accurate characterisation of the in-

[118] CPP0005, CPP0013

cident as well as better information about what has occurred. In the absence of an intelligence system to analyse and use information in relation to child well-being and protection, incident reports are the only pathway for information to reach decision making systems. The existing incident classification system does not produce useful information. It is likely that a suitable system already exists within Australia, and could be readily obtained.

In the Panel's discussions with Serco, there was support to adopt a uniform incident classification system that provided greater granularity of description, and allowed for more tailored and proportionate responses.

Suggested actions

The Department should review the incident classification systems used by its contractors and reach agreement on a single system that provides the information that is required to effectively manage individual incidents of child abuse or neglect in detention, and to manage risk. This requires joint effort from the Department and contractors.

These actions could be implemented by the Child Protection and Wellbeing Branch with the assistance of contract providers and the Detention Capability Review Taskforce.

4.3 Comprehensive investigation of child protection matters

Issues

At the heart of many of the child protection cases reviewed by the Panel was a situation where there had not been a timely, robust and comprehensive investigation[119]. This resulted directly in the Department and its contractors not knowing what had actually taken place. In addition to a lack of known facts, well intentioned responses were sometimes initiated without this baseline understanding of what had occurred.

Whilst immediate protective action is required to support the victim and other children in such cases, it is paramount that a comprehensive investigation follows either in tandem or in close proximity to this protective response. To make substantive responses without the detailed knowledge that a thorough investigation brings, creates serious risks to all stakeholders. The reasons for this lack of knowledge are many and varied, including delays in the reporting of incidents, confusion about roles and responsibilities, lack of investigative capability, intelligence weaknesses, complaint withdrawal, sub-standard third party responses (particularly from the police), and ineffective investigative coordination and leadership to name a few.

There is also a fundamental misunderstanding of the difference between investigative management and individual case management.

It was uncommon in the cases reviewed by the Panel to find a child abuse case that proceeded to the courts. Given this observation, the use of investigative outcomes to manage departmental risks and inform departmental decisions is more critical than ever.

It was a very common characteristic of the incident management practices of Serco that a case would be closed as soon as a referral had been made to police, regardless of any information about whether or not the police would investigate the incident. Indeed, it was noted that Serco policy restricts the investigation of matters. The common outcome of this practice was that there was no substantive investigation of the incident.

Conversely, on the odd occasion where there was a timely investigation involving comprehensive crime scene evidence gathering, medical examinations, interviews with victims, POIs and witnesses, greatly enhanced outcomes were achieved. This was seen to have both inculpatory and exculpatory results. In these instances, the quality of the investigation made it possible to establish that a POI did pose a threat to children or that a person was being falsely accused.

[119] CPP0001, CPP0038, CPP0040, CPP0050, CPP0168 *et al*

Panel view

There needs to be substantial improvement in the initiation, conduct, coordination, review and conclusion of investigations to ensure they are timely, comprehensive and transparent to all stakeholders.

Given the focus of the review on the protection of children, it is paramount to ensure that immediate action is undertaken to ensure the safety of the child or children concerned while the incident is being assessed and an investigation undertaken.

Of concern, the Panel observed a very high number of cases where the complaint was withdrawn at an early stage and the investigation closed prematurely. It is important to ensure in such cases that complaints are withdrawn freely and that there can be no basis to suggest any influence has been exerted on the person to withdraw their complaint. For this reason, there needs to be a level of both independence and formality about the process required to withdraw a complaint, including an electronically recorded or signed statement indicating why the complaint is being withdrawn.

Even where a complaint is withdrawn, it remains an imperative for relevant parties to be interviewed and the facts established.

The Department has a critical role in regularly auditing the management and outcome of complaints and investigations, including oversight of service providers regarding their systems and responses, and ensuring that there is clear evidence of actions undertaken.

In addition, investigative responses need to be subject to clear performance measures within the Superintendent's role.

Suggested actions

Centre Superintendents are best placed to ensure that timely and comprehensive investigations and linked responses in line with the 'triple track' approach are carried out. To achieve this objective, the Superintendents need the necessary authority, specialist support and external engagement with stakeholders, such as police and child protection authorities. They must, in turn, be held accountable for the proper functioning of this critical investigative activity and consequent responses.

A broad multi-agency response capacity needs to be established at each centre where child abuse and other related investigations are undertaken. Weekly meetings need to be held, under the leadership of the Superintendents to drive the investigative outcomes and subsequent stakeholder integrated responses in line with the 'triple track' approach. Other aligned meetings should be incorporated into this process where possible.

4.4 Target recidivist POIs

Issues

In reviewing the cases allocated to it, the Panel was struck by the number of POIs who were identified in multiple incidents involving children. These 'recidivist' POIs included parents abusing their own children, unaccompanied minors, and adults with an intellectual disability. In one concerning case of parental abuse of a child, more than 30 separate incidents of the physical abuse of a very young child have been identified[120]. Other documents available to the Panel would suggest the recidivist issue extends to matters beyond its terms of reference. For example, one POI had 41 child abuse matters, but 175 incidents of concern recorded in relation to him overall[121].

Given the weaknesses in the case management systems and intelligence processes, it is clear that the risks associated with this population are not being well managed, despite there being a relatively small number (estimated to be less than 20).

Panel view

The Panel considers that there is merit in compiling an intelligence-driven list of POIs who represent the highest risk to children, based on their behaviour to

[120] SGN058 and family

[121] HFM030, CPP0032

date. For each of these POIs, an individual action plan should be developed to manage the particular risks associated with the person, and prevent or reduce future opportunity to harm children. It is noted that similar strategies have yielded very positive results for law enforcement agencies, as well as child protection authorities. The Panel notes that this approach to risk is a significant change for the Department and its contractors. Until now, risk assessment has focused on the physical security of a centre.

This strategy would yield significant benefits in terms of improved safety of children, prevention of incidents that would otherwise require reporting and responses, and reduced administrative burden to the Department. In combination with suggested strategies to reduce incident over-classification, the Panel is of the view that this will free up resources to improve responses to the most serious and complex cases.

Suggested actions

This targeting role is best performed by trained and experienced intelligence officers, most likely attached to the Intelligence Division. Their work will require them to engage with a wide range of stakeholders both within and outside the department, including centre Superintendents, other relevant departmental officers (including those who decide on the pathway and movement of detainees), State and Federal Police and child protection agencies. The lists will need to be comprehensive and contemporary, so that the POIs who are the highest risk to children are the focus of necessary attention.

Consideration could be given to the implementation of performance measures for the Intelligence Division and detention centres, to ensure that the appropriate action is taken and results achieved.

4.5 Target most at risk victims

Issues

Just as there are a considerable numbers of matters involving a fairly small cohort of POIs, it is apparent from the Panel's review that there are a small number of children who have been involved in multiple incidents. These children have an increased ongoing risk of harm. To protect these children and others like them in the future, the Panel considers that the Department should develop an intelligence based method of identifying them and making sure that parents and staff supervise them effectively to prevent future incidents.

The Department's existing individual planning processes do not focus on child safety and wellbeing. The Security Risk Assessment (SRAT) process focuses on risk to facilities not on risk to the safety and wellbeing of children and is overseen by staff who have a centre security focus. Similarly, information gathered about potential risks during the development of Individual Management Plans (IMPs) is not always integrated into day to day supervision of the child involved. For example, the IMP of a child identified that the parent had left the child unsupervised and that a plan to deal with this should be developed. Subsequently the child was the victim of an attempted sexual assault when left unsupervised at night[122].

The information to manage the risks that these children face often exists but is not coordinated. Many of the incidents involving children, especially those between children, happen in locations such as play areas where they are in open view and should be under the supervision of staff. The knowledge of staff about the behaviour of children needs to be captured systematically. Similarly, the information captured through medical assessments, IMPs and other formal records needs to be integrated.

It is clear to the Panel from the cases it has reviewed that abuse can occur over a lengthy period in more than one centre, and for staff not to be aware of this pattern of events. For example, in one case of serious abuse by a step parent, it emerged that the child had been treated for a fractured arm in a previous centre. This was also the result of abuse, but either not rec-

[122] CPP0013

ognised as such at the time or the information not communicated to the centre to which the child and parents were moved[123].

Panel view

There are practical things that the Department can do to better protect this small group of children who are at greater risk of abuse or neglect. The revision of the SRAT and IMP processes to focus specifically on the risks to the safety and wellbeing of children in detention will improve the information available to all staff.

The implementation of the Department's proposed Child Protection and Wellbeing Framework will enhance the protection of this group. That framework includes two new mechanisms. Child Protection Assessments will help to identify the ongoing risk to a child who may have been the victim of abuse or inappropriate behaviour. On a more proactive basis, Wellbeing Assessments will provide the opportunity for all information regarding a child to be collated and assessed when they enter a centre or transfer between facilities.

In addition, practical measures such as identifying children involved in multiple incidents should signal the need for a heightened response in terms of protection.

The planned introduction of one or more specialist centres for families and children, and the introduction of child protection staff into facilities where children are held will also ensure a more effective focus on children who are at risk.

The Panel also considers that there are two other specific actions the department could take. The first is for each centre to develop and maintain a list of children who are at risk and for the child protection specialist and the Superintendent at the centre to ensure that the children on the list are managed closely. The second is for the responsible area of the Department to collate these lists, negotiate their incorporation into wider departmental intelligence holdings, provide quality assurance that measures are in place to protect the children identified, and ensure that intelligence about them is shared when they move between facilities.

Suggested actions

Utilising the new assessment mechanisms contained in the draft Child Protection and Wellbeing Framework, Superintendents should identify those children who are at risk of abuse and put in place arrangements to ensure their protection.

This information could be aggregated nationally and shared between centres when a child at risk is moved from one Centre to another. To support this, the Department and its contractors should revise the scope of the Security Risk Assessment process used in centres to include risks to the wellbeing of children.

[123] CPP0024

Part 5 - Improving centre management

5.1 Superintendents' authority

Issues

One of the clearest themes to emerge during the Panel's review of cases was the lack of clarity about decision-making authority in matters concerning the well-being of children in detention. At best, the authority was diffuse and often characterised by a lack of urgency, even when it was reasonably apparent that harm to a child was continuing. This particularly applies to matters where a decision might be in conflict with a general policy position of the Department, in complex cases involving parental abuse of a child, or where there is a need to remove a POI from their current environment.

In one case, it was clear that a father was continuing to abuse his sons for a period of several months, during which time the Department sought several pieces of legal advice[124].

During visits to centres, Panel members were told by centre staff on several occasions that they were 'waiting for a head office decision' on matters involving children. This was also apparent in the Panel's review of documentation in the cases it examined. It was apparent that staff were quite conflicted in a number of these cases, having a sense of urgency to act, but being constrained from doing so.

Panel view

With the implementation of the new organisational design that establishes Superintendents as the officers responsible for all matters within the detention centre they lead, it is imperative that this authority extends to all case matters involving children. It simply does not work to have operational case decisions taken by a central unit or officer within the Department. This causes inevitable delays, and impacts on the Superintendent's capacity to act urgently to ensure the protection of the child.

This does not mean that decisions should be taken in the absence of any sensible consultation and advice with central office experts. However, the need for this will lessen as centre based child protection staff gain expertise and confidence. Given the 24/7 nature of the detention environment, it will also be a challenge for centrally based staff to ensure the availability of advice to Superintendents on a similar basis, should they be requested to do so.

Suggested actions

The Department needs to ensure that all departmental policies and procedures reflect the authority of Superintendents to make all decisions regarding the management of cases involving children.

5.2 Facilitate incident reporting

Issues

The work of the Panel involved a review of the individual cases identified by Mr Philip Moss. In many of these cases, the complaint made to him was the first time the matter had been reported to anyone in authority, even though the event had often occurred some months previously. Reasons for not doing so ranged from concern about family or cultural repercussions, lack of confidence in the process or outcomes of any investigative process, or concern about potential implications for the resolution of the person's immigration status.

There is also a reluctance to report matters in the onshore environment, but it does not appear to be quite as widespread as for offshore matters. Review of case documentation indicates a prevalent view that making a complaint about another detainee might impact on that person's chances of a favourable immigration decision, as well as their own.

The timely reporting of child abuse matters is essential to their effective management, and the use of a range of mechanisms to facilitate complaints and

[124] CPP0157

reports is essential for the protection of children, as well as the good order and management of the centre.

Panel view

The Panel considered the need for a range of strategies to encourage detainees to bring matters (not just complaints) forward to centre management for further action. These included promotion of existing strategies such as suggestion boxes and resident committees. Given the experience of Mr Moss receiving many 'first time' complaints, with individuals citing his independence as the reason for their approaches to him, it could be worth considering the implementation of an 'official visitor' type scheme, commonly used in mental health or correctional environments at monthly intervals, in addition to the role played by the Ministerial Council on Asylum Seekers and Detention (MCASD).

The Panel also considered that it was critical to improve confidence in the complaints system. In a number of cases reviewed, no feedback was provided to the child (depending on age) or the child's family about action taken or progress made on investigating or addressing the complaint, so they formed an incorrect view that nothing was happening, which in turn discouraged further disclosures. These processes need to be formalised, and undertaken with transparency and integrity to protect the interests of all stakeholders.

Suggested actions

The Department should see that existing complaint and reporting mechanisms for detention centres (including the provision of feedback to complainants) are reviewed and included in national Standard Operating Procedures, with the implementation of the SOPs at a centre level undertaken by Superintendents. An option for the Department is to consider a trial of an 'official visitor' scheme to assess its usefulness in a detention environment.

5.3 Information sharing

Issues

Problems in information sharing across the Department and between the Department and contractors do not support action that is focused on protecting the wellbeing of children in detention. Panel members experienced these problems themselves in accessing complete and reliable information regarding incidents relating to children in detention. In addition to these issues, there a number of other areas in which the failure to share information has an adverse effect on the well-being of children. These include:

- Poor systems management and lack of capacity to integrate records within the Department (for example between case managers and other staff and between detention facilities) and between the Department and contractors
- Some contractor records are difficult to access because they are hand written and sometimes are of poor quality
- External service providers having information and intelligence that is unable to be accessed by the Department
- Refusal by some external service providers to share information with the Department, based on an apparent misapprehension of statutory privacy provisions
- Information about detainees that are relevant to decisions regarding placement within the detention network, community detention and visa issues are not available to decision makers
- Information about detainees, including the risk they pose to children, is not effectively communicated when detainees move between facilities, and
- Information about vulnerable child detainees is not always communicated when those children move between facilities.

Panel view

There needs to be a much greater integration of the information that is held by the Department and its contractors at the detention centre level. This information needs to be used to develop expanded risk profiles and behaviour management plans for those who pose a risk to children and for children who are at risk.

From discussions with the contractors undertaking work on the Department's intelligence capability, it is clear that information regarding children at risk, children who have been harmed, and the persons identified as POIs is not a focus of the intelligence effort.

The current risk assessment processes need to be expanded from their current focus on the security and good order of the centre to include risks to the safety and well-being of children. The Panel saw several examples where incidents that had occurred were not included in subsequent risk assessments.

In some of the cases reviewed, there appeared to be a particular disconnect in the flow of information from contractors to departmental Case Managers. The result of this situation is that Case Managers are often not aware that a detainee is a POI in an incident involving a child. This information should inform visa and other placement decisions. As importantly, the Panel saw numerous instances where the Case Manager advocated for the detainee in a way that conflicted with decisions that have been taken to protect a specific victim or children generally. For example, in the case of a child detainee accused of rape and moved to a single men's compound, the Case Manager advocated for the return of the POI to the family compound, where the victim was located, because the POI was 'missing his family'[125].

The Panel is of the view that privacy concerns are inappropriately used by some contractors to not share information. The Department should be clearer with contractors about their contractual obligations to share information with the Department and other contractors.

The Panel believes that there are several opportunities to improve the flow of information within and between centres. Regular meetings between superintendents and all stakeholders to identify those who are a risk to children and children who are at risk should assist. This information should be used to inform individual risk assessments and Behaviour Management Plans and be conveyed to Case Managers.

It is the view of the Panel that all information about a detainee – including the risk they pose to children – should be fully disclosed when detainees move between facilities, and between facilities and community detention. This will help prevent further risk to children.

The Panel considers that there are two areas which the Department could further clarify policy. The first is the extent to which information about a detainee's behaviour in offending against children can be taken into account in placement and visa decision making when, as is usually the case, there has been no court conviction. The second is to clarify for departmental officers and all contractors that the sharing of information about the behaviour of detainees is consistent with statutory privacy provisions and part of the obligations of contractors.

Suggested actions

The Department should take steps to ensure that complete information about risk to children, or risk represented by POIs, is collated and shared at the detention centre level between the Department and its contractors, and when transfer to another centre or setting is considered.

departmental policies should clarify that decision making regarding placement and status determinations can take into account behaviour which has been documented, but may not be the subject of criminal conviction, and to enable sharing of appropriate intelligence about harm to children, and the POIs responsible for those harms.

[125] CPP160

5.4 Internet safeguards

Issues

At the time of the Panel's first visit to an onshore detention centre – before any cases had been reviewed - one of its earliest observations related to internet use. The internet room was unstaffed and unmonitored, and there did not seem to be any security protocols for access and use. Although the Panel was advised that the system blocked access to unsuitable sites, concern remained about the potential for misuse of the internet for child exploitation or radicalisation purposes, and the inability to link use of a terminal to a particular individual at a particular time, as would routinely be the case in most public internet sites.

As a result of these observations, the Panel's concerns were referred to the Detention Assurance Team, who undertook an assurance review. This review found that current controls were inadequate, and made a number of recommendations.

A review of the cases confirmed that an associated problem was the inappropriate use of USB devices to download, store and share pornographic material. The viewing of pornography on USBs featured in several cases of sexual assault[126], and it appeared that such material was exchanged freely. There are also no systems in place to ensure that children can access only material that is age appropriate, in line with age related classification restrictions. There were a number of examples where very young children were exposed to material rated MA or above[127].

Panel view

The Panel supports the findings of the Detention Assurance Team's review, and is keen that they monitor its implementation. It is further considered that the data transfer capability on computers in internet rooms should be disabled. It is understood that residents often have copies of their official documents and correspondence on USBs, so there may be a need to provide a terminal with data transfer capability in a supervised administration area for this purpose only. Generally, the free circulation of USB sticks represents an unacceptable risk.

The issue of aged related classification restrictions is a slightly broader one, as it relates not only to internet use, but the screening of DVDs and the like for children, as part of their recreational activities. The Panel considered that this issue needs to be addressed in centre protocols.

Suggested actions

The Department should progress the implementation of the report of the Detention Assurance Team, and further consider the issues and risks associated with data transfer capability on computer terminals in detention centres, as well as the use and exchange of USBs.

The Department may wish to develop procedures for centres to ensure that children are limited to viewing only material that is age appropriate, whether online or on DVDs.

5.5 Staff professional conduct

Issues

The issue of professional conduct of staff is quite different when reviewing incidents in offshore centres and onshore centres.

In relation to offshore facilities, the conduct of staff, primarily local staff employed in a security capacity, emerged as a key issue. Areas of concern included:

- opportunistic assaults on children;
- failure to maintain appropriate professional boundaries in their dealings with children transferees (This manifested in behaviours ranging from exchanging personal details and attempting to 'friend' children on social media, to making explicit and unwelcome sexual overtures);
- difficulties in identifying staff;
- inappropriate use of force against children,

[126] CPP0051, CPP0172

[127] CPP0183, CPP0188

- staff reported to be under the influence of alcohol or other drugs; and
- staff remaining on site after the end of their shift for the purpose of harassing detainees.

In relation to onshore held detention, the Panel is concerned at a pattern of understating the seriousness of behaviour against children when arranging the removal of the POI to another centre.

Panel view

In relation to offshore facilities, expectations of professional conduct will be further reinforced by a requirement for officers to wear a form of identification on their uniforms. It is suggested that this include an employee number as well as a first name, to allow for identification of officers by transferees who may be functionally illiterate, or who cannot read English.

In relation to complaints that some officers appeared to be regularly affected by alcohol and/or other drugs while on duty, the Panel considers that this contributed to a sense of disinhibition and the commission of inappropriate or even criminal acts. There should be systems in place in all facilities to determine whether an officer is fit for duty when they arrive for work, and the means to send them home if they are not.

A number of cases reviewed by the Panel related to staff apparently over-reacting to children's behaviour perceived by them as being cheeky or provocative. None of the reporting associated with these cases indicated an awareness of normal behaviours exhibited at particular ages, or the ways in which children often use behaviour to attract adult attention or express their feelings. The Panel considered that the emotional maturity of applicants needed to be assessed prior to confirmation of employment, more specifically how they deal with provocation and their ability to defuse and de-escalate tense situations. While this ability can be enhanced by training in the use of specific techniques and strategies, employees need to display a level of maturity and understanding of children if they are to be assigned to work in areas where children and their families are located.

The Panel also considered that Standard Operating Procedures should be developed about situations in which more than one officer is required. Such situations included the induction of new officers through 'buddy' arrangements, provision of any kind of personal assistance to children where other adults are not present, and in high risk situations where there are aggressive or self-harming behaviours or imminent risk of these.

In relation to onshore facilities, the Panel has discussed earlier in this report the need for full disclosure and sharing of information between detention facilities especially when a detainee is a risk to children in detention. Such information must not be understated to facilitate the removal of a detainee from a centre. The understating of the seriousness of a detainee's behaviour is not consistent with the APS values and Code of Conduct.

Suggested actions

In relation to offshore facilities, the Department should review the contractual requirements of the lead contractor to ensure that professional conduct standards are developed and enforced including effective integrity programs, use of proper identification, zero tolerance for drug and alcohol use, and inappropriate contact with detainees. In addition to effective pre-employment suitability testing, it is considered that training in responding to provocative behaviour by children would be useful. The department should also consider the expanded use of body worn cameras by all operational security staff.

In relation to onshore held detention, the Department should remind all staff of the requirement to fully disclose a detainee's history when that detainee is being moved between centres or to community detention.

Part 6 - Enhancing stakeholder and system responses

6.1 Single detention network

Issues

Despite the best efforts of individual departmental officers to undertake their duties diligently, the Department's approach to the management of its detention network has been characterised by fragmentation and lack of clear accountability. This situation creates a number of issues in relation to the well-being and protection of children

The first and most important of these issues is an apparent lack of a system wide view of, and clear criteria for, the placement and transfer of individuals across the network of detention centres. In many cases reviewed by the Panel, the circumstances of a child protection incident made it imperative to move one or both of the parties involved. Documentary evidence indicates that, historically, departmental officers often had to make a persuasive case for another centre to agree to the transfer. In a number of cases, this involved the downplaying of serious incidents in which the person had been involved. In other cases, the need for negotiations with other centres created unacceptable delay.

A second issue relates to the challenges of sharing good practice initiatives across the network. Although the need to establish specialist centres for children and families was argued in Part 3.3 of this paper, this related issue is about mechanisms to ensure conscious sharing of innovation and best practice between centres in areas such as programs and tailoring accommodation to meet the needs of families. For example, the Melbourne Immigration Transit Accommodation centre had adapted demountable accommodation to enable parents and children to sleep in separate but interconnected rooms, allowing for greater parental privacy.

The third issue is that the National Detention Placement Model does not specifically address the need to place families and children in the most appropriate forms of accommodation. Nor does the risk assessment process contained in the Model address the placement of those who are judged to be a risk to children.

Panel view

With the detention network viewed as a single service system with a range of locations, there should be a more rational and consistent approach to the placement and transfer of individuals within and across the network, and a greater recognition of the needs of families in the National Detention Placement Model. There is a need to develop criteria that reflect a priority for child protection matters e.g. the movement of POI to another centre in circumstances where it may not be reasonably practicable to keep the POI and child victim separated in their current environment. Such an approach would allow for decisions to be made expeditiously, and avoid the current delays caused by negotiation with the centre proposed to receive the person.

A single network approach also provides the organisational architecture that allows for specialist centres to be nominated and developed, and to determine the best placement of families and children within the detention network. It also facilitates the sharing of best practice within a collaborative model, and its applicability is much broader than just for children and their families; it could also apply to other groups with special needs such as people with an intellectual disability.

The Panel has discussed these proposals with the Detention Capability Review Taskforce, Serco, the Commander, Detention and Compliance, and the contract manager. There is support for these suggestions.

Suggested actions

The Department needs to view the detention network as a single entity, and develop specific criteria for the placement and transfer of families and children within that network. Opportunities for the identification and sharing of good practice within centres, whether by contractors or departmental staff, should be facilitated. The redeveloped National Detention Placement Model should specifically address the appropriate placement of families and children, and those who are judged to pose a risk to children.

In the short term, there should be a national mechanism that ensures families and children are placed in the detention facilities that are most suited to their well-being and protection, using the IRH model in particular.

6.2 Use of intelligence in key decisions

Issues

With the amalgamation of the Australian Customs Service and the Department of Immigration and Citizenship, the intelligence capacity in place, such as it was, served different purposes, none of which were directed to the protection of children in detention. Indeed, the Department's intelligence capacity was not directed to support detention operations, with the exception of limited contractor intelligence functionality that was directed to the physical security of the centres.

Having the right information and intelligence assessments available to decision makers, at the right time, is pivotal in reducing the risk of harm, including to children, in detention. The Panel reviewed a disturbing number of cases where it was clear that information available to the Department had not been collected, collated, analysed, assessed and disseminated[128]. The Panel formed the view that in some cases, child abuse could have been prevented had the intelligence process been properly applied and different decisions taken[129].

It was of concern to the Panel that the behaviour of POIs in child abuse matters did not seem to be taken into account in determining eligibility for community detention, or in any other immigration decisions, unless there was an ongoing criminal justice matter or a criminal conviction recorded.

At the time of completing this Issues Paper, of the 152 cases reviewed by the Panel, none had resulted in a criminal conviction, although it is acknowledged that a couple of cases are still before the Courts. The reasons for this outcome have been previously highlighted and in the Panel's view are not likely to change substantially, at least in the short term.

Panel view

The Panel is of the view that there are two main issues regarding the intelligence function in the Department. The first is about the broadening of its focus towards supporting detention operations generally, and incorporating a specific emphasis on child protection matters.

The Department and Panel are in broad agreement that the intelligence function has not been directed towards supporting Detention Operations, including the protection of children. The resetting and reform of the Department's intelligence capacity will not be an easy task and will likely take considerable time.

Despite previous investment by government, access to departmental information and systems remains fragmented and disconnected. Further, the quality of information within these systems, including incident details, and information reports are substandard.

The second issue is about the use of the expanded intelligence function in informing key decisions about visas and placement. The current situation of relying on criminal convictions or questions about whether there are matters before the court is too limiting,

[128] CPP0081, CPP0160 *et al*

[129] CPP0029, CPP0032, CPP0073, CPP0076, CPP0077, CPP0201 *et al*

and potentially exposes children (and others) to risk. The Panel noted that, in some cases, the available information would likely have produced a compelling intelligence assessment, and likely altered the decisions made.

Discussions with the consultants who are undertaking the Intelligence Review and with the officer heading the Department's Intelligence Division have identified weaknesses and acknowledged gaps in intelligence capability which impact the detention environment. These gaps and weaknesses should be rectified. There is broad support in the Intelligence Division to focus resources on detention operations to support Superintendents, particularly in their important role of protecting children.

Suggested actions

There is a need for the Department to recognise that, in reviewing and strengthening its intelligence capability, it should specifically address the role that intelligence can play in protecting children in detention. Consideration needs to be given to how this enhanced intelligence capability can be integrated with the detention and child protection processes.

Intelligence assessments relating to the character of detainees, particularly the risk posed by detainees to children, should be considered by key departmental decision makers in matters such as detention placement, transfer or movement decisions. Ultimately, the Minister requires accurate information when deciding immigration pathways and status for detainees. It is acknowledged that this may be contentious, and represents a policy shift for the Department.

6.3 Working with State and Territory authorities

Issues

Despite the complexity of the different legislative regimes across Australian jurisdictions, there has been a high level of compliance by the Department and its contractors with mandatory reporting obligations. Indeed, there has been a level of over-reporting, largely driven by the limitations of the current incident classification system as discussed in Part 4.2 of this paper. There is a similar over-reporting issue with referrals to police regarding matters that may warrant a criminal justice response.

The response of police and welfare authorities across the different Australian jurisdictions varies markedly. At best, information is shared, response is as rapid as the situation demands, and a collaborative approach is demonstrated. More commonly though, communications between police and welfare authorities and detention centres are characterised by a lack of understanding of the role and purpose of detention centres, a lack of a sense of urgency and a reluctance to become involved in matters. In some jurisdictions, it was acknowledged that welfare authorities do not necessarily pass on child abuse reports received by them to the Department, when the disclosure is first made to a State agency by a third party such as a teacher or a medical practitioner.

The Panel considered the model of embedding local police in a centre (such as is the case at Wickham Point) has some advantages, although it is acknowledged that this would probably only be practicable for larger centres.

The Panel notes the position taken by at least one State concerning their view that they lack jurisdiction to respond to child protection matters in detention.

These issues need to be resolved, particularly for those (very few) serious matters that would warrant consideration of the child being removed from parental care, at least in the short term. Problems also arise in situations where police give a general direction to the centre to 'do nothing' when a report in made, but do not respond within a reasonable time frame. This places centre management in an invidious position, as they continue to have a duty of care to ensure the safety of all residents. Except in the most serious of situations, it is reasonable for the centres to conduct preliminary investigations in consultation with police to establish what has actually occurred.

Panel view

There is a need to develop new and mature relationships with State and Territory police and welfare authorities so that all parties are acting collaboratively for the common purpose of protecting children, and with an understanding of each other's functions and powers. This situation will be assisted by any decisions made by the Department to have greater specialisation of centres, as fewer jurisdictions will be involved. At the very least, protocols about the sharing of information need to be developed and agreed.

The most urgent needs relate to:

- child abuse matters where a child or children need to be removed from their parents, at least for a period. For example, if a parent is suffering severe mental health issues and cannot care for their child for the time being, lawful arrangements for the alternative care of the child need to be made
- sexual offences against children, where there is an urgency to arrange forensic medical examination of the child, and specialist interviewing of the child having regard to their stage of development.

In the case of Nauru, a more selective approach could be adopted for referral of matters to the Nauruan Police Force (NPF), and the centre undertaking a greater part of the investigative process internally.

Suggested actions

Following the Department's determination of whether it wishes to establish specialist locations for families and children within Australian jurisdictions, a senior departmental officer could be assigned the task of developing and executing a strategy to make new agreements with police and welfare authorities in those jurisdictions where children will be located.

6.4 Use of State and Territory facilities

Issues

One of the challenges of the detention centre environment is managing the safety and security of a resident population with vastly different needs and attributes, including very young children, people with mental health issues, people with intellectual disability with challenging behaviours and offenders who have just been released from prison.

It was surprising to the Panel that, even in the relatively few cases that resulted in formal action such as the laying of criminal charges, a person could be remanded back to the 'custody' of the detention centre, or bailed with conditions to reside in the detention centre. Not only did this strain the resources and the facilities of the detention centre (e.g. the need to keep particular individuals and populations separate), it seemed apparent that the person's needs could be better accommodated in one of the specialist facilities operated by State and Territory authorities, including correctional centres, juvenile detention centres, or forensic mental health or disability services. It would also serve to reduce risk to the victim and POI, where they were still located in the same centre.

In one of the cases reviewed by the Panel, an unaccompanied minor was returned to held detention from community detention after being charged with a range of criminal offences, some of which related to stalking and harassment, and was placed back in the detention centre after being charged with a further offence related to an assault of a sexual nature on a younger girl[130]. It is difficult to understand why this child was not placed in a juvenile detention centre.

Panel view

The Panel is of the view that much greater use could be made of State and Territory facilities for detainees who are charged with criminal offences, especially

[130] CPP0189

where they have special needs such as mental health, intellectual disability or where they are children. The number of individuals in these categories is not high, and there is no consequent risk of 'swamping' State and Territory services with demand for services.

This proposal is likely to require considerable discussion and negotiation with State and Territory authorities, including the briefing of police prosecution services, DPP offices and judicial officers about the role and limits of immigration detention facilities and services. It may be necessary to establish a right for Department officials to be heard by the court in such matters, to ensure that the court is fully appraised of the relevant issues in making a determination.

Suggested actions

It may be useful to await the outcome of the current Detention Capability Review before implementing this proposal, as any specialisation or rationalisation of facilities will impact the jurisdictions with which discussions need to be held.

6.5 Data access and quality

Issue

This issues paper has earlier stressed the need for an improved intelligence function that expands its scope to include material relevant to the protection of children. However, this will only be achievable if the information 'building blocks' underpinning the intelligence function are also in place. Currently, this does not appear to be the case.

The Panel experienced significant difficulty in accessing data to identify and analyse incidents of child abuse and neglect within the detention network. Departmental records associated with these incidents are fragmented, with information on aspects of an incident held in a range of locations within departmental systems.

Before the Panel could commence its review of a case, it was necessary for the data on that case to be extracted from various systems and then 'packaged' for the Panel to review it. Often, information relating to an incident was discovered iteratively requiring further assessment of cases that had been reviewed earlier by the Panel as additional information came to light.

The fragmentation of data holdings within systems is exacerbated by some information being held locally by Branches. In one instance regarding cases that occurred on Nauru, the Secretariat discovered an additional 74 cases that were held in a Branch, their existence apparently unknown elsewhere in the Department. The Panel was also made aware of a number of 'local arrangements' where departmental staff kept important data on spreadsheets and the like, without it being logged in departmental information systems.

While individual incidents of child abuse or neglect are reported to departmental management as they occur, the Panel's analysis was the first time that all the information in relation to an individual case had been collated and reviewed, and the first time that systemic issues had been analysed.

The quality of data held is also an issue. Incident reports completed by contractor staff are the primary source of information about an incident. These reports often do not contain sufficient information to understand the detail of what happened and what action was taken as a result. In particular these reports often fail to describe an incident in detail. Similarly post incident reviews are, more often than not, a perfunctory analysis of whether the response to the incident was appropriate.

Panel view

The Panel considers that there is a need to have a case-related data system that is integrated, allows for ongoing review and analysis of how incidents of child neglect and abuse are being managed, and identifies issues or trends that may be apparent. This will provide further assurance that appropriate action has been taken and allow an understanding of what actions can be undertaken to prevent future incidents. To do this cost-effectively and reliably, the

Department will need to develop a way to extract the information that is required for such an analysis, and to identify the themes that emerge.

It is also imperative that departmental officers are directed to use the Department's own client information system to record information, as the current fragmentation can be partly attributed to the occasional practice of departmental officers keeping their own records locally.

Strengthening the performance of contractors in relation to the quality and accessibility of incident reports is critical. The Panel notes that, while the systems put in place by the onshore contractor are more sophisticated, this issue applies to both onshore and offshore contractors.

Suggested actions

The Department needs to review where and how data relating to incidents involving children are held and how they can be efficiently and reliably integrated. Without access to this data, the Department cannot undertake the level of analysis that is required to mitigate the risks to children held in detention. At a policy level, there needs to be a decision that data is held in a way that is accessible to all who need it.

Contractors must meet an agreed minimum quality in relation to incident reporting. It is critical that these reports accurately and comprehensively describe an incident and that information generated through them is made available to all who need to know it and integrated with other Centre.

Part 7 - Conclusion

Originally, it was intended that the Panel provide an interim report to the Secretary in October 2015, with a final report to be delivered in April 2016. There was a shift in the first part of this project plan, largely due to the challenges experienced with obtaining data and records necessary to conduct case reviews.

Instead, it was agreed that the Panel would prepare an issues paper prior to the end of the calendar year. This allows reporting of the major themes identified to date, and signals the Panel's view of the actions that would have the greatest impact on securing the safety and protection of children in detention centres.

While the work of the Panel is not yet complete, this paper identifies action that the Department can take now to improve the wellbeing and safety of children in detention. The issues identified are supported by substantial evidence derived from the review of a large number of cases, observations made during visits to centres, discussions with Departmental officers and contractors and review of contemporary practice.

Although the Panel is yet to commence its work in relation to community detention, it considers that while this work may identify additional issues for the Department to consider, these will not affect any of the actions proposed in this paper.

The issues identified in this paper have been discussed with Departmental officers and contractors and there is broad agreement to many of them.

Many of the issues that the Panel has identified can be addressed by technical changes to practice and procedure that are readily within the control of the Department and can be addressed in the short term. There are a few issues that involve more complex policy considerations, and two issues, the greater use of intelligence in the child protection space and information systems improvements that will require longer term development and focus.

The Department has a strong commitment to reducing the numbers of children in detention centres, and minimising the time they are in such settings. This direction is strongly supported. However, it is likely that there will continue to be a small number of children in detention settings, whether they are in transit or on return pathways with their parents, or where a parent has an adverse security assessment and the family chooses to stay together. For these reasons, the efforts of the Panel may continue to be of use to the Department in its work to protect children, and promote their wellbeing.

John Lawler 17/12/15 Margaret Allison 17/12/15 Dominic Downie 17/12/15

Appendix 5 Visits and consultation

Date	Meeting attendees/visits	Panel member(s)
9 April 2015	DIBP and service provider staff, Wickham Point Alternative Place of Detention, Northern Territory	John Lawler and Margaret Allison
9 April 2015	Department of Education, Northern Territory state schools	John Lawler and Margaret Allison
10 April 2015	Department of Children and Families, Northern Territory	John Lawler and Margaret Allison
10 April 2015	Special Operations Command, Northern Territory Police	John Lawler and Margaret Allison
21 April 2015	Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
21 April 2015	Deputy Secretary and First Assistant Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
21 April 2015	Assistant Secretary, Child Protection and Wellbeing Branch, DIBP	John Lawler, Margaret Allison and Dominic Downie
22 April 2015	Mr Philip Moss	John Lawler, Margaret Allison and Dominic Downie
23 April 2015	DIBP and service provider staff, Melbourne Immigration Transit Accommodation	John Lawler, Margaret Allison and Dominic Downie
7 May 2015	Department of Children and Families, Northern Territory	Dominic Downie
7 May 2015	Department of Education, Northern Territory state schools	Dominic Downie

Date	Meeting attendees/visits	Panel member(s)
7 May 2015	Northern Territory Branch of the National Association for Prevention of Child Abuse and Neglect	Dominic Downie
8 May 2015	DIBP and service provider staff, Wickham Point Alternative Place of Detention	Dominic Downie
12 May 2015	Commander, Detention Operations, SBC, ABF	John Lawler, Margaret Allison and Dominic Downie
12 May 2015	Principal Legal Officer and Senior Legal Officer, Legal Opinions B Section, Legal Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
12 May 2015	Acting First Assistant Secretary, Infrastructure and Services Division; and Assistant Secretary, Offshore Operations Branch, Infrastructure and Services Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
13 May 2015	Chief Executive Officer, Australian Customs and Border Protection Service	John Lawler, Margaret Allison and Dominic Downie
19 May 2015	DIBP and service provider staff, Brisbane Immigration Transit Accommodation	John Lawler, Margaret Allison and Dominic Downie
19 May 2015	A state high school, Queensland	John Lawler, Margaret Allison and Dominic Downie
20 May 2015	DIBP and service provider staff, Sydney Immigration Residential Housing	John Lawler, Margaret Allison and Dominic Downie
3 June 2015	First Assistant Secretary, Integrity, Security and Assurance Division, DIBP	John Lawler, Margaret Allison and Dominic Downie

Date	Meeting attendees/visits	Panel member(s)
10 June 2015	Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
14 June 2015	Assistant Secretary, Detention Health Branch, Infrastructure and Services Division; and Acting Assistant Secretary, Contract and Services Management Branch, Infrastructure and Services Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
16 June 2015	Deputy Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
23 June 2015	Commander, Detention Operations, SBC, ABF; Regional Commander, New South Wales; another member of the SBC, ABF; and Assistant Secretary, Temporary Protection Visa Assessment Branch, DIBP	Dominic Downie
25 June 2015	Superintendent, Detention Capability Section, SBC, ABF; and representatives from Noetic	John Lawler, Margaret Allison and Dominic Downie
25 June 2015	First Assistant Secretary, Children, Community and Settlement Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
30 June 2015	DIBP and service provider staff, Brisbane Immigration Transit Accommodation	Margaret Allison
16 July 2015	Transfield representatives	John Lawler, Margaret Allison and Dominic Downie
16 July 2015	Save the Children Australia representatives	John Lawler, Margaret Allison and Dominic Downie
21 July 2015	International Health and Med-	John Lawler and Marga-

Date	Meeting attendees/visits	Panel member(s)
	ical Services representatives	ret Allison
22 July 2015	DIBP and service provider staff, RPC3	John Lawler and Margaret Allison
23 July 2015	Australian High Commissioner to Nauru	John Lawler and Margaret Allison
23 July 2015	Tour of a Nauru school	John Lawler and Margaret Allison
23 July 2015	Tour of a Nauru school	John Lawler and Margaret Allison
23 July 2015	General tour of Nauru	John Lawler and Margaret Allison
23 July 2015	Minister for Education and Home Affairs, GoN	John Lawler and Margaret Allison
23 July 2015	ABF leads at the RPC	John Lawler and Margaret Allison
23 July 2015	AFP representatives	John Lawler and Margaret Allison
23 July 2015	Representatives from Brisbane Catholic Education	John Lawler and Margaret Allison
23 July 2015	Evening tour of RPC3	John Lawler and Margaret Allison
24 July 2015	Representative from the Department of Justice and Border Control, GoN	John Lawler and Margaret Allison
24 July 2015	Representatives from Transfield Services and Wilson Security	John Lawler and Margaret Allison
24 July 2015	Representatives from Save the	John Lawler and Marga-

Date	Meeting attendees/visits	Panel member(s)
	Children Australia	ret Allison
24 July 2015	Representatives from International Health and Medical Services	John Lawler and Margaret Allison
24 July 2015	Attendance at the Asylum Seeker Consultative Committee – families at RPC3	John Lawler and Margaret Allison
24 July 2015	Pacific Technical Assistance Mechanism, Gender Based Violence Counsellor/Specialist	John Lawler and Margaret Allison
29 July 2015	First Assistant Secretary, Children, Community and Settlement Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
30 July 2015	16th General Meeting – Minister's Council on Asylum Seekers and Detention	John Lawler, Margaret Allison and Dominic Downie
11 August 2015	Assistant Secretary, Identity and Intelligence Capability Branch, DIBP	John Lawler
12 August 2015	Deputy Commissioner Support, and Deputy Commissioner Operations	John Lawler, Margaret Allison and Dominic Downie
13 August 2015	Minister for Immigration and Border Protection	John Lawler, Margaret Allison and Dominic Downie
7 October 2015	Representatives from the Royal Australasian College of Physicians	Margaret Allison and Dominic Downie
8 October 2015	First Assistant Secretary, Children, Community and Settlement Division, DIBP	John Lawler and Margaret Allison

Date	Meeting attendees/visits	Panel member(s)
20 October 2015	First Assistant Secretary, Children, Community and Settlement Division; and Acting Assistant Secretary, Child Protection and Wellbeing Branch, DIBP	John Lawler, Margaret Allison and Dominic Downie
20 October 2015	Deputy Chief Police Officer, AFP	John Lawler
21 October 2015	First Assistant Secretary, Intelligence Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
22 October 2015	Deputy Secretary, Corporate Group, DIBP	John Lawler, Margaret Allison and Dominic Downie
23 October 2015	Secretary, DIBP; and Commissioner, ABF	John Lawler and Margaret Allison
10 November 2015	CMO/Surgeon General	John Lawler, Margaret Allison and Dominic Downie
11 November 2015	Integrated Intelligence Capability Review members	John Lawler and Dominic Downie
11 November 2015	Assistant Secretaries, Detention Capability Review, DIBP	John Lawler, Margaret Allison and Dominic Downie
11 November 2015	Representatives from UNICEF Australia	Margaret Allison and Dominic Downie
12 November 2015	Commander of SBC, ABF	John Lawler, Margaret Allison and Dominic Downie
12 November 2015	Minister for Immigration and Border Protection	John Lawler, Margaret Allison and Dominic Downie
17 November 2015	Serco representatives	John Lawler, Margaret Allison and Dominic Downie
19 November	DIBP and service provider staff,	John Lawler

Date	Meeting attendees/visits	Panel member(s)
2015	South Australia Immigration Transit Accommodation	
20 November 2015	DIBP and service provider staff, Perth Immigration Residential Housing	John Lawler
8 December 2015	Commander of Detention Operations, SBC, ABF	Dominic Downie
15 December 2015	Deputy Secretary, Intelligence and Capability Group; and First Assistant Secretary, Intelligence Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
15 December 2015	Deputy Secretary, Detention Capability Review, DIBP	John Lawler, Margaret Allison and Dominic Downie
16 December 2015	Deputy Commissioner Support; and First Assistant Secretary, Children, Community and Settlement Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
16 December 2015	Assistant Secretary, Community Operations Branch, Children, Community and Settlement Division, DIBP	John Lawler, Margaret Allison and Dominic Downie
16 December 2015	Deputy Commissioner Operations; and Commander of Detention Operations, SBC, ABF	John Lawler, Margaret Allison and Dominic Downie
17 December 2015	Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
11 February 2016	First Assistant Secretary, Children, Community and Settlement Division; Assistant Secretary, Community Operations Branch; and Assistant Secretary, Community Support Branch, DIBP	John Lawler, Margaret Allison and Dominic Downie

Date	Meeting attendees/visits	Panel member(s)
11 February 2016	Representatives from Case Management NSW, Case Management WA and Community Protection Branch, DIBP	John Lawler, Margaret Allison and Dominic Downie
12 February 2016	Representatives of the Australian Human Rights Commission	John Lawler and Dominic Downie
1 March 2016	CMO	John Lawler, Margaret Allison and Dominic Downie
1 March 2016	First Assistant Secretary, Community Protection Division; and Assistant Secretary, Public Risk Assessment Branch, DIBP	John Lawler, Margaret Allison and Dominic Downie
2 March 2016	Marist Youth Care representatives	John Lawler, Margaret Allison and Dominic Downie
3 March 2016	Migration Support Programs, Australian Red Cross representatives	John Lawler, Margaret Allison and Dominic Downie
3 March 2016	ACCESS Community Services representatives	John Lawler, Margaret Allison and Dominic Downie
4 March 2016	Secretary, DIBP	John Lawler, Margaret Allison and Dominic Downie
9 March 2016	Representative of the Ministry of Health, Nauru	Dominic Downie
15 March 2016	IHMS representatives	John Lawler and Dominic Downie
15 March 2016	Broadspectrum representatives	John Lawler and Dominic Downie

Date	Meeting attendees/visits	Panel member(s)
15–16 March 2016	ABF and service provider staff, Wickham Point Alternative Place of Detention	Margaret Allison
16 March 2016	ABF Programme Coordinator and ABF leads at Nauru RPC	John Lawler and Dominic Downie
16 March 2016	Australian High Commissioner to Nauru, and Deputy High Commissioner to Nauru	John Lawler and Dominic Downie
17 March 2016	ABF and service provider staff, Sydney Immigration Residential Housing	Margaret Allison
17 March 2016	Representatives from Broadspectrum, Nauru RPC	John Lawler and Dominic Downie
17 March 2016	Representatives from Brisbane Catholic Education, Nauru RPC	John Lawler and Dominic Downie
17 March 2016	GoN Operations Managers and GoN Settlement Team	John Lawler and Dominic Downie
17 March 2016	IHMS representatives, Nauru RPC	John Lawler and Dominic Downie
17 March 2016	Wilson Security representatives, Nauru RPC	John Lawler and Dominic Downie
17 March 2016	Connect Settlement Services lead, Nauru RPC	John Lawler and Dominic Downie
17 March 2016	Secretary for Education, GoN; and Director for Schools, GoN	John Lawler and Dominic Downie
17 March 2016	Director, Nauru Child Protection	John Lawler and Dominic Downie
17 March 2016	Commissioner Nauruan Police Force	John Lawler

Date	Meeting attendees/visits	Panel member(s)
17 March 2016	Superintendent and Police Adviser, AFP	John Lawler
17 March 2016	Afternoon tour of RPC3, Nauru	Dominic Downie
17 March 2016	United Nations Country Development Manager, Nauru	Dominic Downie
17 March 2016	Evening tour of RPC3, Nauru	John Lawler and Dominic Downie
18 March 2016	ABF and service provider staff, Melbourne Immigration Transit Accommodation	Margaret Allison
18 March 2016	Deputy Secretary, Justice and Border Control, GoN	John Lawler and Dominic Downie
6 May 2016	Secretary, DIBP; and Commissioner ABF	John Lawler, Margaret Allison and Dominic Downie

ABF = Australian Border Force; AFP = Australian Federal Police; CMO = Chief Medical Officer; DIBP = Department of Immigration and Border Protection; GoN = Government of Nauru; RPC = Regional Processing Centre; SBC = Strategic Border Command.

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