QCPCI

Date: 6.9.2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Exhibit number: 68

STATEMENT OF Queensland Health witness Andrew Vernon White

I, Andrew Vernon White, of the Townsville Hospital, 100 Angus Smith Drive, Douglas, in the State of Queensland, Director of Paediatrics, Townsville Hospital, solemnly and sincerely affirm and declare:

1. I am the Director of Paediatrics for the Townsville Hospital and Health Service having been appointed in June 2011.

2. I also hold a position of Senior Staff Specialist in Paediatrics for the Townsville Hospital and have held this position since April 2008. I report to Dr Andrew Johnson, Townsville Hospital and Health Service Executive Director Medical Services.

3. I am also a part time Senior Lecturer at the James Cook University, School of Medicine and have been in this position since April 2008.

4. I am one of the Child Protection Advisors for the Townsville HHS.

5. Prior to these appointments, I was a Remote Health Service Paediatrician for the Northern Territory Department of Health where I was responsible for the delivery of paediatric outreach service services to remote, mostly indigenous communities in Central Australia.

6. I hold the following qualifications:
   - Bachelor of Medicine, Bachelor of Surgery, MBBS, University of Adelaide, 1986;
   - Fellow of the Royal Australian College of Physicians (FRACP) 1999
   - Master of Public Health and Tropical Medicine, James Cook University, 2006
   - Diploma of Obstetrics, Royal College of Obstetricians and Gynaecologists, 1990.

7. This statement has been prepared with the assistance of and in collaboration with a number of staff from the Women and Children's Institute including the Townsville Hospital Child Protection Unit.

ROLE

8. The purpose of my role, as the Director of Paediatrics, and Senior Staff Specialist in Paediatrics include:
   - Leading paediatric clinical service
   - Providing leadership for development of paediatric services in the Townsville District
   - Participation in acute clinical service including after hours roster
   - Regular hospital and community paediatric clinics
   - Outreach clinics to Julia Creek, Richmond, Hughenden, Palm Island and to the Townsville Aboriginal and Islander Health Service
   - Participation in child protection advisor role and forensic examinations
   - Participation in department education programs, registrar training and junior doctor training and peer review.

9. My role also includes the following:

- Member Queensland Clinical Senate.
- Reviewer of Queensland Primary Clinical Care Manual, and Chronic Disease Guidelines
- Reference Committee – Indigenous Ear Health Infonet Edith Cowan University and Menzies School of Health research.
- Member Queensland Health Child and Youth State Clinical Network
- Member North Queensland Child Protection Clinician Network
- Member Queensland Child and Youth Northern Clinical Network
- Steering Committee Queensland Rheumatic Heart Disease Program
- Reviewer for Medical Journal of Australia, Journal of Paediatrics and Child Health, BMC journal of Paediatrics
- Lecturer JCU School of Public Health. Tropical Paediatrics Course.

10. My duties and activities as a Child Protection Advisor play a key role in the provision of child protection services both at the HSS and interagency level. It is recognised that there are varying degrees of knowledge and expertise about child protection clinical practice amongst clinical staff. Within this HHS, this child protection advisor role provides support, guidance and advice to all clinical staff to effectively respond to the presentation of possible child abuse. - Specifically, this role is to:
    - provide clinical expertise, support and advice to all clinical areas and staff in relation to children who have been harmed or who at risk of harm
    - provide advice and expertise to partner agencies such as Child Safety and the Queensland Police Service
    - be the Townville HHS core member agency representative on the Suspected Child Abuse and Neglect (SCAN) teams and Information Coordination Meetings
    - contribute to the improvement of the health, safety development and wellbeing

11. The Townsville Hospital and Health Service (HHS) has a long history of commitment to service delivery involvement with children and young people who have been harmed or are at risk of harm. It strives continually to play its vital role in ensuring that children and young people are provided with responsive, comprehensive and coordinated health services which address primary, secondary and tertiary prevention as well as the impact of child abuse and neglect.

12. The Townsville HHS Child Protection Unit is comprised of:
    - Three Child Protection Liaison Officers (equivalent to 2.FTE) who are located at the Townsville, Charters Towers and Ayr Hospitals;
    - A Staff Paediatrician, Lead Child Protection Advisor.

13. The unit is also supported as required by seven other Senior Paediatricians who are also Child Protection Advisors for the HHS. These paediatricians and the Child Protection Unit staff have significant child protection and clinical expertise both here in Queensland and overseas – especially the United Kingdom.

Key issues and Current Challenges

14. The reporting threshold for health professionals is set out in the Section 191 of the *Public Heath Act 2005* and requires health professionals to report once they have formed a reasonable suspicion that a child has been, is being, and is likely to be harmed.

15. The legislation provides a definition of harm as being ***harm***, to a child, as meaning any detrimental effect on the child's physical, psychological or emotional wellbeing—

(a) that is of a significant nature; and
(b) that has been caused by—
(i) physical, psychological or emotional abuse or neglect; or
(ii) sexual abuse or exploitation.

16. This health legislative mandatory requirement and threshold provides a more considered identification of harm than the previously poorly defined, uncoordinated and poorly complied with mandatory requirement of Section 76K of the *Health Act 1937*. However, in recent years, it appears to fall short of the Child Safety threshold of a "child in need of protection" and as such, results in a degree of ongoing tension between the two agencies. Previously, the reporting of significant harm alone (or maltreatment or neglect) was the mainstay entry point of previous child protection investigations with the additional determinant and interpretation of a "parent willing and able" being an outcome of the chid protection investigation and assessment.

17. There is no acknowledgement in the current *Child Protection Act1999* that correlates or supports the legislative reporting requirements set out in Section 191 of the *Public Health Act 2005.*

18. The health professional's reporting threshold appears to have a reducing relevance for the statutory Child Safety threshold as defined in the *Child Protection Act 1999*. It appears to be sometimes regarded by Child Safety Services as a default position where health professionals:
    - negate their ongoing responsibilities and subsequent contact with the complex children and families;
    - place all responsibility for risk and need on Child Safety;
    - cause children and families to be unnecessarily and permanently listed in a child protection data system;
    - overload the existing system.

19. Townsville HHS staff are encouraged to respond to both the needs and risk of children and their families. They are supported in their mandatory reporting of harm with the following:
    - Resources developed by the former Queensland Health Child Health and Safety Unit;
    - Ongoing education and training provided to the staff by Townsville HHS Child Protection Unit staff;
    - Provision of phone and face to face contact, advice and support by staff from the Townsville HHS Child Protection Unit to assist them with their formulation of a reasonable suspicion of harm and the reporting process;
    - In addition, staff utilise a framework (available on a dedicated QHEPS website) developed by the Townsville HHS Unit to assist staff in their assessment of clinical presentations to determine whether a matter reaches the threshold for a mandatory report;
    - Support is also available to all staff on a 24 hours basis with the provision of after hours support via the Paediatrician on call.

20. Over the last three or more years, there have been over 1500 Mandatory Reports of a Reasonable Suspicion of Child Abuse and Neglect made by health staff within the region that comprises the Townsville HHS. In 2009, there were 420 Reports with 380 in 2010, 570 in 2011, and with a projected 650 for 2012. Reasons for this increase are speculative but may be attributed to the following:
    - Population growth (5% per annum - ABS)

- Increasing awareness of impact of substance abuse, mental illness, domestic violence, intergenerational abuse on parental capacity
- Increased response by staff to fulfil their mandatory reporting responsibilities
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21. Additionally, over the last 18 months or so, there has been a number of matters involving Townsville Hospital staff where children have been seriously injured and as well as a number of child deaths from alleged abuse and neglect.

22. Outcomes of Townsville HHS Mandatory Reports of Child Abuse and Neglect reports are predominantly Child Concerns Reports with approximately 25 % reaching the higher Child Safety notification response. There are very few that are assessed by Child Safety as being a General Inquiry and therefore are not child protection related.

24. Challenges in reporting to Child Safety by our Townsville HHS staff have included reported instances that have shown:
    - A lack of understanding by Child Safety Officers of health professionals' mandatory reporting requirements and processes;
    - A reluctance to accepts a health professionals' reports because as they are overloading the system and result in significant administrative processes that takes many hours;
    - A rejection of assessed identified concerns with responses of *"you don't need to report that"* despite the health professional's assessment and identification;
    - A lack of understanding of the seriousness of the clinical concerns identified in mandated reports such as unexplained injuries in a child under the age of twelve months;
    - A lack of any consistent response to multiple reports of repeated or recurrent parental behaviour with demonstrated child impact consistently reaching the Child Concern Report outcome;
    - Advice to health professionals to contact the Queensland Police Service (QPS) and **not them** in matters of alleged extra sexual familial abuse (PHA 2005 doesn't differentiate for the purpose of mandatory reporting);
    - A lack of understanding that health professionals are not obligated to report matters to QPS;
    - A lack of understanding of Child Safety's obligations related to Section 14(2) of the CPA 1999 to report matters to QPS;
    - An emphasis in the intake process of assessing limited available information relevant to "a parent willing and able" over the reported identified significant harm.

25. Despite these challenges, the number of mandated reports within the Townsville HHS continues to increase as staff assume and fulfil their legislated and policy responsibilities.

26. It is the view of staff of the Townsville HHS Child Protection Unit, that there are very few reports that originate from a risk management perspective to avoid the legislative penalty or implication from involvement in a potential adverse outcome and that as a result of frequent clinical records review, there are many more occasions of non reporting of incidents / presentations of significant harm.

27. Queensland Health professionals appear to have the most onerous reporting requirements of any other mandated reporters. Under legislation and policy, QH staff are required to:
    - Formulate a reasonable suspicion of child abuse and neglect;
    - Complete the QH Report of a reasonable suspicion of child abuse and neglect;
    - Immediately telephone the North Queensland Regional Intake Service;
    - Fax a copy of the completed form to the North Queensland Regional Intake Service;
    - Fax a copy of the completed form to the Townsville HSS Child Protection Unit;
    - File the original white copy in the correspondence section of the child's clinical record.

28. Townsville HSS Child Protection Unit has identified some issues with this process:
    - Feedback from staff that there are too may actions to be completed after a reasonable suspicion is formed;
    - The multi layered reporting process may sometimes compete with other clinical demands and be delayed or only partially completed on the basis that it takes too much time to complete all the steps;
    - Information documented on the Queensland Health Report of Suspected Child Abuse and Neglect (SW010) sometimes may not reflect the same information as perhaps provided verbally by the health reporter;
    - Child Safety Intake staff will advise staff just to fax through the identified concerns without seeking additional information directly from the reporter;
    - Health professionals will sometimes opt just to fax the form without verbally notifying Child Safety and believe that this is sufficient to fulfil their reporting mandatory requirements;
    - Delays are frequently experienced with the receipt of a copy of the SW010 being forwarded to the staff of the District Child Protection office so the identified concerns can be reviewed and assessed in a timely manner.

29. The introduction of the provision of the report outcomes by Child Safety to support the SCAN referral criteria proves, has resulted in an unanticipated additional layer of work for the staff of the Townsville HHS Child Protection Unit which involves the review and assessment of the outcomes of all mandatory reports made by the health professionals of the Townsville HHS. This review provides an internal effective quality improvement process relative to the reports as well as to the identified concerns.

30. In undertaking this review process, the following challenges have emerged:
    - Not all outcomes are provided within the set 5 business days;
    - Outcomes frequently have to be sought by Townsville HHS Child Protection Unit staff.

31. Additionally, the Child Concern rationales:
    - Are variable in their assessment of the identified concerns;
    - Sometime contain no mention of the identified harm;
    - Minimise the identified harms due to the child or family's assumed engagement with other agencies without seeking or assessing any qualitative information of the engagement;

- Consider the provision of a weekly Child Health Home visit as monitoring a situation and sufficient to allay concerns where it has been the Child Health professional who has made the report;
- Consider the presence of any health home visiting service as a protective factor without consideration of the limitations of the service and the scope of the role of the visiting health professional;
- Minimise the impact of domestic violence on children:

  "Although the incident detailed in previous event appears tho have been ***significant in that police attended and mother had injuries that required medical attention****, this report does not indicate that the DV in the home is a regular occurrence or that it is escalating in frequency or severity. There is little doubt that witnessing the violence would have* ***been traumatic for the children*** *however it is unlikely that this in itself with have a significant impact on the children's long term emotional and psychological well being."*

- Sometimes minimise and rationalise the impact of actual harm despite the provision of health information in relation to a hospital presentation:

  "Child…… presenting to Hospital with superficial injuries in …..and disclosing that her mother assaulted her with a rock and scissors. Whilst the child received minor visible injuries as a result of parental action, there is no clarifying detail in relation to the assault to state what has actually occurred between mother and child. A Pre-Notification Check occurred with CPIU with no Police records indicating that Police were involved in any matter between mother and child around the stated date of the incident."

- Contain interpretations relative to medical conditions/injuries which are out of the scope and expertise of their statutory role. For example: Concerns were raised by a health professional about a newborn baby's weight loss and possible failure to thrive, and mother's failure to have baby clinically assessed in the context of impaired parental capacity due to alleged drug use. Matter was assessed as a CCR with inclusion of statement that: "child was sighted ….. and appeared fine". Child was eventually admitted to hospital with "failure to thrive".
- Make assessments based on the age of the children and the assumed capacity and ability of the subject children to identify that they themselves are experiencing abuse and are therefore able to seek appropriate assistance;
- Make assumptions that because children attend school that other professionals would identify harm and report it therefore minimising the health professional's assessment of any concern;
  - *"Two of the children are of school age and as such are exposed to other professional people who would report any concerns in relation to the children"*
  - *"Both children attend school and have access to this support"* with one child in this instance being just 7 years old.

32. The current Townsville HHS response to all mandated reports is as follows:
    - Copies of all reports are forwarded to the relevant Townsville HHS Child Protection Liaison Officers; (CPLOs);
    - Each completed report is reviewed by the CPLO to assess the identified concerns for their significance, urgency and health response;
    - Some are referred to the Child Protection Advisor (CPA) for a review of the adequacy of the clinical response;
    - The clinical records of the subject child and relevant family members are reviewed to inform a holistic view / assessment of the identified concerns;

- All reports are then reviewed at a multidisciplinary meeting composed of the CPU staff, all HHS CPLOS, senior paediatricians, social workers and other relevant health staff to achieve the following outcomes: regardless of the Child Safety outcome to the report;
    - compliance with the required reporting threshold and reporting process;
    - assessment of the identified concerns from a risk and needs perspective;
    - assessment of the adequacy of the health response;
    - consideration of referral to additional services (both internal and external and at any level - plus targeted or tertiary) to respond to the risk and needs identified in this review process;
    - assessment of the Child Safety outcome and response;
    - consideration if matter requires a referral to the SCAN or ICM teams.
- Discussion, outcomes and actions are formally documented for the purposes of accountability and transparency.

33. This process supports the view recently provided to the Child Protection Inquiry by Queensland Health's former Child Safety Director, Ms Corelle Davies, that Queensland Health's responsibilities and responses to child protection extend beyond the reporting of a reasonable suspicion of child abuse and neglect.

34. These processes of staff support, education, case review and quality improvement activities facilitate and provide for more considered and better outcome for children. However, the Townsville HHS Child Protection Unit's responses to the children subject to mandatory reporting are however very much limited to available resources, (scope and capacity) within our HHS and externally in the community.

35. Service level gaps are clearly apparent especially for those complex families with both high need and risk. More specifically, families with babies and young children, and adolescents over 14 years have been identified by some clinicians, as the emerging sub categories within this group whose needs are not matched by current community resources.

36. Additionally, a number of specialised services within our HHS, interface with Child Safety clients. A percentage of these clients could be categorised as 'involuntary clients' – that is they have not willingly sought the services, (for example, ATODS, Child Health) to address the concerns relative to the protective needs of their child/children. Their engagement is the result of a degree of strong encouragement and advice from Child Safety to seek assistance/treatment. As a result, engagement can sometimes be hindered and compromised but can also result in an effective agency / client partnership and outcomes for a child that could not be achieved without the intervention of Child Safety involvement.

37. Information sharing between Child Safety and the Townsville HHS is governed by the information Sharing Provisions of Chapter 5 of the *Child Protection Act 1999* which were introduced in 2005/6. These provisions have a very clear purpose:
    - To protect children and young people from suffering harm from abuse or neglect
    - For early intervention to ensure that children and young people get the services they require.

38. Townsville HHS has a strong commitment to achieve these objectives but have been confronted with the following challenges:
    - Child Safety's lack of a consistent request framework; - tighten up
    - Lack of a centralised information system within the HHS and multiple information data/information systems sets in addition to the hard copies of clinical records;
    - Child Safety's interpretation and varying applications of the legislative provisions of the CPA - resulting in requests:
        - fishing for **'anything and everything'**
        - under 159M, 159N, and 159O
        - for copies of the entire chart/progress notes;
    - Increasing number of Requests by Child Safety seeking information;
    - Information already provided through SCAN but additional and separate requests made;
    - Information already provided at the time of the mandatory report.
    - Pressure of time frames, lack of time frames to provide relevant information to Child Safety;
    - Huge demand for information and our limited capacity to respond in a timely way;
    - Resultant tensions when requests are challenged as per Section 159c of the *Child Protection Act 1999.*
    - How Child Safety use the provided information;
    - If the information is used at all;
    - The inclusion of this information in affidavits;
    - The inclusion of health staff's names in court documents without their knowledge;
    - The lack of a standardised state-wide HSS form to seek information and respond to information requests.

39. Child Safety are able to seek the application of Unborn Child High Risk Alerts in particular health facilities within our HHS under specific circumstances which require the provision of advice to Child Safety by HHS staff upon the birth of a subject child. The subsequent outcome of this advice ranges from nil action to significant intervention (removal of child from parental custody) after birth.

40. Issues for Townsville HHS staff identified in the application and response to these alerts include:
    - Inappropriate or poorly considered rationale for their origins – there are occasions where these alerts appear to be no more than just a message or notification of a child's birth even in circumstances where the mother is engaged with Chid Safety Services;
    - The timeliness of their provision – sometimes too late;
    - The lack of information contained on the alerts about the intended response to the notification of the birth;
    - The lack of a documented coordinated response that is able to be implemented out of hours;
    - The limited availability of Child Safety staff over a 24 hour period to respond to the alerts especially in the instance of birth at 2 AM on the weekend;
    - The reliance on the After Hours Child Safety Service Centre located in Brisbane to respond to HHS staff's response to these alerts;
    - Inappropriate requests by Child Safety to HHS staff to separate mother and baby after birth without authority;
    - Lack of detailed planning on matters where separation is planned;

- Efficacy of the decision making process in assessing the gravity of the risk Vs impact of separation at birth and subsequent attachment disruption and sequelae – especially in those instances where it is likely that the child will be returned to the mother's care;
- Inappropriate requests by Child Safety to serve faxed Temporary Assessment Order (TAO) documentation on parents;
- The restrictions of parental contact as a result of a TAO which may inhibit parent – child attachment;
- Lack of any other consideration of alternate options other than a TAO such as the provision of some form of outsourced Child Safety supervision during the critical post birth period;
- Lack of complex cases being referred to SCAN by Child Safety for a coordinated response.

41. Additionally, there is inconsistency in the application of these alerts as they only appear in the public health system within this region. Similar processes for their application are not established in the private sector to our knowledge.

42. Townsville Hospital has had a number of recent incidents involving children under the age of 24 months with suspicious or unexplained injuries in the last 12 – 18 months. Evidence identifies that children in this age group are the most vulnerable to harm.

43. Recent hospital experiences in these matters have identified:
    - Lack of HHS policy and procedures to respond and manage these types of clinical presentations in a consistent and coordinated manner;
    - Lack of a timely and immediate assessment of significant identified harms by the Regional Intake Service;
    - Lack of a timely coordinated joint response by Child Safety and Queensland Police Service;
    - Advice from Child Safety that Queensland Police Service officers are unavailable to undertake joint interview;
    - Advice from Queensland Police Service that Child Safety officers are unavailable to undertake joint interview;
    - Health staff waiting for several days during child's admission for a joint response.

44. Townsville HHS Child Protection Unit staff are currently developing HHS policies and procedures as well as an interagency protocol in cooperation with Child Safety and the Queensland Police Service to address this issue.

45. Care and Treatment Orders for a Child are a unique and powerful instrument where delegated medical officers are able to detain a child in a hospital under particular conditions. It has only been invoked on one occasion in the Townsville HHS several years ago.

46. Their application is very complex and has many administration processes that are time consuming plus the circumstances of their application also lack specific clarity for health professionals especially around what constitutes treatment.

47. There is no prescribed correlation or agreement in legislation or policy of its application to a report to Child Safety and the preferred outcome of a 24 hour notification response. This appears to be an example of a health service child protection practice developed in isolation to the child protection statutory response.

48. The Townsville Suspected Child Abuse and Neglect (SCAN) Team has been operational since the 1980s. Since this time, there have been several revisions of SCAN processes and policies which in practice have had the following impact on SCAN team functioning in Townsville:

- A reduction in the number of referrals;
- A more limited criteria for referring matters to SCAN;
- A referral system that is based more on the statutory threshold and intervention response of Child Safety to risk rather than on vulnerable and at risk families with multiple and complex risk and need as identified by the scope, role and expertise of other member agencies;
- Delays in referring matters to SCAN given the reliance on the provision of report outcomes from Child Safety in a timely manner;
- Silo based decision making occurs with the lack of shared power, responsibility and accountability between the agencies;
- Child Safety are the decision makers and the other agencies are only able to provide information and agency expertise relative to the Child Safety assessment.
- The legislation that enshrines the SCAN system doesn't strengthen SCAN practice, purpose or process. It provides a framework for limited discussion only.

49. The current Manual lacks clarity in a number of areas:

- Definition of what it means as per the Section 259 (L) (b) *CPA* - "best endeavours –about assessing and responding to the protection needs of particular children'.
- The referral criteria is limited and has been open to incorrect interpretation to SCAN coordinators - for example, matters have not been accepted on the basis that Child Safety have completed their Investigation and Assessment of a notification and are no longer involved with the child/family.
- The escalation process appears to be impossible to initiate;
- The scope of each agency' ability and responsibility to monitor recommendations as per Section 159(L) (d).

50. The Information Coordination Meeting component is a parallel process to SCAN and in practice relates more to challenging an outcome as opposed to assessing the protection needs and risk of a child.

51. The SCAN team meeting process lacks an operational framework that focuses information and discussion to achieve particular defined outcomes that correlate to the protection needs of a child. – risk and need from everyone's perspective

52. This lack of undefined outcomes leaves the SCAN system as a potentially unaccountable and vulnerable entity with its functioning primarily dependent on the individuals participating in it and the level of partnership that results from the collaboration.

53. Finally, it is our understanding that there are no identified Key Performance Indicators in the service agreements between Queensland Health 'Corporate Office' and HHSs in relation to child protection and the existing roles and responsibilities that have been imposed on each HHS as a result of the previous significant Child Protection Inquiries.

54. It is expected that there will be changes to current functioning as a result of this current Commission of Inquiry. These factors give rise to how the current and future challenges

of child protection service delivery within the Townsville HHS can be maintained and responsive so that an immediate and effective response characterized with high standards of professional practice, cooperation between agencies and coordination of services across agencies can be ensured.

Declared before me at Townsville this 26 day of September 2012.

(Solomon Rowland)

Signature of officer _____ Witness Signature _____