FINAL REPORT

Prepared by

Commission for Children and Young People

and Child Guardian

CONFIDENTIAL

An independent assessment of the case management of the child by departmental officers at a Child Safety Service Centre during 2009 - 2011

QCPCI

Date: 23.10.2012

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WARNING!

Confidentiality statement

This report may contain information of a confidential nature under the *Child Protection Act 1999* and the *Commission for Children and Young People and Child Guardian (CCYPCG) Act 2000.*

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Executive Summary

Background

The mother and her support person initially contacted the CCYPCG's Complaints Team in February 2011 requesting assistance to resolve outstanding practice issues by departmental officers at a Child Safety Service Centre (CSSC) that were allegedly impacting on the case management of the child. Due to the mother's ongoing dissatisfaction with the case management practices of departmental officers at the CSSC and her belief that departmental decisions were negatively impacting on the child, the mother requested an independent review be conducted by CCYPCG. The Department of Communities, Child Safety Services (the Department) agreed with this approach by letter dated 24 May 2011.

On 16 May 2011, a Member of Parliament (MP) also requested that the CCYPCG undertake an independent review of the mother's complaint.

In making my assessment of the mother's complaints, I relied on the following information and documentation:

- documentation provided by the mother to support her complaint
- the Department's file records relevant to the complaints issues raised regarding the case management of the child
- Child Protection Act 1999 (CPA)
- Child Safety Practice Manual (CSPM) (November 2010 edition), and
- case notes compiled by CCYPCG officers, regarding conversations with the mother and her support person.

On 10 October 2011, the CCYPCG completed a preliminary independent assessment report. In accordance with natural justice requirements, a copy of this report was provided to Department's Director-General and a copy of the relevant sections of this report were also sent to the officers named within the report for comment. All parties were invited to provide comment to this report within 28 days.

On 11 November 2011, the CCYPCG received an electronic copy of the response from the Department. Further departmental records were provided for consideration by the CCYPCG prior to finalizing the independent assessment report. Departmental officers named within the preliminary assessment report also provided responses. These comments and additional documentation have now been reviewed by me and incorporated into the relevant sections of the review, where appropriate.

Jurisdiction to undertake independent assessment

This is an independent assessment of the complaint made by the mother and was conducted under Chapter Four, Part Three of the *CCYPCG Act 2000.*

Limitations of the assessment

The Department was requested to provide only documentation that was relevant to the allegations raised by the mother. Subsequently, there may be additional records held by CSSC, not provided to CCYPCG that may influence of the direction of conclusions made during this review.

On 22 July 2011, the CCYPCG requested by email that the Client Relations Officer, Central Queensland Regional Office provide additional information. However, this request for information was not met.

Complaint issues

The issues raised by the mother have been categorized into nine specific case management issues relevant to the CSSC that were required to be assessed. These nine issues were:

Issue 1 - Intake process
Issue 2 - Investigation and assessment process
Issue 3 - Discrimination of the mother by departmental officers
Issue 4 - Contact arrangements
Issue 5 - Case planning
Issue 6 - Therapeutic intervention
Issue 7 - Social assessments
Issue 8 - Placement arrangements
Issue 9 - Misconduct/conduct issues

Outcome of independent assessment and proposed recommendations

I have assessed that departmental officers have met their legislative obligations. However best practice expectations have not been consistently met and in some instances negatively impacted on the case management of the child and the working relationship with the mother. I have identified a number of professional development and/or training opportunities that I recommend be implemented at CSSC to address the abovementioned practice issues. These are set out more fully throughout the report and specifically in Chapter 11.

I make the following recommendations:

Recommendation 1
I recommend that the Department provide professional development or training to officers at CSSC, in particular CSO1, in the gathering and recording of information and the level of detail to be included in the CPN. Additional mentoring or training is recommended on the

Structured Decision Making (SDM) tools, specifically all harms to be screened and recorded, and a detailed rationale for the outcome of these screening processes to be documented.

Recommendation 2
I recommend that the Department review and/or develop strategies and procedures implemented at the CSSC for investigating CSOs when a child discloses abuse being perpetrated by the parent, primary caregiver, or household member.

Recommendation 3
I recommend that the Department provide professional development or training to officers at the CSSC, in particular CSO2 and the relevant Team Leader (at that time), in relation to the obligation to ensure the child's safety and complete a safety assessment prior to leaving the family home. It is of the utmost importance that such mentoring or training emphasizes the need for the investigating CSO to discuss the outcome of the safety assessment and develop a safety plan for any child remaining in the home when the outcome of the safety assessment has been determined to be unsafe.

Recommendation 4
I recommend that the Department provide professional development or training to relevant officers at the CSSC in the use of SDM tools to improve practice and promote consistent decision making. The mentoring or training should provide the opportunity to reiterate to departmental officers at the CSSC that each assessment must review and document the progress made by the parents during the intervention period and what further action is required by the parent to address the child protection concerns.

Recommendation 5
I recommend that the Department provide professional development or training to officers at the CSSC in relation to the appropriateness of Assessment Care Agreements being undertaken rather than a Temporary Assessment Order.

Recommendation 6
I recommend that the Department review and/or develop a written explanation of the interim custody process provided to parents to promote their understanding of Court proceedings and in particular rulings in relation to interim custodial periods.

Recommendation 7
I recommend that the Department take steps to ensure that mediation occurs between the mother and departmental officers who will continue to have case management and case decision making responsibility for the child to resolve the impact of previous communication issues on the working relationship between the mother and departmental officers.

Recommendation 8
I recommend that the Department take steps to arrange for the child's psychologist to be consulted to develop an appropriate incremental contact schedule, including milestones/goals to be reached that support contact progressing to unsupervised contact and the mother being given the opportunity to demonstrate appropriate boundaries and parenting skills.

Recommendation 9
I recommend that the Department provide training to officers at the CSSC, in particular CSO3 and the relevant Team Leader in the use of the SDM tools and formation of comprehensive case plans, based on evidence and underpinned from a strength-based perspective.

Recommendation 10
I recommend that the Department review the current case plan for the child and update it to include more specific actions required of the mother to address outstanding concerns held by departmental officers that indicate the child is at risk of emotional harm.

Recommendation 11
I recommend that the Department take steps to ensure that individual and joint counselling is undertaken with the mother and the child with the view of establishing a healthy parent-child relationship and to meet the child's attachment needs to the mother, his only relative willing to care for him.

Recommendation 12
I recommend that the Department take steps to engage an appropriate therapeutic service to provide support to the mother and the child until it has been assessed by the treating psychologists that goals of therapeutic sessions have been met.

Recommendation 13
I recommend that the Department take steps to ensure that the child's psychologist inform departmental officers on what form and level of contact is in the child's best interests.

Recommendation 14
I recommend that the Department take steps to ensure that the child and the mother's psychologists articulate how reunification should be progressed and what specific goals the mother would need to achieve before consideration be given to unsupervised contact and/or reunification occurring.

Recommendation 15
I recommend that the Department provide professional development to Team Leader1 and CSO3 in relation to refraining from making subjective comments to other professionals and if they are going to express an opinion, to ensure the other professionals document contextual information that supports his/her opinion. I also recommend that the Department have a written agreement with report writers specifying interview material obtained from departmental officers must not be transcribed as comments without including the relevant contextual information.

Recommendation 16
I recommend that the Department provides professional development to Team Leader1 and CSO3 on how to clearly articulate to clients each concern held by the Department, even those concerns that differ from other professionals, such as the treating psychologists or therapist commissioned to undertake a social assessment.

Implementation

I will require the Department to inform me of the steps it proposes to take in order to implement each of the above recommendations within 28 days of delivery on my final report.

1. Intake process

1.1 Allegations that notifier may have been vexatious/malicious

The mother raised concerns regarding the Department's decision to record a child protection notification (CPN). The mother believes that the information received by departmental officers in relation to the child's safety should have been considered as vexatious/malicious in nature. Her rationale supporting this belief is based on the fact that there was a significant delay between the notifier being made aware of the concerns and notifying the Department.

My assessment

In accordance with Section 186 of the CPA, a response to this issue is not possible, as the identity of the notifier cannot be confirmed. However, consideration was given to this issue by reviewing the intake process.

It is acknowledged that within the Child Safety Practice Manual (CSPM)[1] the context of a child protection notification can, at times, be determined to be malicious or vexatious at the point of intake. The CSPM provides the following definitions for consideration by departmental officers when determining whether a notifier should be recorded as vexatious or malicious:

> *A vexatious notifier is a person who contacts Child Safety repeatedly with concerns about a child that are without grounds. A malicious notifier is a person whose ulterior motive for contacting Child Safety is ill will towards another person.*
>
> *In both circumstances, concern about the best interests of the child is not the reason for the notifier's actions. It includes situations where a number of previous investigation and assessments have been unsubstantiated and the same notifier continues to contact Child Safety with similar concerns, which appear to meet the threshold for a notification.*

The Child Safety Officer (CSO) responsible for receiving the notification should attempt to gather information related to the motivation of the notifier in contacting the Department about the allegations made[2]. However, the overarching principle for the Department's decision making processes is that the safety and wellbeing of the child is paramount[3] and must take precedence in all departmental decision making. There are a number of alternative reasons that determine when a person chooses to notify the Department of child protection concerns, such as extended family members attempting to address the concerns with the child's parent. Malicious intent is therefore only one explanation for a possible delay in notifying the concerns. Malicious intent would again be considered during the investigation process,

[1] Chapter 1 Intake, What If the Notifier is Vexatious and Malicious, CSPM.
[2] Chapter 1 Intake, Section 1.1 Gathering information from the notifier, CSPM. See also Practice Resource – Vexations and malicious notifiers
[3] Section 6A CPA

however, there is no information contained within departmental records provided to the CCYPCG that suggests the notifier met one of the above definitions.

[redacted]

- [redacted]

Based on the allegations made and the alleged impact on the child, the Department was obligated to assess the intake information and determine the appropriate departmental response to the allegations made. Although there is no information contained in the intake records to suggest CSO1 considered malicious intent during her review and assessment of the notified concern, it may not have been appropriate to do so in this instance. I have assessed that malicious/vexatious intent is unsubstantiated and further, that the Department made the appropriate decision to record a CPN and investigate the child protection concerns raised by the notifier. My review of the intake process undertaken by CSO1 has identified a number of practice issues, as detailed below.

The intake record contains additional contextual information that was not recorded in the CPN. [redacted]

- [redacted]

Based on the information provided to the CCYPCG relating to the intake process, CSO1 did not appear to redirect the notifier to focus on articulating the observed harm to the child

caused by the mother's behaviour, which is specified as best practice obligations of an Intake CSO[4]. CSO1 was required to seek further clarification from the notifier in relation to:

- the frequency of the alleged inappropriate sexualized incidents
- where these alleged incidents occurred
- the dates when the alleged incidents occurred to seek clarification of whether the child was referring to one or more discrete incidents
- the relevance of some of the comments made by the notifier such as the mother being "obsessive" about the child's appearance and school work
- the impact of the mother's alcohol use on her parenting and the child's wellbeing, and
- what actions the child allegedly wants his mother to "stop doing".

It is unknown if this level of detail may have been collected at the point of Intake and not recorded in the CPN or on the Intake Record document. It is acknowledged that some of the information contained in the Intake Record may not have been recorded in the CPN to protect the notifier's identity. Notwithstanding this fact, this level of detail is required to inform the Intake decision making process and to also inform the investigating CSO. Consequently, the level of harm to the child is implied rather than verified by the notifier. Although psychological harm indicators, [redacted] were identified and met the threshold for recording a CPN, best practice supports a more comprehensive Intake process (as outlined above) to inform the most appropriate departmental response priority to the child protection concerns raised and the investigative process. It should however be acknowledged that notifiers regularly focus on risk factors operating within the child's environment, such as abusive incidents and may not be able to articulate harm indicators related to the child's presentation. The Intake CSO is required to exercise professional judgement in these instances, and the level of harm experienced by the child determined during the investigation and assessment processes. Within the Department's response to the CCYPCG preliminary assessment, the Department agreed that further clarification should have been sought from the notifier by CSO1 during the Intake process, as this would have resulted in a 24 hour response priority being allocated to the CPN.

[4] Chapter 1 Intake, Section 1.1 Gathering information from the notifier, CSPM

2. Structured Decision Making Screening Criteria

A CPN was recorded on 21 September 2009 and approved on 24 September 2009 with the harm categories of sexual abuse and emotional harm. In the details of harm section, CSO1 made reference to child sexual abuse as *"any sexual activity or behaviour that is imposed on the child by his parent, including inducement or coercion of the child to engage or assist any person and in this case, parent, in sexually explicit conduct."* CSO1's rationale for recording a CPN was that the information received suggested that the child is being sexually abused by the mother by [redacted]

The screening criteria/response priority recorded on 21 September 2009 by CSO1 determined the final response timeframe to be 10 day response priority.

My assessment

Departmental guidelines indicate that the intake process is to be completed within 48 hours of receiving the notifier concerns,[5] however this timeframe was not met.

I have assessed that incorrect decisions were made by CSO1 who completed the Structured Decision Making (SDM) Screening Criteria/Response Priority document, given the alleged concerns reported, particularly relating to sexual abuse of the child. In particular, CSO1 did not complete the *"response decisions"* screening criteria correctly, due to the following:

- the person responsible for the alleged harm of the child, his mother, was recorded as not having access to the child within the next 24 hours and that there was no immediate threat to his safety[6]
- It was recorded that the child had not been sexually abused in the past, nor had the alleged events occurred within the past 12 months[7], and
- It was determined that an ICARE interview could be delayed without increased risk to the child's safety and wellbeing[8].

The most appropriate responses to the first two points above was "Yes", as the child was residing in the full time care of the mother, who was the alleged perpetrator of harm to the child. There was no information recorded in the CPN to indicate the child was not residing with the mother to support CSO1 selecting "No" for the above two response decisions. Had the correct answer of "Yes" been selected at this point, the recommended response timeframe would have been 24 hours, rather than the 10 day response priority that was recorded.

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[5] Chapter 1 Intake, Section 1.1 Gathering Information from the notifier, CSPM
[6] Section 1 – Response decisions, Response priority assessment, Screening criteria/Response Priority SDM tool: *"Will the person alleged to be responsible for the harm/risk have access to the child within the next 24 hours, or is the person responsible unknown and it is probable the child's immediate safety is threatened?"*. No was selected.
[7] Section 1 – Response decisions, Response priority assessment, Screening criteria/Response Priority SDM tool: *"Did the reported events occur within the past year and/or has the child been sexually abused in the past?"* "No" was selected.
[8] Section 1 – Response decisions, Response priority assessment, Screening criteria/Response Priority SDM tool: *"Can an ICARE interview be delayed more than 24 hours without increasing the risk to the child's safety and wellbeing?* "Yes" was selected.

The response to the third point is also of concern, as the alleged sexual abuse was perpetrated by the mother, the child's sole residential parent. Subsequently, based on the information provided, I have assessed that "No" would have been the more appropriate response decision.

Further, I have assessed that the selection criteria/response priority process was not completed in relation to the alleged emotional harm, which was selected by CSO1 as the additional harm category on the CPN. The CSPM indicates that the response priority should be completed for each of the abuse or harm types selected in the screening criteria, until a recommended response timeframe is reached for each abuse or harm type[9]. Where more than one timeframe is indicated, the recommended response timeframe should always be the shortest timeframe. The details of the emotional harm of the child allegedly perpetrated by the mother were not recorded on the CPN, which appears to be additional practice issue. The information provided by the notifier would indicate that the child was experiencing some level of emotional harm, as evident through [redacted] ongoing exposure to his mother's alleged inappropriate behaviour.

The outcome of pre-notification checks conducted during the intake process is not recorded on the CPN. Consequently, it would appear that CSO1 did not conduct pre-notification checks to further inform the intake decision-making process[10]. However, CSO1 did appropriately submit a referral to the Queensland Police Service (QPS). Further validation of the emotional harm experienced by the child would have been obtained by CSO1, had a pre-notification check been conducted with staff at service provider 2. It is however noted that the investigating CSO2 conducted this check before commencing the investigation and assessment process.

Within the Department's comments to the CCYPCG preliminary assessment, the Department advised that a pre-notification check is only required when there is insufficient information provided during the intake process to complete the screening criteria and determine an appropriate departmental response to the child protection concerns raised for the child[11]. The Department acknowledged that a pre-notification check would have provided additional information, however this was not required in this instance to complete the intake process. I agree that there was sufficient information gathered by intake CSO1 to complete the Department's screening criteria and determine a CPN be recorded and investigated.

[9] Chapter 1 Intake, 2.3 Complete the response priority, Assess the information and decide the response, CSPM.
[10] Chapter 1 Intake, 1.4 Conduct a pre-notification check if required, CSPM
[11] Chapter 1 Intake, 1.4 Conduct a pre-notification chick if required, CSPM

3. Investigation and Assessment process

3.1 Interview process

The mother raised concerns over the request made of her to wait in the backyard for a period of time while the interview with the child was being conducted. The mother also queried the child not having a support person present during the interview.

The guidelines and directions relevant to the investigation and assessment process are provided within the CSPM[12] as follows:

> *Investigation and assessments are undertaken with the cooperation and agreement of parents wherever possible... Contact or interviews with a child may occur either by an unannounced visit to the home or an arranged appointment. Contact may happen in the family home, it can also occur in other locations such as a hospital, the child's school, a child care or day care centre, a police station, a CSSC or another location suitable to the child and family and appropriate to the circumstances of the investigation and assessment...*
>
> *If a criminal offence may have been committed, and a joint investigation with the QPS is to occur, make decisions about sighting and interviewing children in consultation with the QPS, including whether or not the interviews will be recorded in line with the ICARE procedure[12].*

My assessment

I have assessed that interviewing the child at the mother's residence was an appropriate decision, as this would be considered the least intrusive measure as opposed to conducting an interview at the school[13] or another location such as a police station. It is standard departmental practice to negotiate and seek consent from the parent to interview the child at an agreed time and venue, once the child's parent has been informed of the CPN[12]. Documentation relating to the investigation and assessment process provided by the Department did not indicate whether CSO2 provided the mother with these options or whether she explained that statutory powers would be executed if the mother did not agree with the child being interviewed at that time[14].

It is however standard departmental practice to request the parent not be in the same location as the child during the interview, as the parent's presence may reduce the likelihood of a child disclosing harm, if the child has been subjected to child abuse and the parent is the alleged perpetrator. The mother being requested by CSO2, or Plain Clothes Senior Constable (PCSC) to wait in an alternative location to where the interview with the child was being conducted was appropriate. A Suspected Child Abuse and Neglect (SCAN) AM Team referral record documented that the mother only consented to the child being interviewed at

[12] Chapter 2 Investigation and Assessment - 2. Engage with the family and gather information, 2.3 Interview and sight the child, CSPM
[13] Section 17 CPA
[14] Record of interviews

her residence on 29 September 2009. It was also documented in this record that *the mother was in the back yard during the interview and the child was cognisant of her presence*[15]. However, it could not be determined from departmental records whether the mother was requested not to be present in the room where the interview was being conducted, as opposed to being directed by CSO2 or PCSC to wait in the backyard.

CSO2 has recently advised that the mother was advised on 29 September 2009 that the Department and QPS had been informed of some concerns relating to the child's welfare (including allegations of inappropriate touching) and requested permission to interview the child. The mother provided consent for the child to be interviewed and enquired whether she could be present during the interview. CSO2 advised the mother that it would be preferred for her not to be present during the interview. The mother agreed with this request and remained in the kitchen, adjoining the lounge room where the interview was conducted with the child. CSO2 asserts that the mother was not requested and did not wait in the backyard during the interview with the child. There appears to be conflicting information relating to the location of the mother during the interview, based on SCAN record, CSO2's recall and the mother's recall of this event. Although the location of the mother cannot be conclusively proven, it would appear that some level of discussion occurred with the mother in relation to the interview process.

The child's right to have a support person present is clearly documented in CSPM; however the support person cannot be the person allegedly responsible for the harm[16]. Subsequently, it was within the mother's right to request the interview be delayed until an appropriate support person for the child could be organized. The advantage of the mother allowing the child to be interviewed, not only demonstrates her willingness to engage with the departmental and QPS officers, but also reduces the likelihood and possibility of the mother influencing, or being accused of influencing the child not to disclose harm, if it was occurring. It is my understanding that the final decision on the child having a support person present would be made by PCSC and dependent on criminal investigation processes.

3.2 Records of interview

The record of interview recorded on 29 September 2009 and conducted by CSO2 and PCSC with the child at the mother's residence detail [redacted] disclosures made by the child:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[15] SCAN Form 1 SCAN AM Team referral from QPS referring officer dated 18 August 2010
[16] Chapter 2 Investigation and Assessment, Section 2.1 Interview and sight the child, CSPM and Practice Paper Role of a support person

The record of interview recorded on 29 September 2009 and conducted by CSO2 and PCSC with the mother at a Police Station detail [redacted] disclosures made by the mother:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

My assessment

It is unclear from departmental records provided to the CCYPCG for the purpose of this review whether CSO2 and PCSC attempted to have the child particularize his statements that indicate he was experiencing abuse perpetrated by the mother. It is also important to draw attention to the fact that CSO2 and PCSC did not, based on the record of interviews, seek clarification of what the child wanted his mother "to stop" doing. Nor did they explore with the child the impact of the mother's behaviour on him, especially when she was under the influence of alcohol. This information would have informed the investigation process and informed the level of abuse and associated harm to the child. However, it is acknowledged that CSO2 may not have documented her attempts to gather this level of information from the child. Evidence of this fact can be found in a SCAN AM Team Supplementary Information[17] by a referring QPS officer, who recorded that the child did not make any disclosures, until prompted, [redacted]

Within the Department's comments to the CCYPCG preliminary report, the Department referenced CSO2's handwritten notes that document the child being unwilling to speak further about the allegations of a sexual nature. The Department also highlight that it would

[17] SCAN Form 2, SCAN AM Team Supplementary Information by Referring officer dated 4 November 2009

not have been in the child's best interests to have continued questioning him in relation to this content, as this action may have caused the child to become distressed. CSO2 recently clarified that every question and attempt to gather information from the child was not documented; instead the record of interviews indicates when the child did not elaborate.

I have reviewed the record of interviews and CSO2's handwritten notes; however it remains unclear what attempts were made to seek clarification from the child in relation to other risk factors operating within the child's environment, [redacted] I do agree that further questioning may have caused the child some level of distress and may not have been in the child's best interests. However, I believe that further attempts should have been made to explore other risk factors impacting on the child's psychological wellbeing.

CSO2's handwritten notes indicated that if the child felt scared he would inform the mother, whereas the record of interview indicates that the only person the child would advise if he felt unsafe was a person other than his mother.

The above records of interviews indicate inappropriate boundaries between the mother and the child, limited insight by the mother in relation to the effects of her behaviour and actions, and alcohol misuse on the child's wellbeing, which together would warrant further investigation to determine how the child's protective needs could be met. The disclosures made during the interviews also provide some validity for the allegations documented in the CPN. Further, the outcome of the interview with the child would indicate that he has experienced some level of harm, requiring CSO2 to conduct a safety assessment.

3.3 Safety Assessment

An initial safety assessment is to be completed after the face-to-face interview is conducted with the child and parent and prior to the CSO leaving the home[18]. The outcome of the safety assessment is to be communicated to the parent. This includes advising the parent of what actions and/or interventions are required to ensure the ongoing safety of the child is met[19].

The "Safety Interventions" section on the Safety Assessment document indicates that if one or more harm indicators are present, then a range of interventions need to be considered to mitigate the immediate danger to the child[20]. Further, a combination of interventions will most likely be required to ensure a child's safety in the home, which should be more specifically detailed in the safety plan. The CSPM [21]states:

> *When the outcome of a safety assessment is recorded with an outcome of 'unsafe' and the child needs to reside outside the home for a period of time due to the level of risk identified, the parents may agree to take protective action and arrange for the child to stay with a family member or friend under a non-custody arrangement for generally two*

[18] Chapter 2 Investigation and Assessment, 2. Engage the family and gather information, 2.6 Complete a Safety Assessment, CSPM
[19] Practice Resource – Safety Assessment
[20] Chapter 2 Investigation and Assessment, 2. Engage the family and gather information, 2.6 Complete a Safety Assessment, CSPM
[21] Chapter 2 Investigation and Assessment, 2. Engage the family and gather information, 2.6 Complete a Safety Assessment, CSPM

to three days, to allow parents time to take immediate actions required to address the safety issues identified.

Alternatively a placement intervention is considered by the Department under the following circumstances:

- *It is in the best interests of the child to be provided with a formal, legal care arrangement*
- *It is assessed that the parent (and/or the proposed person to care for the child) may not adhere to a private arrangement and the child will return to the parent and the environment where the high risk factors exist, and the parent is more likely to adhere to a formal arrangement, and*
- *when the parent cannot identify a person to care for the child and the child requires a placement with an approved carer such as a Child Safety foster carer.*

A placement intervention can occur by way of:

- *a care agreement - where the parents agree to work with Child Safety in a voluntary capacity*
- *an assessment order (Temporary Assessment Order or a Court Assessment Order with custody to the chief executive) - where a parent does not agree to the placement of the child in out-of-home care, and*
- *an interim order, or a child protection order with custody or guardianship to the chief executive, because no other interventions are available to adequately ensure the child's immediate safety.*

CSO2 indicated that a combination of community agencies and the child being placed in a departmentally approved placement was required to ensure his safety[22].

My assessment

The safety assessment document was recorded with a safety assessment date of 23 September 2009 and a created date of 28 September 2009, which appears to be incorrect, as these dates are before the investigation commenced on 29 September 2009. Therefore, it is uncertain when the safety assessment was conducted. Further, it is unclear whether the outcome of the safety assessment was communicated to the mother.

The safety assessment also indicated that the child was exhibiting severe behavioural indicators of emotional harm as a result of the mother's alleged emotionally abusive treatment of him[23]. Although there is no indication of this within the initial interview notes that were provided to the CCYPCG, the information provided by staff at the service provider 2 provided some evidence to support the child was experiencing psychological issues.

The outcome of the safety assessment indicated that the home environment was *unsafe and the child was removed*[24]. This outcome is misleading, as the child was not removed from the mother's care until 6 October 2009, seven days after the initial interviews were conducted

[22] Safety Assessment document dated 28 September 2009, Section 2 Safety Intervention, option 3 (use of community agencies or services as safety resources) as the non-custodial intervention and option 9 (the child's parent agrees to place the child in a departmentally approved placement) as the custodial intervention.
[23] Safety Assessment document dated 28 September 2009, Section 1 Immediate Harm Indicators, response to Question 10)
[24] Safety Assessment document dated 28 September 2009, Section 3 Safety Decision

with the child and disclosures made in relation to the alleged inappropriate sexualized behaviour between the mother and the child.

It is the Department's practice to immediately remove a child from an unsafe home environment when no other interventions are available to adequately ensure the child's immediate safety. This can be undertaken by executing one of the following sections of the CPA:

- *section 18* - Child at immediate risk may be taken into custody
- *section 27 – Making of* temporary assessment order (TAO)
- *section 44 – Making of* court assessment order (CAO)
- *section 59 – Making of* child protection order (CPO).

Alternatively, an assessment care agreement can be negotiated with the child's parents, where a child's parents agree to place the child in a departmentally approved placement.

The information provided to the CCYPCG indicates that a safety plan was not implemented, nor was a safety assessment completed before leaving the mother's home or the Police Station on 29September 2009. Further, it is of significant concern that CSO2 had assessed, using the safety assessment tool, that the child was deemed unsafe in the mother's care, and despite this assessment, the child remained in her care for a further seven days.

At minimum a safety plan should have been implemented, [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Due to the above not being completed or communicated with the mother on 29 September 2009, the mother and the child travelled to Brisbane, resulting in the child not being placed in out-of-home care until 6 October 2009. This inaction could have resulted in the child being subjected to further harm.

3.4 Removal of the child from the mother's care

The mother acknowledged she has made some mistakes in relation to her care of the child, however, she was willing to work with the Department, and therefore she claimed that it was unnecessary to remove the child from her care.

My assessment

It is acknowledged that the mother's willingness to work collaboratively with the Department to address the child protection concerns is positive demonstration of her commitment to providing a safe and stable home environment to support reunification of the child. However, parental willingness to engage with the Department does not necessarily reduce immediately risk factors to an acceptable level to support a child remaining in the home. It is my assessment that the Department's decision to place the child in out-of-home care while further assessments were being conducted should have occurred on 29 September 2009.

It is of significant concern that CSO2 conducted interviews with the child and the mother on 29 September 2009, and both parties indicated inappropriate sexualized incidents had occurred and the child stated that he was uncertain whether he felt safe. Despite this information, a case discussion involving senior officers at CSSC did not occur until 1 October 2009. Further, the outcome of this discussion determined the child to be a child in need of protection who should be removed from the mother's custody; however departmental officers did not take action to place the child in out-of-home care until 6 October 2009. This appears to be a significant lapse of time, given the Department had assessed the child to be unsafe six days earlier.

Best practice indicates a clear decision/determination regarding the child's safety in the care of the mother being made on 29 September 2009, given the child disclosed some level of harm, the mother confirmed she had allowed inappropriate interactions to occur between her and the child, she had experienced depression and misused alcohol since the breakdown of her relationship with the child's father. Further, the delay in this process could have placed the child at increased risk of harm and in my opinion, has negatively impacted on the working relationship between the mother and departmental officers.

3.5 Alleged bullying of the mother by the Department to consent to an assessment care agreement

The mother advised she felt bullied into signing the assessment care agreement.

My assessment

An assessment care agreement ensures the child's immediate safety while allowing the child's parents to work with the Department on a voluntary basis to collaboratively address the child protection concerns, reduce the level of risk within the familial environment and promote the child's safe return to the home. Although the mother would have experienced a sense of disempowerment, namely no choice in relation to the child being placed in out-of-home care, this is directly related to the involuntary nature of child protection work. CSO2 negotiating the mother consent to an assessment care agreement for the child is considered appropriate given this is deemed to be the less intrusive option as opposed to the alternative, statutory intervention.

3.6 Inappropriate use of Temporary Assessment Order (TAO)

The mother queried statutory intervention being executed, when an assessment care agreement was in place.

My assessment

It appears that the Department's decision to apply for a TAO for the child on 23 October 2009 was warranted based on the statements allegedly made by the mother on 21 October

2009 that she did not agree with the ongoing placement of the child, that she wanted the child returned to her fulltime care, that she did not believe that he had been harmed in her care and that her actions were nothing more than "maternal". It is my opinion that the mother statements could constitute a withdrawal of her consent for placement of the child. In these instances, the CSPM states that if a parent terminates the care agreement without providing two days notice, a safety assessment must be undertaken and if the child is determined to be at significant risk, then departmental officers must take action under s18 CPA or make an application for a TAO to gain custody of the child to ensure the child's ongoing safety[25].

Whilst the mother indicated that she did not agree with the placement and wanted the child to return to her care, she did not indicate that she wished to end the assessment care agreement. Nor is there any record of CSO2 seeking clarification if this was the mother's intent. Furthermore, a safety assessment was not conducted to inform this decision making process regarding the most appropriate departmental response to the mother's withdrawal of consent to the assessment care agreement.

It is acknowledged that an assessment care agreement is the least intrusive measure to ensure a child's safety during the assessment period. The CSPM stipulates that this action should only be taken when a parent is willing to work with the Department and there are no safety concerns or significant risk to the child if the parent resumed custody[26]. It is my understanding that the mother had consistently made similar statements during the interview process and on 6 October 2009, immediately before the decision was made to implement an assessment care agreement.

If the risks to the child had been assessed as significant should the mother resume care of the child, then the initial decision to implement an assessment care agreement was not appropriate. Execution of statutory powers, under a TAO, would have been more appropriately made at the time of the initial interviews and informed by the outcome of the safety assessment. My assessment has been informed by the fact that although additional statements had been received by departmental officers between 6 and 23 October 2009 to validate the alleged child abuse perpetrated by the mother towards the child, the mother had commenced engagement with service provider 1 to address the child protection concerns and the mother had consistently indicated from 29 September 2009 that she did not believe the child should be placed in out-of-home care.

3.7 The child remained in the care of the Department after Court Assessment Order (CAO) expired

The mother questioned how the Department retained custody of the child after the CAO expired and prior to the child being subject to a custodial CPO.

[25] Chapter 2 Investigation and Assessment, Section 6 Complete a Safety Assessment, CSPM and practice paper
[26] Chapter 2 Investigation and Assessment, Section 6 Complete a Safety Assessment, CSPM and practice paper

My assessment

Departmental records indicate that an application for a custodial CPO was created on 16November 2009 and submitted to the Magistrate at the Childrens Court, prior to the CAO expiring on 26 November 2009. Under subsections 67 (1) and (2) of the CPA, this action results in the Department retaining interim custody of the child until the scheduled date for the application to be presented to the Magistrate at the Childrens Court. During the first mention, the Magistrate will determine whether to extend interim custody to the Department until a determination is made in relation to the application for a CPO. Copies of standard departmental correspondence to the mother by CSO3 would appear to have been sent each time the Childrens Court granted an interim child protection order, providing a brief explanation stating the Department would retain custody of the child until the end of the adjournment period[27].

Although CSO2 recently advised the CCYPCG that she engaged in a number of discussions with the mother to explain statutory processes, it would appear that the mother did not fully understand this process and continued to seek clarification on how the child was able to remain in out-of-home care without a CPO being granted. This issue remaining unresolved highlights a communication issue between the mother and departmental officers and also between the mother and her legal representation.

3.8 Family risk evaluation tool

On completion of the investigation and assessment process a family risk evaluation is undertaken to inform the level of ongoing intervention required to reduce the risk of future harm to the child[28]. The outcome, namely the risk level (low, moderate, high, very high) will later inform the family reunification assessment process, when evaluating the family's progress.

My assessment

The family risk evaluation document was dated 28 September 2009, which would appear to be an incorrect date, given the initial interviews were not conducted until 29 September 2009 and the investigation and assessment was not finalized until November 2009. Departmental guidelines indicate that the family risk evaluation tool is not to be completed until all relevant information is gathered to inform the investigation and assessment process. Departmental records indicate that interviews and conversations conducted with the mother after this date, informed her of the outcome of the investigation and assessment decision making process and supported the use of a TAO and CAO.

Further, the family risk evaluation document appears to have been incorrectly completed by CSO2, in relation to the primary care giver having a "mental health problem"[29] being recorded as "No". However, the mother indicated that she has experienced "depression" and had been self-medicating with alcohol, which was impacting on the child's emotional

[27] Multiple copies of outgoing correspondence to the mother, compiled by CSO3, including correspondence dated 7/6/10, 9/8/2010 and 30/8/2010
[28] Chapter 2 Investigation and Assessment - 3.1 Complete the family risk evaluation, CPSM
[29] Family Risk Evaluation document, Question 8, "Does the primary caregiver have a mental health problem?" dated 28/9/09

wellbeing. The mother also articulated that her adult relationships had been characterized by domestic violence, namely "violated by" most of her partners and she has experienced significant grief and loss issues[30]. Further, information gathered from the child's school also indicated that the mother had disclosed that she has depression and that she has been attempting to reduce her alcohol consumption over the past 12 months.

Within the Department's comments to the CCYPCG preliminary assessment, the Department indicated that parental mental health is only scored positively on the family risk evaluation when one or more of the following indicators are identified for the primary parent:

- a significant mental health disorder or condition determined by a mental health clinician, excluding drug or alcohol misuse
- repeated referrals for mental health/psychological assessments
- treatment or hospitalization recommended by a psychiatrist or mental health authority, and
- mental health problems being present during the past 12 months and/or present at any time prior to 12 months.

The Department indicated that there was no indication that the mother met the departmental criteria for a primary parent who has/had a mental health problem. However, the Department acknowledged the link between depression and substance abuse and that these factors are relevant in the determination of the risk level to the child. CSO2 also recently acknowledged the mother had indicated she has experienced depression and an Obsessive Compulsive Disorder, however CSO2 did not believe these self-disclosures met departmental guidelines to select parental mental health problem on the Family Risk Evaluation tool. Overall, this feedback would appear contrary to the Department's case planning goals, as there are several notations in relation to the impact the mother's childhood abuse has had on her psychological wellbeing and the recommendation for ongoing counselling.

The mother's mental health status should have been clarified during the assessment process. If the mother was determined to have a mental health issue, then the outcome would have been recorded as "high". This practice issue did not impact on the overall outcome for the family risk evaluation process, as departmental officers applied a policy override and changed the outcome from "moderate" to "very high risk"[31]. This decision is in accordance with the CSPM guidelines that stipulate that when a policy override is applied, the 'scored risk level' is adjusted to 'very high'[32,33].

The CSPM Family Risk Evaluation practice guide also indicates that an Intervention with Parental Agreement (IPA) case or a CPO be implemented when the outcome of the Family Risk Evaluation is recorded as very high.

It is my assessment that applying the policy override is in accordance with departmental practices. The policy override would appear warranted, [redacted] An extension of the CAO may have been an alternative statutory decision, as the mother and the child had commenced engaging with service provider 1 to undergo counseling and a psychosexual

[30] Record of Interview with the mother on 29 September 2009 conducted by CSO2 and PCSC
[31] Family Risk Evaluation document dated 28 September 2009
[32] Chapter 2 Investigation and Assessment - 3. Assess the notified concerns and the child's need for protection, 3.1 Complete the family risk evaluation
[33] Practice resource: Family Risk Evaluation, CSPM

assessment. My rationale for a CAO extension is that the outcome of the psychosexual assessment would have been completed during the CAO extension period and further informed the most appropriate and least intrusive statutory intervention, to ensure the child's ongoing protective needs were met.

It is however noted that CSO2 has recently advised that she did not believe an extension of a CAO to be the most appropriate statutory intervention as CSO2 had completed the investigation and assessment process. Based on the outcome of this process, a Child Protection Order was determined by CSO2 as the most appropriate intervention to ensure the child's safety. CSO2's rationale for progressing to a CPO rather than an extension of a CAO is reasonable and within the Department's legislative practices.

3.9 Rationale for the investigation and assessment outcome being substantiated

The mother believes the Department should not have identified the child as a "child in need of protection" and that least intrusive statutory power could have been undertaken to work with her and the child to ensure his safety and wellbeing.

On 24 November 2009, CSO2 completed the investigation and assessment process and determined the child to be a child in need of protection, substantiating emotional harm, emotional harm caused by sexual abuse, risk of emotional harm and risk of emotional harm caused by sexual abuse with the person responsible being the mother. CSO2 documented the [redacted] rationale for the outcome in the investigation and assessment document:

- [redacted]

My assessment

The purpose of an investigation and assessment is to determine whether a child is in need of protection. A child in need of protection[34] is a child who:

- *has suffered harm, is suffering harm or is at unacceptable risk of suffering harm, and*
- *does not have a parent able and willing to protect the child from the harm.*

The CSPM stipulates that the outcome of the investigation is determined by the harm experienced by the child and the child being assessed as at unacceptable risk of harm in the future. The alleged child abuse incidents or actions are not the focal point of the outcome decision. The outcome must be informed by a holistic risk assessment, taking into consideration indicators of cumulative and protective factors within the child's environment that mitigate the level of risk to the child[35,36].

It is my assessment that CSO2 completed a holistic risk assessment, as her decision making process was informed over a two month period and included information gathered from interviews conducted with the child and the mother, observations during contact visits, information obtained from relevant agencies and persons.

Based on my assessment of the material, I am of the opinion that sufficient evidence was gathered by the Department, from interviews with the mother and the child, to inform this outcome. Specifically, the statements made by the child on 29 September 2009 [redacted] would indicate sufficient evidence to warrant a substantiated outcome and conclude the child has experienced harm. Further, the key points summarized below from discussions between the child and CSO2 conducted on 18 November 2009, also indicates the child has experienced some level of harm[37].

- CSO2 advised the child that he would need to remain in out-of-home care for possibly 2 years. [redacted]
- [redacted]

The above discussion should be interpreted with caution, as comments made by CSO2 have been assessed as leading statements. [redacted] Although the child indicated he felt unsafe in the mother care, CSO2 and PCSC were unable to clarify in what context the child felt unsafe. [redacted]

[34] Section 10 CPA
[35] Chapter 2. Investigation and assessment, 3. Assess the notified concerns and the child's need for protection, 3.2 Determine whether the child is in need of protection
[36] Practice guide: The assessment of harm and risk of harm, CSPM
[37] Departmental record of face to face meeting with the child conducted by CSO2, with the child's Community Visitor being present, on 18 November 2009.

The mother's lack of insight on age-appropriate boundary setting and the confirmed negative impact of the mother's alcohol misuse on the child would provide sufficient evidence to indicate the child was at risk of harm in the future. Together, these factors support statutory intervention being undertaken to determine the extent of harm to the child and provide the mother with the opportunity to address the child protection concerns.

Although a number of practice issues have been identified, the CSPM specifies best practice rather than legislative practice. The Department complied with its legislative requirements in its assessment of the child protection concerns received for the child. Consequently, there appears no significant basis to recommend that the Department consider reversing the outcome of the Investigation and Assessment. During the assessment process, officers have appropriately considered both risk and protective factors present in the household in reaching a substantiated outcome. The outcomes recorded on the Investigation and Assessment, on the balance of probabilities, was justified based on the evidence recorded.

4. The Department allegedly discriminated against the mother due to her having experienced sexual abuse as a child

The mother appears not to fully understand the emphasis being placed by departmental officers on her childhood experience of sexual abuse. The mother believes departmental officers are unfairly using her experience of childhood abuse against her, and consequently feels discriminated against by departmental officers.

My assessment

Research on the effects of childhood sexual abuse on maternal parenting is limited. According to the research obtained during my review, the effects are dependent on the severity of the abuse, the child's resilience, and co-morbidity of child protection issues, such as parental drug and alcohol abuse, domestic violence and parental mental health issues. The common effects on adult survivors of childhood sexual abuse are cognitive processing issues, such as cognitive distortions, an inability to set age appropriate boundaries and limits and an inability to respond appropriately to the child's sexual curiosity/exploration and aggression. Adult female survivors/mothers also have a tendency to oscillate between being overly emotive to aggressive and do not recognize the trigger for their response as their experience of childhood sexual abuse.

The risks associated with childhood abuse on parenting and the need for a mother to understand and recognize the cognitive and behavioural characteristics that negatively impact on her parenting and the child's long term emotional/psychological wellbeing has not been clearly articulated to the mother. This is evident through the mother continuing to feel discriminated and punished by departmental officers throughout the intervention, due to her being a survivor of childhood sexual abuse. Further, the compounding effects of factors operating in the mother childhood familial environment, such as parental mental health issues, abandonment issues and emotional abuse by her mother and step-mother has not been adequately explained to the mother for her to understand her cognitive processing issues [redacted] her emotional dependency and parentification of the child, and her behaviours as an adult that perpetuate harm to the child.

5. Concerns regarding contact arrangements

The mother is seeking departmental approval for an increase in contact and progression to unsupervised contact, as the case plan goal is reunification and for contact to progress, at least to semi-supervised contact. The mother advised her ability to demonstrate her parenting skills, ability to prioritise the child's needs over her own, and her ability to set respectful boundaries within a short visitation that focuses on engaging in social activities, such as playing cricket, is limited. In addition, the mother feels that the Department is undermining her authority as a mother.

My assessment

The contact decisions made by the Department are not supported for the following reasons:

- the majority of reports and social assessments conducted have recommended contact be increased
- the outcome of the court ordered conference conducted on 4 August 2010 was that the parties agreed contact will progress towards semi-supervised contact[38]
- the majority of reports and social assessments determined that the mother is not a "sexual predator"[39] and there is low risk of her sexually offending against the child in the future[40]
- the child has consistently indicated to departmental officers and other professionals that he enjoyed contact with the mother and that he wanted contact to continue
- there are no departmental records of the child demonstrating fear of the mother during contact
- counselling had been implemented and reports from service provider 1 indicated both the child and the mother were making positive progress in addressing the goals of the case plan[41], and
- in the most recent social assessment conducted by the social assessor dated 12 November 2010, the child indicated he was "lost in care" and wanted to return home[42].

I have been unable to identify evidence to support the mother's allegations that departmental officers are undermining the mother as a parent. I acknowledge the mother's belief, however I encourage the mother to reflect on her actions during contact that have resulted in the child feeling some level of discomfort, which required the departmental officer supervising contact to intervene and redirect the mother and the child to engage in alternative activities.

It is acknowledged that concerns were raised during the October to mid-November 2009 period by CSSO1 and CSO2 in relation to the mother's conduct and expression of affection during contact. However, departmental records indicate that the outcome of the majority of contact sessions between the mother and the child have been positive. Some of the observations made by the supervising departmental officer would appear hyper vigilant, which of course is the role of this officer during supervised contact sessions. However, I

[38] Email correspondence from Independent Separate Representative for the child, dated 8 August 2010 to departmental officers, and mother's Legal Representative
[39] Social assessment report by social assessor dated 5 July 2010, page 18, paragraph 7.4
[40] Report prepared by social worker service provider1 dated 30 July 2010, page 4
[41] Updated social assessment report by social assessor dated 12 November 2010,, page 6, paragraph 4.1
[42] Updated social assessment report by social assessor dated 12 November 2010, page 9, paragraph 6.3

have assessed that it would be beneficial to the child for a psychologist to review departmental records on contact and make recommendations, especially in regards to whether the mother's conduct and responses to the child were outside the normal range of parent-child interactions particularly, a parent who has had their child removed from their care, following eight years of being the sole carer of this child.

I have also assessed that it would be important for the Department to seek feedback on the appropriateness of the child being responsible for determining the level and conditions of contact. The rationale for this assessment is based on the power imbalance between the child and the mother being reversed and potentially the child being responsible for making decisions beyond his age and his "wants" dominating contact. Whilst it is acknowledged that a child's views and wishes are important considerations when determining appropriate contact schedules, it is concerning that contact decisions are being made by the child based on alternative activities that are happening with his foster carers, to the detriment of his relationship with the mother. It is my opinion that at some point, the mother needs to be provided with opportunities to exercise her parental rights and in doing so, be provided with the opportunity to demonstrate her parenting skills and ability to set appropriate limits, rather than the focus of contact being "fun" activities. Joint counselling for the mother and the child must be implemented to address their parent-child relationships and promote healthy parent-child attachments.

I have further assessed that it is reasonable for the mother to want to engage in telephone contact with appropriate limits, boundaries and consequences developed and implemented by the child's psychologist. It is very concerning that the majority of social assessments have indicated that the child is experiencing emotional abuse by being in out-of-home care.

Within the Department's comments to the CCYPCG preliminary report, the Department highlighted that the child stating he was "lost in care" may have been a consequence of his long term placement with carer1 and carer2 ceasing, rather than an indication of the child experiencing harm by being in out-of-home care. This reflection is further supported by clinical and forensic psychologist reporting the child to have had a positive experience whilst in out-of-home care. I acknowledge that the child has had a positive experience in out-of-home care, whilst placed with carer1 and carer2. I agree that the child's comments would to some degree be related to his long term placement with carer1 and carer 2 being terminated. However, earlier reports had also indicated that out-of-home care was not conducive to the child's long term wellbeing. Further, until recently the child has consistently indicated a preference to return home and if this is not possible to continue residing in his primary placement.

It is also concerning that over the past six months, the child is less willing to engage in contact with the mother and that the strength of their bond is deteriorating, especially given the child has never indicated that he felt abused by the mother. Consideration does not appear to have been given to the fact that the child may feel conflicted between his bond with the mother and carers 1 and 2. This fact may create confusion for the child in relation to his preferred level of contact with the mother. It will be important that the mother be given the opportunity to engage in contact with the child during curricula and extra-curricular activities, such as school carnivals and soccer (respectively) to increase the level of "normality" for the child in his relationship with his mother. It is my opinion, that this will be important for the child's future wellbeing, [redacted]
Contact arrangements and conditions should be informed by a psychologist and progressed with caution given all assessments conducted to date indicate the mother's emotional dependency and regulation issues places the child at increased risk of emotional harm.

5.1 The Department has separated the child from the mother

The mother raised the following issues in relation to the child holidaying with his carers:

- the child travelled [redacted] with carer1 during the Easter holiday period in 2011. This resulted in the mother missing two visits with the child. The mother believes this would be contributing to the child developing an unhealthy relationship with his carers and that this is "inappropriate"
- the mother was not informed by the Department that the child would be participating in this type of holiday, the child told the mother
- the mother believes she has the right to be informed of the child's whereabouts
- the mother did not want the child travelling on the roads at Easter with a carer who has a medical condition, and
- [redacted]

The mother also requested additional contact for mother's Day, however there was a delay in this request being approved by the Department.

My assessment

It is my assessment that the above incidents emphasize ongoing communication issues between the mother and departmental officers. Easter holidays can be a difficult time for families with children in out-of-home care. Delays in advising the mother of the intent to allow the child to travel [redacted] negatively impacted on a collaborative working relationship between the mother and departmental officers. Furthermore, the lack of communication to resolve this issue between the mother and departmental officers negatively impacted on the quality of contact between the mother and the child, prior to Easter. Although the mother needs to take responsibility for her actions and persistence in wanting to discuss Easter plans with the child during contact, departmental officers are also partially responsible for the situation that developed at contact. This assessment is based on the mother allegedly not being advised by departmental officers prior to the child informing the mother that he wished to travel [redacted] with carer1 over Easter.

As the mother has retained guardianship of the child, it is standard practice for departmental officers to gain approval from a child's parent prior to travel arrangements being approved. However, approval by the child's guardian is not required, as the Department consider this type of travel to be classified as a day to day care decision. In my opinion, it would have been in the child's best interests for these discussions and negotiations to have occurred with the mother and the child's carers, prior to the child being advised of the planned [redacted] holiday. The final decision should have been determined by the mother. Further, it was also reasonable for the mother to request confirmation and details of where the child would be residing and with whom he would be having contact during this period. While it is acknowledged that in some circumstances, placement details are not provided to a child's parent, the mother has never demonstrated inappropriate conduct towards the child's carers and therefore did not present a risk to the child if she was informed of his location [redacted]

I acknowledge the mother's feelings in relation to not being able to engage in contact with the child and her disappointment with not being able to share an experience [redacted] with the child. However, the decision to allow the child to engage in this

activity and travel to the [redacted] would appear in his best interest, given he was aware of these plans, prior to consent being sought from the mother.

On the other hand, it is commendable that the child's carers wanted to involve him in their holiday plans and festive situation. A child being accepted within the carer's familial environment is a very important aspect of ensuring the child develop positive attachments to significant others. It would be ideal for the mother to be able to perceive the child's relationship with his carers as positive, rather than oppositional and negatively impacting on her bond with the child.

Departmental records indicate that carer1 and carer2 encouraged the child to engage in some form of contact with the mother on Mother's Day. Carer1 supporting Mother's Day contact could be considered as positively influencing the child to maintain his bond with the mother. The delay in determining what form of contact would occur on Mother's Day should not have occurred and this decision should have been determined by departmental officers in a timelier manner. Further, it would not appear appropriate for the child to be responsible for determining whether he would/would not engage in contact with the mother on Mother's Day.

5.2 The child is becoming emotionally withdrawn and is no longer bonding with the mother

The mother believes that the child is starting to show disrespect towards her during contact visits.

My assessment

Based on my assessment of the information provided to the CCYPCG, I have identified some issues regarding what appears to be a diminishing relationship and bond between the mother and the child, and I am significantly concerned regarding departmental officers not taking account of a number of reports that indicated an increase in contact is warranted. I understand that this decision may have been impacted by the charges laid against the mother on 19 August 2010; however, departmental officers were granted decision-making powers in relation to future contact arrangements, including authorizing unsupervised contact. Criminal charges, per se do not always impact on the goals of the case plan being implemented namely contact conditions specified in the case plan being implemented. Criminal charges may however impact on reunification decisions, as it would not be in the child's best interests to be reunified prior to the outcome of criminal proceedings being known.

I have assessed that it is in the child's best interests for a contact schedule to be immediately developed and implemented to clearly articulate to the child and the mother what frequency and types of contact will occur. Further, I have assessed that these decisions should be informed by the child's psychologist. Whilst I acknowledge the child has experienced child abuse, the child has not demonstrated ongoing fear or significant emotional reactions to contact with the mother. On review of the departmental records provided to the CCYPCG, the child has not made ongoing disclosures of child abuse, except for during the initial interview on 28 September 2009 and again during a conversation with

CSO2 on 18 November 2009[43]. The mother has willingly engaged with therapeutic support services to address the child protection concerns. Positive feedback from these therapeutic support services in relation to the mother's and the child's progress during counselling sessions would indicate an increase in contact should have occurred. There is a strong need for therapeutic support services to address contact between the mother and the child and in doing so, promote a healthy parent-child relationship and meet the child's attachment needs. Further, the mother needs to take responsibility for the child requiring statutory intervention, resulting in the need for out-of-home care and the impact this has had on his wellbeing and their relationship. It is important for the mother to demonstrate acknowledgement of the child protection concerns and remain focussed on addressing the child protection concerns to promote a safe and stable home environment for the child, for the progression of reunification.

Within the Department's comments to the preliminary report, the Department indicated that departmental officers have over the past 12 months encouraged the child to maintain a healthy relationship with his mother and to enjoy contact. The Department also indicated that departmental officers have worked with the child to express his views and wishes. The Department also referred to clinical and forensic psychologist recommending supervised contact continues until the following therapeutic goals were achieved by the mother:

- acknowledge and accept personal responsibility for complete sexual offending history
- improve understanding of human sexuality and identity, including normal sexual development and functioning, and sexual health
- develop an understanding of how sexual assault/offending negatively impacts the victim and to develop appropriate empathy for the child's victimization
- develop social and relationship skills to improve her ability to meet social/sexual needs through appropriate relationships with appropriate-age partners
- separate maternal-role, and nurturing rationalization from sexual behaviour; and to improve emotional processing skills to remediate other motivations if identified
- clarify her personal, past sexual-offence cycle; including thoughts, feelings, behaviours and situations preceding actual offences; and to demonstrate an ability to recognise any high risk aspects of the cycle
- actively change any identified distorted thinking and lifestyle issues that may have enabled her past sexual offending behaviour
- develop realistic, achievable self-intervention plans for each step in her sexual assault cycle; and to demonstrate an ability to intervene in cycle
- develop motivation and commitment to recovery and to remaining offence-free, and
- explore unresolved issuers from personal victimisation, sexual or other, and work toward changing any negative legacy of such on current functioning.

The Department indicated that the mother has not yet addressed the above therapeutic goals. I have assessed that these goals should have been included in the most recent case plan to ensure the mother understood that these specific goals must be addressed during therapy to support contact progressing to unsupervised contact. It would appear that the mother continues to engage in counselling to demonstrate her willingness to address the child protection concerns, improve her parent skills and insight and minimize the risk of future harm. However, the mother's therapeutic support service does not appear to have been informed of the above goals at the onset of the therapeutic intervention. Subsequently, the mother's engagement with therapeutic services does not appear to influence contact decisions. This fact negatively impacts on the child, as reunification goals have not been

[43] Departmental record of face to face meeting with the child conducted by CSO2, with the child's Community Visitor being present, on 18 November 2009

progressed and the lack of progression in contact appears to have negatively impacted on his attachment with his mother. It is acknowledged that the mother's therapeutic support service has now been informed of the need to address the above goals during therapy.

6. Case planning process

6.1 Case plans

The mother believes that she has complied with the case plan goals, however reunification has not progressed.

The case plan developed by departmental officers in conjunction with the mother on 27January 2010 articulated that the child protection concerns relate to the child being exposed to alcohol misuse by the mother [redacted] the mother perpetrating sexual abuse against the child, the mother not addressing the childhood sexual abuse she experienced through counselling, the mother's mental health needs requiring clarification and the mother demonstrating limited insight on the effects of this abuse on the child's emotional wellbeing. The outcomes for the case plan goals are summarized below:

- the mother to attend regular individual counselling with social worker at service provider 1 for 12-18 months or until the mother understands and is able to articulate:
  - the impact of her behaviour on the child's emotional wellbeing
  - age appropriate boundaries
  - "normal" child development
  - parenting skills development
  - how her alcohol misuse has affected the child
- joint counselling sessions with the mother and the child "to commence at a time when social worker believes they are emotionally ready and feel safe"
- the mother will not misuse alcohol in front of the child, and
- the child will attend fortnightly counselling with social worker to learn:
  - to be more confident in his relationship with the mother
  - to express his feelings and concerns without being overly worried about the mother's reactions and emotions.

The case plan also specified that the outcome of the psycho-sexual assessment of the mother conducted and completed on 19 December 2009 informed the above requirements of the mother. Contact arrangements documented in the case plan included twice weekly face to face contact from 2.45 pm to 4.35 pm and telephone contact with the mother on Mondays, Wednesday and Fridays (as requested by the child). Contact arrangements were to be reviewed by 27 April 2010.

My assessment

It is my assessment that this case plan was adequate; however it did not address important factors that contributed to the child experiencing harm by the mother. This is based on [redacted] information recorded in the Family Group Meeting document dated 18 November 2009:

- [redacted]

- [redacted]
- [redacted]

It is my assessment that the case plan should have included the mother addressing her emotional dependency on the child, and age-appropriate mother-child dyads during counselling. Further, counselling outcomes should have been more clearly articulated and focussed specifically on correlation between the mother's behaviours and the child's severe behavioural indicators of emotional harm, the effects of alcohol misuse on the mother's mental health stability, coping ability, decision making and risk of child abuse. Departmental officers should have also negotiated that the mother undergo a psychological assessment to determine if she has an undiagnosed mental health issue and the outcome of this assessment inform counselling goals.

The case plan refers to the childhood sexual abuse experienced by the mother as being an unaddressed issue; however this is not included as a topic to be addressed during counselling. The mother also experienced abandonment and emotional harm during her childhood. Research links these types of childhood abuse with adult attachment issues and combined with sexual abuse increase the negative impacts on the victim. These factors should have also been a focus of counselling to increase the mother's awareness of how her childhood emotional harm has negatively impacted on her adult relationships, emotional regulation, coping abilities and the child's wellbeing.

[redacted] the severity and frequency of the alleged child abuse has not been established. Although the child has advised his day care mother of incidents, he has not (to my knowledge) disclosed specific occurrences associated with these events.

[redacted] It is unclear if departmental officers have clearly articulated to the mother the severe behavioural indicators of emotional harm

[44] Record of interview with The mother on 29 September 2009
[45] Record of information gathered from day care provider
[46] Handwritten notes from carer in October 2009
[47] Report from service provider2 dated 29 July 2010

demonstrated by the child and how this has been assessed as directly related to the mother's parenting skills and behaviour.

Within the Department's comments to the CCYPCG preliminary report, the Department referenced the family group meeting (FGM) convenor's handwritten notes to indicate the mother's alcohol misuse, the effects of the mother's alcohol misuse on the child and behavioural indicators of the child's emotional state were discussed at length at the FGM. Further discussions were conducted during the FGM in relation to therapeutic support to be provided to the mother and child by service provider 1. This record has been reviewed and it is agreed that there is additional information in relation to the discussions held during the FGM. However, this record does not provided evidence of the specific discussions undertaken. More importantly relevant information should have been recorded on departmental database and articulated in the case plan.

The Department also indicated that the report from service provider 1 dated 18 December 2009 was received on the day of the FGM. It is acknowledged that this fact resulted in departmental officers not being informed of the extent of psychological factors impacting on the child and his mother, prior to the family group meeting. Although service provider 1 staff attended the FGM and would have been able to articulate the assessment outcomes of the draft report, it would have been difficult for departmental officers to incorporate all aspects of this report into the case plan at the time of the FGM. However, any specific psychological risk factors identified within the draft report could have been incorporated and negotiated with the mother, after the meeting and prior to the case plan being finalized.

The case plan review document dated 6 July 2010 noted that the mother had completed the following during counselling with social worker at service provider 1:

- safety plan
- education on the effects of sexual abuse
- trauma focused work related to the mother experience of childhood sexual abuse
- parenting skills development
- child development education
- boundary setting, and
- personal coping skills[48].

Counselling for the child with social worker of service provider 1 addressed:

- feeling awareness and recognition
- assertiveness language and behaviour
- protective behaviours education
- self-esteem and confidence building, and
- social skill development and relationship with the mother.

Joint counselling sessions between the child and the mother has focussed on their communication and interactions with each other. Contact observations recorded within departmental documents indicated the mother demonstrated improved boundary setting with the child, [redacted]

Further documented is the mother continuing to manipulate the child through her body language and also during telephone contact to avoid terminating the call[49].

[48] Assessment report dated created by CSO3 on 6 July 2010
[49] Assessment report dated created by CSO3 on 6 July 2010

The July 2010 case plan review also documented[50]:

- service provider 1 assessed the child to be at risk of emotional abuse, in the form of parentification of the child, and the mother seeking to meet her own emotional needs through the child
- service provider 1 to complete another Child Behavioural Checklist Test (CBCT) to establish a baseline for the child's emotional wellbeing at this point in time, and prior to contact changing, and
- contact to progress after the CBCT is completed, to include:
  - the mother collecting the child from school for contact sessions conducted on Tuesday and Thursday afternoons
  - CSSO1 supervising the remainder of these contact sessions at the mother's residence
  - the child to be advised contact is progressing to support future reunification
  - the child's homework to be completed during contact with the mother
  - safety plan to be developed by CSO3 for the above contact sessions
  - telephone contact to continue 3 nights per week and discussion to occur with carers in relation to the child using Skype to engage with the mother during telephone contact
  - the mother will engage in semi-supervised contact with the child on his birthday
  - the mother to also attend a birthday party with the child on [redacted]

The August 2010 case plan did not however acknowledge the above progress made by the mother and the child in addressing the previous case plan outcomes. Subsequently, the outcomes for the August 2010 case plan remained the same as the previous case plan. It was specified in the August 2010 case plan that service provider 1 has requested the mother engage in counselling with social worker for another six months and feedback be provided to the Department on the mother's progress in addressing the child protection concerns.

The August 2010 case plan indicated that a referral had been made to a support agency to engage with the mother and the child, as this service works closely with families in an effort to safely reunify children with their parents. Monthly feedback received by the Department from this service was intended to guide reunification and contact progression.

The case plan dated 24 May 2011 indicated that the same child protection concerns were present as those documented in the first case plan development in January 2009. The rationale for the case plan goal of reunification is similar to what was listed in the August 2010 case plan, specifically indicating that the mother would work with a reunification service to demonstrate her capacity to care for the child and ensure he does not experience sexual abuse or emotional harm in the future.

In general, the case plans developed throughout the intervention period do not adequately reflect the progress made by the mother during counselling to address the child protection concerns held by departmental officers. Social worker reported in July 2010 that the mother has shown remorse over the abuse she perpetrated towards the child, she understands child psychological/emotional and physical developmental stages and she has been developed healthy cognitive skills when dealing with the effects of her childhood abuse[51]. However, the outcome section of the May 2011 case plan is seeking confirmation from the mother's counselling service that she is able to comprehend and understand the impact of her behaviour on the child's wellbeing and discuss "normal" child development and mother-child

[50] Assessment report dated created by CSO3 on 6 July 2010
[51] Report prepared by social worker service provider1 dated 30 July 2010, page 2.

interactions[52]. Reference is also made to the mother not misusing alcohol while caring for the child or during reunification.

It is my assessment that a strengths-based approach would be more conducive for maintaining a collaborative working relationship between departmental officers and the mother. Consideration of the progress made by the mother and the child since 29September 2009 should have been more clearly articulated and the case plan goals reflective of this progress. Further, the case plan goals must be more specific in relation to what was required of the mother to achieve in counselling sessions prior to reunification progressing, given she had been engaging with service provider 1 staff since November 2009 to address the abovementioned child protection concerns and case plan goals.

6.2 Family Group Meeting (FGM) procedures

The mother indicated that the FGM was not appropriately facilitated, the conduct of departmental officers were inappropriate and during the initial FGM, departmental officers discussed the mother's personal child protection history in front of her support persons without her consent.

My assessment

I have been unable to establish whether the mother was informed that specific information relating to the alleged child abuse of the child and her history of childhood sexual abuse would be discussed at the FGM. I am aware that it is a standard of practice that FGM convenors must ensure participants are provided with information and understand the FGM process and agenda items to be discussed during the FGM. The initial stages of the FGM or interview with participants allows FGM convenors to gain an understanding of parents and stakeholder's position and to raise any concerns/issues parents may have and confirm whether they would like some items from the agenda list removed or added.

I have been unable to establish whether the mother was informed that specific information relating to the child abuse of the child or her history of childhood sexual abuse would be discussed at the FGM. Section 51M of the CPA stipulates departmental officers' legislative requirements to inform parents/stakeholders of information pertaining to FGMs and what is to be discussed at the FGM and section 187 of the CPA stipulates legislative requirements of maintaining confidentiality within FGM. It is unclear whether participants were made aware of this requirement.

Information contained within departmental records indicated that the FGMs conducted with the mother have been appropriate. However, I have been unable to determine the emotional content of these meetings and subsequent conduct of all parties. I acknowledge the mother feelings and that FGM's can be difficult to mediate, as parents often have competing viewpoints to that of the Department. In my opinion, it will be important for all parties to acknowledge previous conflict during meetings and to agree to adopt a strengths-based approach to achieving the joint outcome of addressing the child's daily care and protective needs. I encourage the mother to focus on negotiating appropriate boundaries for future interactions with departmental officers.

[52] Case plan for the child dated 24 May 2011

6.3 The Department not taking the child's wishes into account

The mother believes departmental officers have not taken the child's wishes into account when determining contact arrangements and progression of reunification.

My assessment

In my view the child's wishes do not appear to have been responded to by departmental officers, as the child appears to have requested to be returned home on a number of occasions throughout the intervention[53,54, 55] at least until January 2011. However, in making a determination about what is in the child's best interests, departmental officers need to take into account the child's ability to make this determination given his young age and also the likelihood of harm occurring if the child was reunified with the mother prematurely.

During the social assessment conducted in November 2010, the child advised the social assessor that "I'm just lost" and that his first choice would be to live with his mother[56]. The social assessor articulated that the focus on proving the mother to be an unfit mother has been at the expense of insufficient attention to the psychological welfare of the child[57]. The social assessor documented that the child is being "emotionally damaged" by being in care, noted in his presentation observed by social worker and the social assessor[58]. This opinion was further supported by the child advising the social assessor that he cries when no-one else is present.

During the clinical and forensic psychologist's assessment, the child advised that his first wish was to be returned to his mother's care. The child indicated that he had been placed in out-of-home care [redacted] The child indicated that he enjoyed contact arrangements with the mother. The child also indicated that he has asked his CSO to be returned to the mother's care and that it is a "bit annoying sometimes" that he cannot return immediately to her care. Like the social assessor, interactions between the child and the mother were observed by the clinical and forensic psychologist to be appropriate.

Based on the feedback received from professionals involved in this case, I have assessed that it would have been in the child's best interests for a gradual progression towards reunification to have commenced in November 2010. However, this progression would be dependent on the mother demonstrating her ability to set age-appropriate boundaries, respond appropriately to the child's needs and demands, and most importantly, demonstrate her ability to take responsibility for the child abuse perpetrated by her against the child.

[53] Affidavit prepared for the Childrens Court of Queensland, by CSO3, sheet 5, paragraphs 14, 20 and 30
[54] Report prepared by social worker service provider1 dated 30 July 2010, page 3.
[55] Report prepared by social worker service provider1 dated 30 July 2010, page 3
[56] Updated social assessment by social assessor dated 12 November 2010, page 9, paragraph 6.3
[57] Updated social assessment by social assessor dated 12 November 2010, page129, paragraph 7.6
[58] Updated social assessment by social assessor dated 12 November 2010, page 12, paragraph 7.6

identify triggers for her behavioural responses to situations that place the child at increased risk of harm, identify strategies to prioritize the child's needs over her own, address her emotional needs and clearly articulate the impact of her behaviour on the child's short and long term wellbeing and social development. It should also be noted that the mother has been developing this insight throughout the statutory intervention period by engaging with therapeutic services.

6.4 Parental strengths and needs assessment/reassessment document (PSNA)

Departmental records indicated that PSNA documents were created on 24 November 2009 by CSO2 and 8 October 2010 by CSO3, with similar responses, including the following:

- *Alcohol and drug misuse evident by the mother.* [redacted]
- *Limited support networks, however recently commenced engaging with* service provider 1 *at the Department's request*
- *Destructive/abusive parenting skills towards the child.* CSOs referred to the mother denial and minimization of the child protection concerns and more specifically the sexual abuse of the child
- *Inadequate emotional stability, as the mother identifies as experiencing depression and Obsessive Compulsive Disorder and through speaking to a counsellor at Centacare she now believes she has Bipolar Type 1. The mother has significant emotional issues in relation to her past sexual abuse. The mother personal presentation might reflect a possible mental illness due to her erratic mood, lack of understanding, etc, and*
- *Childhood harm as a result of abuse/neglect, major current negative effects: the mother has a childhood history of sexual abuse by her father which occurred from the time she was 9 until 14 years old.* [redacted]

Both CSOs selected the following parental needs within the PSNA:

- *Alcohol and drug use*
- *Social/community support network*
- *Parenting skills*
- *Mental/emotional health*
- *Parental history of child abuse and neglect*

The rationale for assessment of priority needs documented on the PSNA was as follows:

- *the mother has significant issues in relation to her past sexual abuse which she has not addressed. It is believed that when the mother starts to address her past abuse, then she will find other coping mechanisms besides alcohol, and*

- *the mother has offended against her child sexually and this issue is the primary concern and needs to be addressed so she does not continue to offend against the child if he was to be reunified with her in the future.*

My assessment

The PSNAs completed by CSO2 and CSO3 raise significant practice issues. Firstly, these documents were a direct duplication, and CSO3's assessment does not take into account the following:

- the influence of counselling provided by service provider 1 on the mother's insight into the inappropriateness of her behaviours
- the mother engaging with drug and alcohol service, without direction from departmental officers to do so
- the outcome of psychosocial assessment by service provider 1 that indicated the child was at low/no risk of future sexual abuse being perpetrated by the mother
- the outcome of the first social assessment by the social assessor and reports by service provider 1 indicating the mother had developed more social/community support networks, and
- reports by service provider 1 indicating the mother had undertaken steps during counselling to explore the effects of her history of childhood abuse.

Secondly, to my knowledge, and based on the information provided to the CCYPCG, service provider 1, the departmentally nominated counselling service for the child and the mother were not advised that the mother's alcohol misuse was to be the dual focus during individual sessions with her and the child. It is acknowledged that the case plan makes reference to service provider 1 addressing the mother's alcohol misuse and the court coordinator's handwritten notes from the FGM conducted in January 2010 indicating some level of discussion occurred in relation to this matter. The case plan does not place sufficient emphasis on the impact of the mother's alcohol misuse on the child's wellbeing. Nor does the case plan clearly identify what goals must be achieved by the mother to demonstrate her insight into the effects of alcohol misuse on her parenting ability, her psychological and cognitive functioning, the child's safety and wellbeing and the need for her to develop and implement alternative coping skills. This would appear to be an oversight, given the emphasis placed on the mother's alcohol misuse in the PSNAs and by the child. Although alcohol misuse has been identified as a major issue within the PSNA, departmental officers have not addressed the impact of the mother's alcohol misuse on her parenting ability. Nor have departmental officers determined the frequency and level of alcohol misuse that occurred within the home whilst the child was present, [redacted]

Further, there has been no additional information provided to the Department to indicate that this level of alcohol misuse was an ongoing occurrence or that the mother continues to misuse alcohol. I acknowledge the mother indicated that she commenced misusing alcohol 9 years ago and that she had used alcohol as a form of self-medication. However, the mother also stated that she recently ceased drinking excessively and only had one or two wines per day. The mother's reduction in alcohol consumption prior to departmental intervention was also confirmed by the child[59]. Subsequently, the statements within PSNA relating to alcohol misuse appear to be a biased opinion, rather than an informed fact. Although alcohol

[59] Record of Interview for the child conducted on 28 September 2009 and created by CSO2

consumption was a major concern for the child, departmental officers have not addressed this fact during the 10 month intervention period.

Thirdly, the mother indicated that she had experienced depression. The service provider 1 report indicated that the mother sought professional assistance to address this issue at that time. Social worker also indicated *"the mother's locus of control appears quite stable in all aspects other than in relation to the allegations"*, however her mood was *"liable"*[60]. Although the mother indicated she may have mental health disorders, the mother was not requested to undergo a psychiatric evaluation or psychological testing to determine if she met diagnostic criteria for a mental health disorder. This would appear to be a significant oversight by departmental officers, as the outcome of a psychological assessment would have informed treatment options for the mother and the impact of any identified mental health disorders on the child's safety and wellbeing. This oversight can be attributed to the emphasis placed on addressing the inappropriate sexualized incidents between the mother and the child, opposed to a holistic assessment informing decisions relating to the most appropriate therapeutic support service for the child and the mother.

Fourthly, to my knowledge the assessments conducted on the mother to date have not indicated that she experiences significant emotional issues in relation to her childhood sexual abuse or that she presents with erratic mood. Nor has the treating psychologist for the mother indicated that her alcohol misuse is the result of unaddressed childhood sexual abuse issues. Although the mother's childhood sexual abuse has been linked with her adult functioning, these comments appear to be subjective, as comprehensive psychiatric or psychological testing has not been conducted on the mother.

Finally, the comment in relation to the mother perpetrating "sexual violence" against her son for a number of years[61] appears to be unfounded. There is no indication within the information provided to the CCYPCG that the mother perpetrated sexual violence. Furthermore, the child has not particularized the sexualized incidents that occurred with the mother, nor has he indicated that these incidents occurred over a number of years.

I do, however, agree that the mother familial childhood abuse is likely to have impacted on her parenting abilities and in particular her ability to set age-appropriate boundaries. Whilst research indicates that adult survivors of childhood abuse may experience a range of dysfunctional behaviours, including drug and alcohol dependency issues, there were a number of other contributing factors that resulted in the mother choosing to misuse alcohol as a coping mechanism. The mother experience of childhood abuse was not limited to sexual abuse. I have assessed that the emotional harm perpetrated by significant others against the mother, including her father, mother and step-mother should have been a major focus of counselling sessions, rather than solely focusing on her experience of childhood sexual abuse. Although the mother's experience of childhood abuse may be the underlying or perpetuating factors that influence her decision-making, emotional regulation, adult relationships, cognitive functioning and behaviours, the causal factors should have been determined by psychological testing and counselling during the assessment process.

The rationale for the outcome of the assessment of the PSNA by CSO3 remained focused on the mother's sexual offending and possible recidivism, if left unaddressed. However, the mother had engaged in counselling and psychosexual assessment with service provider 1. The assessment identified the mother to be low risk of sexually offending against the child in

[60] Psychosexual report dated 18 December 2009 by risk assessor, service provider1
[61] Parental Strengths and Needs Assessment (PSNA) document dated 24 November 2009, created by CSO2, PSNA6.

the future[62,63]. I have assessed that the appropriate outcome would have been to focus on the mother developing a comprehensive understanding of the effects of her cognitive functioning and behaviours on her parenting abilities and the child's long term wellbeing and attachment needs, and the mother developing more appropriate coping mechanisms. This in turn would have addressed any unresolved childhood issues and provided the mother with increased understanding of how her childhood abuse (both sexual abuse by her father and emotional abuse by her mother, step-mother and father) was influencing her adult decisions and placing the child at increased risk of harm.

6.5 Family reunification assessment document

The Family Reunification Assessment document - created on 13 July 2010 by CSO3, with the following options selected:

- the risk level from the most recent family risk evaluation was recorded as very high, and
- parental behaviour indicates some progress in one or more of the priority outcome areas and partial participation in pursuing case plan actions.

The outcome was recorded as high, however a discretionary override was applied and the outcome adjusted to very high. The reason for the override was that sexual abuse was substantiated during the investigation and assessment and the person responsible is likely to have access to the subject child.

CSO3 documented that the mother had progressed and/or achieved "most" of the contact outcomes and actions[64]. The responses chosen by CSO3 in *Section C – Parental reunification safety assessment* were as follows:

- Yes to Q2 - During the current implementation period, has a parent or other household member sexually abused a child; or if the child was sexually abused prior to removal, do circumstances suggest that the child's safety may still be of immediate concern?"
- No to Q8 – "Would the child's immediate care and protection needs remain unmet due to the parent's misuse of alcohol or drugs, should reunification occur?"
- No to Q10 – "Is the child exhibiting severe behavioural indicators of emotional harm as a result of a parent's emotionally abusive treatment of the child?", and
- No to Q11 – "Are the child's immediate care and protection needs likely to remain unmet due to the parent's emotional instability, intellectual or physical disability or mental health issues, should reunification occur?".

CSO3 indicated that the risk to the child (if reunified), could be managed by CSO and CSSO supervising contact and the child and the mother attending service provider 1 (refer to "Safety Interventions and Plan" section). CSO3 also recorded reunification to be the outcome of this assessment[65].

[62] Report by risk assessor, service provider1, dated 9 April 2010, paragraph 4.3
[63] Report by social worker, service provider1, 30 July 2010, page 1
[64] Section B – Parent-child contact visit plan evaluation, Parental Strengths and Needs Assessment dated 13 July 2010 created by CSO3
[65] Section E – Permanency plan recommendation summary section, Parental Strengths and Needs Assessment dated 13 July 2010 created by CSO3

My assessment

CSO3 did not complete the resolution of harms section. This would appear to be a practice issue, as the CSPM indicates that this section must be completed when there has been a change in the circumstances since the initial assessment was conducted. The child was initially identified in the safety assessment to be demonstrating significant emotional harm as a result of the mother's "emotionally abusive treatment" of the child, and the child's immediate protection and care needs had not been met due to the mother's alcohol misuse. Subsequently, 3 should have identified how these issues had been addressed during the nine month statutory period (refer to the above responses to Q8, Q10 and Q11).

The outcomes specified within this family reunification assessment appear to contradict the PSNA, which was also conducted by CSO3. More specifically, the responses to Q8, Q10 and Q11 above, completed in July 2010, are diametrically opposite to the outcome of the PSNA completed in August 2010. It is unclear what evidence was obtained between July and August 2010 that supported CSO3 changing his assessment of the impact of the mother's alcohol misuse and mental health stability on the child's wellbeing and her parenting ability. Further, the lack of progression in contact between the mother and the child since August 2010 is not supported based on the outcome of this assessment.

The outcome of the family reunification assessment being recorded as "very high" is not supported. I understand that a policy override was applied, due to the previous sexualized incidents between the mother and the child. However, this decision does not show due consideration to the fact that the mother had willingly engaged with services nominated by the Department to assist her address the child protection concerns. I acknowledge that observations during some of the initial contact sessions raised concerns in relation to the interactions between the child and the mother being inappropriate. Professionals, such as social worker, risk assessor and the social assessor did not make the same assessment. Social worker indicated to the social assessor in November 2010 that observations of affectionate interactions between a mother and child are subjective in relation to what determines an interaction to be overly affectionate[66].

These professionals agree that the child is at low or no risk of future harm caused by sexual abuse from the mother[67,68]. These professionals instead raise concerns over the child being at risk of emotional harm, due to the mother emotional dependency issues[69]. I acknowledge the risk of emotional harm to the child and the risk of emotional harm caused by sexual abuse to the child, if the mother does not receive appropriate therapeutic support to identify appropriate boundaries and indicators of child abuse, learn to adopt more appropriate self-regulation and coping skills and develop healthy relationships with significant others. The mother recognizes the need for further personal development; subsequently she is continuing to seek therapeutic support to demonstrate her commitment to providing a safe and stable home environment for the child.

[66] Social assessment written by social assessor, dated 5 July 2010, page 8, paragraph 4.2
[67] Updated social assessment written by social assessor, dated 12 November 2010, page 6, paragraph 4.3
[68] Social assessment written by social assessor, dated 15 July 2010, page 18, paragraph 7.4
[69] Social assessment written by social assessor, dated 15 July 2010, page 17, paragraph 7.2

7. Therapeutic intervention

7.1 Concerns regarding counselling arrangements for the child

The mother raised concerns over therapeutic support for the child ceasing and not re-commencing at the onset of the child demonstrating an alleged regression in his behaviours. The mother also questioned the rationale for the Department not submitting a new referral to service provider 1 for therapeutic support for the child.

My assessment

It is of significant concern that the Department recommended the child engage with staff at service provider 1 and after a therapeutic relationship was built and substantial work conducted by social worker at service provider 1 with the child, the Department determined that this service was not the preferred therapeutic support service to meet the child's ongoing needs.

I understand the potential conflict of interest given the same therapist was treating the child and the mother, however the rationale for ceasing counselling for the child and joint counselling for the child and the mother when both parties were making significant progress is not supported. Departmental officers were aware that social worker was providing counselling support to both the child and the mother, as this fact had been clearly documented in discussions between departmental officers and staff at service provider 1 and within Family Group Meetings[70].

On 14 March 2011, carer2 requested the child re-commence counselling with social worker at service provider 1, as she had noticed a regression in his behaviour[71]. On 16 March 2011, carer2 advised CSSO1 that the child experienced some level of distress over his involvement in the case plan process. She also advised CSSO1 that the child had disclosed that "what worries me [the child] most is leaving ... [carer1] and going to see mum [the mother] Tuesday"[72]. Departmental officers do not appear to have responded in a timely manner to either carer2's or the mother's request that the child re-commence counselling. The delay in coordinating alternative therapeutic support for the child is unknown and appears to have negatively impacted on his emotional wellbeing.

Within the Department's comments to the CCYPCG preliminary report, the Department confirmed that the counselling services of service provider 1 could not continue for a number of reasons, including the mother's solicitor and Crown Law advising this counsellor was not qualified in relation to the criminogenic issues of the case. The Department also acknowledged that the delay in the child re-commencing counselling was unacceptable. The

[70] Written correspondence from mother's Lawyer
[71] Email correspondence from carer2 to CSO3 dated 14/3/11 requested the child re-commence counselling due to a regression in his behaviour and a contact visit with The mother that negatively impacted on the child's emotional wellbeing
[72] Case note created by CSSO1, dated 23 March 2011 contains record of telephone call between CSSO1 and carer2

Department advised that this was a consequence of the referral process not being correctly completed by the child's general practitioner.

8. Social and psychological assessments

During the first 13 months of the statutory intervention, the child and the mother have participated in the following assessments:

Assessor	Therapeutic support agency	Date of report	Purpose
risk assessor	service provider1	23/11/09	psycho-sexual assessment
risk assessor	service provider1	18/12/09	psycho-sexual assessment
risk assessor	service provider1	01/06/10	review of progress since psychosexual assessment
social assessor	private consultant	05/07/10	social assessment
social worker	service provider1	30/07/10	report on counselling
social assessor	private consultant	12/11/10	social assessment
clinical and forensic psychologist	private therapist	09/11/10	risk assessment report

Departmental officers also requested social worker interpret drawings by the child (report provided on 23/11/09) and Sexual Abuse Counselling Service review the case (report provided on 28/7/10).

The mother also obtained independent reports by two specialists (dated 24 February 2010 and 25 March 2010), which reviewed the reports provided by staff at service provider 1. She also engaged with Drug and Alcohol treatment service and provided a report by specialist 3 dated 29 April 2010.

On 16 April 2010, departmental court coordinator wrote to the child's separate representative suggesting an expert in child abuse be appointed to conduct a social assessment, as the mother's legal representative has previously challenged the credentials of the counsellor/assessor at service provider 1[73]. Correspondence in May 2010 written by the child's independent separate representative to the mother and departmental court coordinator advised that the social assessor would conduct a social assessment for the child on 20 June 2010[74]. Within this correspondence to the mother, the child's independent separate representative indicated that the social assessor has extensive experience in providing assessments to assist the Childrens Court. Interviews with the child and other relevant parties were conducted on 21 June 2010 and again on 7 and 8 October 2010 to inform the outcome of the social assessments conducted by the social assessor.

Written correspondence between CSO3 and clinical and forensic psychologist from 22 September 2010 to 14 October 2010 confirmed that the Department only required clinical and forensic psychologist conduct a risk assessment, not a social assessment[75, 76, 77]. Clinic

[73] Correspondence from departmental Court Coordinator to mother's Lawyer and the child's Independent Separate Representative dated 16 April 2010 and facsimiled on the same date
[74] Copy of written correspondence from mother's Lawyer and the child's Independent Separate Representative to mother's Legal Representative and the child's father dated 12 May 2010, and to CSO3 dated 27 May 2010.
[76] Email correspondence from clinical and forensic psychologist to CSO3 confirming his availability to conduct a social and risk assessment for the child.

al and forensic psychologist advised that he would conduct interviews with the child and other relevant parties on 2 November 2010 and that he would provide his report before the next Childrens Court hearing.[78]

My assessment

Departmental officers requested the mother attend service provider 1 for a psycho-sexual evaluation. Departmental officers should have been aware of the qualifications of the service provider 1 staff prior to the referral being made and prior to utilising this service for psycho-sexual counselling. Departmental officers did not seek this clarification until October 2010[79], due to the mother's legal representative questioning the credentials of the service to provide a psycho-sexual assessment. Based on the information provided to the CCYPCG by the Department, there is no indication that therapeutic support provided by service provider 1 was ineffective to support referral of the child and the mother to an alternative therapeutic support service.

It should be noted that within the Department's comments to the CCYPCG preliminary report, the Department confirmed that service provider 1 is a departmentally funded sexual assault counselling services. This service is also utilized by Probation and Parole to information interventions for sex offenders. The Department did not therefore question the credentials of this service.

The mother willingly engaged with service provider 1, inclusive of individual and joint sessions with the child. The risk assessor of service provider 1 advised CSO2 on 22 October 2009 that social worker had been allocated to work with the child and the mother[80]. Although feedback was provided to departmental officers between November 2009 and July 2010,[81,82,83] departmental officers did not question the fact that the social worker was providing individual and joint counselling to the mother and the child. Counselling services to the child and the mother by social worker was discussed with departmental officers and recorded in departmental records, including discussions held at Family Group Meetings[84,85,86]. The fact that social worker was providing individual and joint counselling to the child and the mother would appear to be an oversight by departmental officers and should not impact on the progression of the case plan.

This decision has, however, had a significant impact on the case management and case planning processes, given departmental officers have not accepted the recommendations of service provider 1, subsequently requesting sexual offenders risk assessment be conducted

[76] Email correspondence from CSO3 to clinical and forensic psychologist confirming the Department only required a risk assesement report for the child
[77] Written correspondence from CSO3 to clinical and forensic psychologist requesting a risk assessment report be provided to the Department
[78] Email correspondence from clinical and forensic psychologist to CSO3 advising interviews would be conducted with relevant parties on 2 November 2010 as part of the risk assessment
[79] Email correspondence between departmental Senior Practitioner and risk assessor dated 3 October 2010 confirmed that risk assessor is not a registered psychologist, however specialized in the assessment and treatment of sexual offenders during the risk assessor's Masters degree
[80] Written correspondence from service provider1 dated to CSO2 dated 22 October 2009
[81] Written correspondence from service provider1 dated to CSO2 dated 22 October 2009
[82] Report provided by risk assessor, service provider1 dated 9 April 2010
[83] Report provided by social worker, service provider1 dated 30 July 2010
[84] Family Group Meeting referral document dated 18 November 2009 written by FGM convenor documented that social worker was providing counselling to both the child and The mother
[85] Family Group Meeting referral document dated 24 June 2010 written by FGM convenor documented that social worker was providing counseling to both the child and the mother
[86] Case plan document dated 27 January 2010, written by FGM convenor documents that social worker was to continue to provide counselling for the mother and the child

by an expert in this field to inform the Department's reunification process[87]. It is my assessment that this decision should have been made prior to the mother and the child engaging with therapeutic services as the progression of reunification has been significantly delayed.

Similarly, the recommendations made by the social assessor were not accepted by the Department, choosing to engage the services of clinical and forensic psychologist to conduct another assessment of the child and the mother. While it is acknowledged that the social assessor was commissioned by the Childrens Court to conduct social assessments on 5 July 2010 and 12 November 2010, it is unclear whether departmental officers suggested that a clinical and forensic psychologist would be more qualified to perform the social assessment than the social assessor given the sexual abuse allegations against the mother.

In response to the CCYPCG preliminary report, the Department also advised that the Department's crown law counsel gave instructions to departmental officers to organize for an expert risk assessment to be conducted to determine whether the risk of *sexual and emotional harm* had been *alleviated to an acceptable level* and make recommendations in relation to reunification.

The child has been required to undergo four assessments within an 18 month period and will now be required to develop rapport with his new psychologist to address his needs and his relationship with the mother. This level of inquiry would appear excessive, especially given the child's young age.

It would appear that the mother has been cooperative during counselling sessions and social assessments, which is evident by the disclosures she has made during these sessions. The mother has willingly participated with services nominated by the Department. Although the Department continues to indicate that the mother has not acknowledged the abuse perpetrated by her on the child, contextual information provided within the professional assessments indicate that the mother has acknowledged that she demonstrated inappropriate behaviour and had limited insight into age appropriate boundaries. It is my assessment that departmental officers need to acknowledge this fact and the progress the mother has made through her willing engagement with therapeutic support services. Further, departmental officers should acknowledge the mother's willingness to engage with recommended services, as parents are often reluctant to do so, especially the alleged perpetrators of sexual abuse.

While the majority of assessments conducted have recommended contact be increased to progress towards reunification, all the assessments conducted have stipulated caution is required and the need for the mother to engage in long term counselling to address her psychological needs and develop further insight into the effects of childhood abuse on long term wellbeing and functioning of the victim.

In summary, the major child protection concern and common theme within all the assessments conducted is the risk of the mother emotionally harming the child. Overall, all the assessments conducted have recommended ongoing therapeutic support for the mother to assist her:

- continue to develop an understanding of the child's emotional needs and the ability to effectively separate her own needs from those of the child

[87] Email correspondence between CSO3 and clinical and forensic psychologist dated 22 and 24 September 2010

- continue to develop an understanding of how her childhood sexual abuse history has impacted on her emotional regulation[88], abilities as a parent and her ability to implement appropriate boundaries, and
- take responsibility for abuse perpetrated against the child[89], recognize and understand indicators and triggers associated with child abuse[90].

The mother and the child have been subjected to a number of assessments. It is my assessment that this should not have been necessary, departmental officers should have initially recruited the services of an expert in sexual offending to inform the case plan and more importantly the therapeutic response.

8.1 The Department disregarded the outcomes of all assessments conducted, except for clinical and forensic psychologist's assessment, which supports their views

The mother questioned the Department placing more emphasis on the outcome of the assessment conducted by clinical and forensic psychologist and not taking into consideration the outcomes of previous assessments conducted by the social assessor and staff at service provider 1. The mother believes departmental officers requested a clinical and forensic psychologist conduct an assessment, as departmental officers were unwilling to follow the recommendations made by other professionals in relation to reunification of the child with the mother.

My assessment

I acknowledge the mother's feelings in relation to departmental officers seeking additional assessments to inform the case planning and reunification processes. The rationale for this direction is unclear, however appears to be based on departmental officers disagreeing with the outcome of previous assessments and having ongoing concerns in relation to the child experiencing further emotional harm if he was reunified with the mother.

The major difference between the report provided by clinical and forensic psychologist and the other assessments conducted is that the clinical and forensic psychologist's report is more prescriptive and has been informed by inclusion of additional psychological assessment measures. The outcome of clinical and forensic psychologist's report recommended a six month review of progress made by the mother to address specific issues during counselling[91]. While other professionals supported progression to unsupervised contact and the goal of reunification occur in 2010, these professionals also recommended further therapeutic support be provided to the mother to enhance her understanding and recognition of the effects of childhood abuse.

For example, the mother advised the social assessor in November 2010 that she *"knows now that what she did was inappropriate but"*[92] she *"never had the intention of anything abusive"*.

[88] Psychosexual assessment report dated 18 December 2009 by risk assessor, service provider1, pg 13
[89] Psychosexual assessment report dated 18 December 2009 by risk assessor, service provider1, pg 14
[90] Psychosexual assessment report dated 18 December 2009 by risk assessor, service provider1, pg 14
[91] Risk assessment report for the child by clinical and forensic psychologist, dated 8 November 2010, paragraph 135
[92] Updated social assessment conducted by social assessor dated 12 November 2010, page 7, paragraph 5.3

The mother stated that the child is her *"purpose"*, which the social assessor believes is an example of the reason departmental officers view the mother as emotionally exploitative[93]. The social assessor stated that the mother *"must somehow demonstrate to the Department that she does not need her son in order to feel emotionally fulfilled"*[94], for reunification to occur. The social assessor indicated that other comments made by the mother, such as *"the child was holding back tears as he knew it upsets the mother*[95]*"* and *"he is always thinking of the mother"*, are indicative of the dysfunctional and emotionally abusive relationship that existed between the child and the mother (the child felt compelled to worry about his mother's emotional wellbeing), prior to the child being placed in out-of-home care[96].

The social assessor refers to the mother being placed in a *"Batesonian Double Bind"*[97], whereby *"there is an expectation that she make forthright and overt admissions around her behaviour, in exchange for which she is punished. Or, she maintains her position around lack of intention to harm, which results in punishment because she is deemed to be minimising and insightless."* Social assessor also highlights *"systemic messages relating to parents not questioning departmental decisions because, to do so, and fight to be with your child, further confirms a lack of insight and awareness*[98]*."* Social assessor however agreed that the behaviours demonstrated by the mother depict a *"psychologically unhealthy relationship with the child and that there is a need for the mother to understand why the Department is continuing with their application"*[99]. *The social assessor* articulates that this is also *"the reason other experts have been somewhat ambivalent about making recommendations for the child's living arrangements"*[100].

In an earlier report written by social assessor (dated 5 July 2010), she indicated that although the mother understands the extent of the inappropriateness of her behaviour towards the child[101], the mother exposure to adults who have denied or underestimated the harm they caused her, has influenced her tendency to minimise the consequences of her behaviour on the child[102]. The social assessor emphasised the need for the mother to recognise the impact of those experiences on her own behaviour. Dialectical Behaviour Therapy or counselling was recommended by social assessor to raise the mother's *"awareness of her own legacy of loss, trauma, abuse and abandonment"*[103] and focus on the mother developing an internal locus of control rather than relying on external factors (e.g. the child) to meet her emotional needs. Additionally, the mother needs to develop insight and awareness of the child's needs and perspectives and differentiate these needs from her own[104].

The psycho-sexual reports by the risk assessor dated 23 November 2009 and 18 December 2009 recommended the mother engage in a long term (12-18 month) therapeutic intervention, underpinned by the following objectives[105]:

- facilitate the mother's acceptance and responsibility for sexually abusing the child

[93] Updated social assessment conducted by social assessor dated 12 November 2010, page 7, paragraph 5.4
[94] Updated social assessment conducted by social assessor dated 12 November 2010, page 7, paragraph 5.4
[95] Updated social assessment conducted by social assessor dated 12 November 2010, page 8, paragraph 5.6
[96] Updated social assessment conducted by social assessor dated 12 November 2010, page 8, paragraph 5.6
[97] Updated social assessment conducted by social assessor dated 12 November 2010, page 10, paragraph 7.1
[98] Updated social assessment conducted by social assessor dated 12 November 2010, page 10, paragraph 7.1
[99] Updated social assessment conducted by social assessor dated 12 November 2010, page 11, paragraph 7.3
[100] Updated social assessment conducted by social assessor dated 12 November 2010, page 11, paragraph 7.3
[101] Social assessment conducted by social assessor dated 15 July2010, page 17, paragraph 7.1
[102] Social assessment conducted by social assessor dated 15 July2010, page 17, paragraph 7.1
[103] Social assessment conducted by social assessor dated 15 July2010, page 17, paragraph 7.1
[104] Social assessment conducted by social assessor dated 15 July2010, page 17, paragraph 7.2
[105] Psychosexual assessment report dated 18 December 2009 by risk assessor, service provider1, pg 14

- develop the mother understanding of her pattern of offending, including beliefs, cognitive distortions and triggers that led her to sexual offending
- resolve the mother sexual abuse issues as a child, and as an adult
- develop emotional regulation and awareness, including intellectual and emotional empathy, victim awareness
- gain a greater understanding of sexual issues and sexuality in herself and her son
- address relationship issues with past partners, parents, peers, and children (including developmentally appropriate behaviour)
- develop her social skills, including age appropriate boundaries, social networks, healthy relationships, and
- enhance her self-esteem and self-concept.

It is my assessment that departmental officers need to clearly articulate what ongoing concerns they have in relation to the mother perpetrating emotional harm to the child in the future and what evidence-based assessments support this belief. Departmental officers should also articulate in detail to the mother the reason for not taking action based on the recommendations made by service provider 1 and social assessor. Further, departmental officers must, in conjunction with either clinical and forensic psychologist, and/or current psychologists linked with the mother and the child, clearly articulate the specific issues/topics to be addressed in counselling and the measures that will be used to determine whether the mother has addressed these issues prior to support for unsupervised contact and reunification progressing.

9. Placement arrangements

9.1 Placement instability/number of placements

The mother raised concerns over the child being subjected to multiple placements within a short timeframe.

My assessment

It is acknowledged that the child has experienced a number of placement changes, however some of these placements have been utilised for respite care. It is standard departmental practice to provide respite care for children in out-of-home care, when required by the child's primary carer.

The child has experienced several placements, and some of these placements represent transitions to alternative primary placements. Although it is not ideal for the child to have experienced instability in his primary placements, I have assessed that the child has experienced placement stability with carers 1 and 2. This placement has been a very positive experience for the child and he has been able to form a strong bond with these carers. It was unfortunate that the child's experience of care was not the same, when these carers experienced circumstances that prevented them from continuing to care for the child.

9.2 Selection of carers

[redacted]

My assessment

Although departmental officers make attempts to match a child with carers prior to placement, the appropriateness of the placement is dependent on a number of factors related to the child, the carers and other children residing in the placement. Departmental officers responded to the child indicating he did not wish to reside with carers3 and if he could not return to the care of carers 1 and 2 then he wanted to return home. Subsequently, departmental officers arranged for the child to be transitioned into carer1's care. This appears to have been an appropriate decision.

I recommend future placement decisions be discussed and negotiated, if possible with the mother and the child. Alternatively, the mother may consider submitting an application to the Queensland Civil and Administration Tribunal to resolve placement options for the child.

10. Misconduct/conduct issues

10.1 Misconduct by Queensland Police Service officers

Concerns were raised by the mother, her support person and MP regarding conduct of Queensland Police Service (QPS) officers. The mother was charged with Indecent Dealing with a Minor under 16 years after complainant 2 brought the concerns to the attention of Parliament on 19 August 2010. Within hours of raising his concerns in Parliament, charges were laid against the mother.

QPS first interviewed the mother and her son the child (alleged victim) on 29 September 2009. The mother was advised by PCSC in February 2010 that no charges would be laid against her as a result of the investigation.

My assessment

Issues regarding alleged misconduct by QPS officers do not fall within the CCYPCG's jurisdiction. Accordingly, on 06 May 2011, one of my officers referred the concerns to the Crime and Misconduct Commission (CMC) for its review and assessment. The CMC is the appropriate entity to investigate alleged misconduct by QPS officers.

10.2 Carers' conduct/behaviour/decisions concerns

On review of correspondence between carers 1 and 2 and departmental officers, I have identified a number of concerns relating to the conduct of these carers and their potential bias towards the mother, as detailed below:

- on 27 March 2010 an email sent to CSSO1 from carer1 indicated that the mother had been overly responsive to the child's needs. In the email from carer1, carer2 wrote that the mother was *"sweating on bonding with us but now she knows that won't happen especially if you tell her to pass everything on to child safety not to ring us"*. Carer2 also refers to the mother telephoning to advise the child that the "jets" [aeroplanes] were being televised on the news. Carer2 wrote *"I give up we don't have anything against her as a person but the child is our responsibility until child safety say otherwise, we will change the phone number if she does not heed that she is to contact you and all other things she can tell the child on visitation"*
- email dated 14 March 2011 sent to CSSO1 from carer2 detailed a conversation she had undertaken with a Theatre Nurse from Base Hospital about the mother. During this conversation carer2 received derogatory information about the mother. Carer2 also wrote that she thinks the child is *"scared that"* the mother *"will not let him see"* her or carer1 if reunification occurs, and

- carer1 and carer2 took photographs of the mother interacting with the child[106,107] at soccer without her permission to do so.

My assessment

In relation to the first point above, the context of this email details a difference in parenting styles and values rather than inappropriate behaviour by the mother. It also demonstrates a lack of understanding and empathy for parents who have children placed in out-of-home care.

While I acknowledge carers 1 and 2 are focussed on the child's best interests, I hold significant concerns regarding their conduct; especially carer2 engaging in a discussion about the mother with the nurse from Base Hospital and carers 1 and 2 taking photographs to gain evidence to indicate the mother's behaviour is inappropriate. These actions could amount to a breach of the *Information Privacy Act 2009* and should be immediately addressed by departmental officers with carers 1 and 2.

I also note that these carers were aware that the mother was attempting to build rapport with them; however they were not transparent about their intent. I have assessed that it would be in the child's best interests for mutual respect to be demonstrated by all parties. Parents whose children are subject to statutory intervention rarely develop good rapport with their children's carers. The mother's willingness to engage in an amicable manner with carers 1 and 2 is in the child's best interests. Mutual respect and ongoing amicable interacting between all parties will promote the mother allowing the child to have ongoing contact with carers 1 and 2 after the child is reunified with the mother.

10.3 Departmental officers' conduct

The mother queried the inappropriateness of comments made by departmental officers, as documented in reports provided to the Department by other professionals. In the mother's opinion, these comments demonstrate bias towards her by the Department officers.

A number of subjective comments have allegedly been made by departmental officers, which I have detailed below:

- on 14 December 2009, CSSO1 commented that she assessed the mother demonstration of affection as excessive. It was suggestive of a teenager's first romance
- in the updated social assessment report dated 12 November 2010, social assessor documented the following responses by team leader1 in relation to the mother seeking media coverage:
  - she believes the mother "really did not want to consent" to a one year custodial child protection order, and "this perhaps prompted her visit to MP"[108]

[106] Affidavit prepared for Childrens Court of Queensland by CSO3 dated 24 September 2010, sheet 8, paragraph 28
[107] Cased note dated 31 August 2010 created by team leader1 detailed telephone call from carer2 to team leader1
[108] Social assessment conducted by social assessor dated 15 July2010, page 4, paragraph 3.1

- "her overwhelming need for him overshadows everything she does...we have a politician saying he could help and she thought she could get him back...she is very vulnerable to advice she wants to hear"[109].
- Of course, the media coverage indirectly resulted in the mother being charged with sexual assault[110].

- the social assessor also documented team leader1 stated that the mother "has booked a holiday to Fiji for her and the child", demonstrating the mother "tendency to act in accordance with her needs", "not what is appropriate for her son", "she does not get it – she is not getting of it" [111] [child protection concerns], and
- In the risk assessment report dated 9 November 2010, clinical and forensic psychologist documented:
  - team leader1 stated that the mother has a "very egocentric personality"[112]
  - CSO3 stated the mother to be "manipulative and immature" [113]
  - team leader1 indicated that the "the social assessment report previously done, and also the report done by service provider 1; have put us in a difficult position; because they recommended returning the child to his mother[114]." and added "But the Department has other, ongoing concerns" [115].

The conduct of Department officers will not be addressed by the CCYPCG, as the matter has been referred to the CMC. I understand that the CMC devolved the matter to the Department to address the issues raised in relation to the conduct of departmental officers involved in the case management of the child. I am aware that a review of this matter has been conducted by the Manager, CSSC.

I have assessed that this matter would have been more appropriately addressed by a senior officer at the Regional Office, alternatively by a senior practitioner located outside the region. My rationale for this assessment is that a review being conducted by a senior officer external to the CSSC would support natural justice principles; given the mother has alleged bias towards her by departmental officers at CSSC.

Further, the above comments would appear subjective opinions, therefore unwarranted and unprofessional. Best practice would indicate that these types of comments should not be made, as departmental officers' comments should be based on fact. Alternatively, if these types of comments are made, then departmental officers must provide contextual information on how these comments are relevant to the current intervention and impact on the child's protective needs, future wellbeing, or future risk of harm.

In relation to the second point above, it is unclear what relevance the mother engaging with the media or seeking support from MP has on the case plan or social assessment as it does not directly impact on the future safety or wellbeing of the child. It has been assessed that this discussion should not have occurred, and as a team leader1 should have the insight not to engage in subjective discussions with other professionals. It is noted that within the Department's comments to the CCYPCG preliminary report that the relevance of this line of

[109] Social assessment conducted by social assessor dated 15 July2010, page 4, paragraph 3.1
[110] Social assessment conducted by social assessor dated 15 July2010, page 4, paragraph 3.1
[111] Social assessment conducted by social assessor dated 15 July2010, page 5, paragraph 3.4
[112] Risk assessment report for the child by clinical and forensic psychologist dated 8 November 2010, paragraph 83
[113] Risk assessment report for the child by clinical and forensic psychologist dated 8 November 2010, paragraph 87
[114] Risk assessment report for the child by clinical and forensic psychologist dated 8 November 2010, paragraph 82
[115] Risk assessment report for the child by clinical and forensic psychologist dated 8 November 2010, paragraph 82

questioning was due to the child being placed in a *vulnerable position given the nature of the regional community* and the mother being identifiable within *the silhouette*.

It is noted that within the Department's comments to the CCYPCG preliminary report that departmental officers did provide additional contextual information relating to the above comments, however do not have control over what information is utilized by the report writers.

Team leader1 made the following comments:

- the social assessor appears to have combined comments made by departmental officers with her personal observations and views on the topic being discussed
- the social assessor did not include contextual information relating to comments made by departmental officers
- the social assessor quoting the Team Leader1 as stating the mother had an "overwhelming need for [a person]" was in reference to the child not the MP
- she did not make the statement that the media coverage indirectly resulted in the mother being charged. Team Leader1 believes this statement to be owned by the social assessor
- she does not recall all the details of the telephone interview conducted by the social assessor and believes her comment that the mother did not "get it", relates to the mother's inability to comprehend the contact limitations for the mother and child due to statutory intervention and criminal proceedings, and
- departmental officers do not usually have the ability to take notes during the interview process.

Without departmental records or the report writers records being available to the CCYPCG for review, it remains unclear who owns the information detailed within the abovementioned reports.

The last point is not a conduct issues, however suggests that departmental officers have not necessarily been transparent during the intervention process, as the "other concerns" held by departmental officers should have been discussed with the mother and therapeutic services to provide the mother with the opportunity to address these concerns. More importantly, these "other concerns" appear to support further intervention and if unknown to the mother, then they are not able to be addressed. This fact would not appear to be in the child's best interests, as he has consistently indicated throughout 2009 and 2010 that he wanted to be reunified with the mother.

10.4 Conduct of SCAN meetings

During my review, the following concerns were identified practice issues in the documented case notes from SCAN meetings. On 18 August 2010, the QPS representative indicated that *"there was no doubt a criminal offence has been committed"*[116]. Later the QPS representative queried whether the SCAN representatives supported QPS progressing to charge the mother with criminal offences[117]. The departmental representative at this meeting

[116] SCAN AM Team minutes dated 18 August 2010, page 2
[117] SCAN AM Team minutes dated 18 August 2010, page 2

advised that the child has indicated throughout the intervention period that the mother's "*drinking habits and numerous men entering the home have had an impact on*" the child[118].

My assessment

The case notes are open to interpretation and criticism in relation to the objectivity of the SCAN process, as the case notes read as if the QPS representative was seeking consensus to progress criminal proceedings. This is not the intent or purpose of SCAN, based on the recorded discussions outlined above. Decisions relating to legal proceedings, such as making criminal charges against an alleged perpetrator, are beyond the scope of SCAN and should not be discussed.

Based on the record of the abovementioned SCAN meeting bias is implied towards the mother. Further, the child's needs and wellbeing do not appear to have been the focus of the meeting. This is based on there being no record of SCAN members discussing the information provided in the service provider 1 report stating the child was suffering emotional harm by being placed in out-of-home care[119].Further, the departmental representative made reference to the mother's alcohol misuse and number of male acquaintances negatively impacting on the child's emotional wellbeing.

I have not been able to identify numerous departmental records of the child disclosing emotional abuse as a consequence of the mother's alcohol misuse or involvement with adult males frequenting the residence or having contact with the child within their social environment. In fact, the majority of the disclosures made in relation to inappropriate sexualized behaviour between the mother and the child and the mother's alcohol misuse, were made by the mother either to departmental officers, social worker of service provider 1, or other professionals. Only one departmental record was identified in relation to the child disclosing an inappropriate sexualized incident, [redacted] The child's concerns relate to the mother misusing alcohol, which appear only to be raised by the child with departmental officers prior to a case plan review meeting.

There appears to be only one case note recorded in relation to the child disclosing to carer2 this concern. Departmental records provided to the CCYPCG indicate that the child has discussed the mother's alcohol misuse with relevant agency staff, prior to departmental intervention. The majority of disclosures made by the child in relation to child abuse perpetrated by the mother are alleged from a relevant source.

I have assessed that the impact of the sexualized incidents between the mother and the child are being over-emphasized and the focus of the intervention should be on the emotional harm experienced by the child. Perhaps the intent and discussions during the SCAN meetings has not been well documented. However, I have assessed that the focus of the SCAN meetings should be on meeting the child's needs and in 2009 focussed on the appropriate supports to be linked with the child and the mother to determine safe reunification strategies for the child, a young child who clearly articulated that he wanted to return to his mother's care.

[118] SCAN AM Team minutes dated 18 August 2010, page 3
[119] SCAN AM Team referral dated 18 August 2010, page 3

10.5 The Department accessed the mother's private information and used it against her to gain the court order

The mother claimed that the Department accessed information disclosed by the mother during counselling sessions at service provider 1 without her permission and used this information against her to gain the court order. The mother does not remember signing a consent form allowing the Department to access information obtained from her engagement with staff at service provider 1.

My assessment

My officer contacted service provider 1 to seek clarification on their processes prior to commencing engagement with clients. Although my officers did not specifically identify the mother, the following advice was provided by a staff member at service provider 1, which is applicable to the mother's case:

- on commencement of services being provided to a client, he/she would have completed a detailed form which outlines limited confidentiality and advises that the client has the right to determine with whom information is shared about his/her personal circumstances, and each counsellor has legal, interagency and organisational obligations to fulfil regarding his/her sharing of information about certain clients. In terms of sharing information, service provider 1 has an Interagency Liaison form which gives service provider 1 permission to share information with other people/agencies
- limited confidentiality refers to situations where the counsellor may have ethical, legal or interagency obligations to fulfil which override the client's right to confidentiality. Limited confidentiality shall be invoked when the counsellor believes that:
  - concerns about a person's safety and wellbeing are held
  - a criminal offence has been or is likely to be committed, or
  - documents are legitimately sought through a subpoena, and
- statutory clients subject to a Child Protection Order or Youth Justice Order will be informed at the Introductory Case Meeting that their progress in therapy will be shared with the CSO, and that upon exit from service provider 1 a copy of the file material will be provided to the CSSC.

My assessment

I have assessed that this matter would be best addressed by the mother seeking legal advice or contacting service provider 1 and requesting a copy of her signed consent form. This matter is outside the scope of the CCYPCG's independent assessment process and jurisdiction.

11. Conclusion

In conclusion, I have assessed that departmental officers have met their legislative obligations, however best practice expectations have not been consistently met and in some instances negatively impacted on the case management of the child and the working relationship with the mother. I have identified a number of training opportunities that I recommend be implemented at CSSC to address the abovementioned practice issues.

Issue 1 - Intake process

I have assessed that the Department's decision to record a Child Protection Notification (CPN) was made in accordance with departmental legislative obligations. Further, allegations made in relation to the notifier being malicious or vexatious were not substantiated.

I acknowledge that the intake process is now undertaken by the Regional Intake Service located within the Central Regional Office. However, I am aware that CSOs located within CSSC are responsible for performing the intake function when notifications are made in person or allegations of child abuse and harm are received for children in out-of-home care.

Recommendation 1
I recommend that the Department provide professional development or training to officers at CSSC, in particular CSO1, in the gathering and recording of information and the level of detail to be included in the CPN. Additional professional development or training is recommended on the SDM tools, specifically all harms to be screened and recorded, and a detailed rationale for the outcome of these screening processes to be documented.

Issue 2 - Investigation and assessment process

I have assessed that the Department's decision making in relation to the investigation and assessment process was made in accordance with departmental legislative obligations. Notwithstanding this assessment, I have determined that best practice has not been consistently met during this process.

Recommendation 2
I recommend that the Department review and/or develop strategies and procedures implemented at CSSC for investigating CSOs when a child discloses abuse being perpetrated by the parent, primary caregiver, or household member.

Recommendation 3
I recommend that the Department provide professional development or training to officers at CSSC, in particular CSO2 and the Team Leader (at that time), in relation to the obligation to ensure the child's safety and complete a safety assessment prior to leaving the family home. It is of the utmost importance that such mentoring or training emphasizes the need for the investigating CSO to discuss the outcome of the safety assessment and develop a safety plan for any child remaining in the home when the outcome of the safety assessment has been determined to be unsafe.

Recommendation 4

I recommend that the Department provide professional development or training to relevant officers at CSSC in the use of SDM tools to improve practice and promote consistent decision making. The mentoring or training should provide the opportunity to reiterate to departmental officers at CSSC that each assessment must review and document the progress made by the parents during the intervention period and what further action is required by the parent to address the child protection concerns.

Recommendation 5
I recommend that the Department provide professional development or training to officers at CSSC in relation to the appropriateness of Assessment Care Agreements being undertaken rather than a Temporary Assessment Order.

This recommendation is based on the documented evidence of the mother consistently articulating to departmental officers that she disagreed with the child being placed in out-of-home care from the commencement of the investigation until a TAO was sought 17 days after the care agreement was initiated.

Recommendation 6
I recommend that the Department review and/or develop a written explanation of the interim custody process be provided to parents to promote their understanding of Court proceedings and in particular rulings in relation to interim custodial periods.

In relation to this recommendation, I suggest that the most appropriate departmental officer to share this information with the parent/clients is the Court Coordinator, as such officer is unlikely to have been directly involved in the removal process or discussions with the parent relating to the Department's decision to execute statutory powers.

Issue 3 - Discrimination of the mother by departmental officers

I have determined this allegation is unfounded; instead this issue appears to be a result of miscommunication. I suggest that the mother should discuss the effects of her childhood abuse on her adult functioning with her current psychologist to gain insight into the Department's emphasis on this issue and the associated risks to the child.

Recommendation 7
I recommend that the Department take steps to ensure that mediation occurs between the mother and departmental officers who will continue to have case management and case decision making responsibility for the child to resolve the impact of previous communication issues on the working relationship between the mother and departmental officers.

Issue 4 - Contact arrangements

Recommendation 8
I recommend that the Department take steps to arrange for the child's psychologist be consulted to develop an appropriate incremental contact schedule, including milestones/goals to be reached that support contact progressing to unsupervised contact and the mother being given the opportunity to demonstrate appropriate boundaries and parenting skills.

This recommendation is based on professionals recommending contact be progressed from as early as November 2009 and all professionals (external to the Department) reporting observations of interactions between the child and the mother to be appropriate.

Issue 5 - Case planning

I have assessed that the case plans developed to date have not clearly articulated the specific expectations of therapeutic services or what actions must be taken by the mother to support contact increasing and progressing to unsupervised contact, and reunification. I have also identified significant practice issues in relation to the use of structured decision making tools that inform case planning decisions. It is of significant concern that some of these tools have been replications of previous assessments, subsequently not acknowledging the progress made by the mother in addressing the child protection concerns for the child. These concerns support the need for training to be implemented with officers at CSSC.

Recommendation 9
I recommend that the Department provide training to officers at CSSC, in particular CSO3 and the relevant team leader in the use of the SDM tools and formation of comprehensive case plans, based on evidence and underpinned from a strength-based perspective.

Although the practice issues identified have to some degree impacted on contact and reunification progressing, the impact on these issues do not support reunification occurring. Reunification plans, including contact progression should be informed by professionals currently engaging with the child and the mother and decisions made in the best interests of the child.

Recommendation 10
I recommend that the Department review the current case plan for the child and update it to include more specific actions required of the mother to address outstanding concerns held by departmental officers that indicate the child is at risk of emotional harm.

Issue 6 - Therapeutic intervention

I have assessed that the decisions made by departmental officers in relation to therapeutic support services has not been in the child's best interests. This assessment is based on departmental officers linking the child with social workers from service provider 1, despite knowing the complexity of this case, the child protection history and qualifications of these practitioners and later recommending the child engage with an alternative therapeutic support service. Further, based on the deterioration in the child's relationship with the mother and his somewhat ambivalence to contact with the mother, it would appear that therapeutic support and in particular joint counselling should have continued.

Recommendation 11
I recommend that the Department take steps to ensure that individual and joint counselling is undertaken with the mother and the child with the view of establishing a healthy parent-child relationship and to meet the child's attachment needs to the mother, his only relative willing to care for him.

Recommendation 12
I recommend that the Department take steps to engage an appropriate therapeutic service to provide support to the mother and the child until it has been assessed by the treating psychologists that goals of therapeutic sessions have been met.

Issue 7 - Social assessments

I am not qualified to determine whether the assessment conducted by clinical and forensic psychologist is more appropriate than the assessments and reports provided by other

professionals noted above. A continuation of departmental officers seeking more than one service to undertake assessments of the child and the mother could be considered systemic abuse and not perceived to be in the child's best interest. I am unable to understand the value in having the child discuss his experiences while in his mother's care with numerous professionals, including departmental officers, QPS officers, and other professionals, especially given the child has only made limited disclosures [redacted]

Recommendation 13
I recommend that the Department take steps to ensure that the child's psychologist inform departmental officers on what form and level of contact is in the child's best interests.

Recommendation 14
I recommend that the Department take steps to ensure that the child and the mother's psychologists articulate how reunification should be progressed and what specific goals the mother would need to achieve before consideration be given to unsupervised contact and/or reunification occurring.

Issue 8 - Placement arrangements

I have assessed that the child has formed a close bond with carer1 and continuation of this placement whilst the child remains in care would be perceived to be in his best interests. This will promote a positive experience for the child of being in care and promote healthy relationships with others in the future through meeting his attachment needs, until he can be safely reunified with the mother.

Issue 9 - Misconduct/conduct issues

Recommendation 15
I recommend that the Department provide professional development or training to Team Leader1 and CSO3 in relation to refraining from making subjective comments to other professionals and if they are going to express an opinion, to ensure other professionals document contextual information that supports his/her opinion. I also recommend that the Department have a written agreement with report writers specifying interview material obtained from departmental officers must not be transcribed as comments without including the relevant contextual information.

Recommendation 16
I recommend that the Department provides professional development to Team Leader1 and CSO3 on how to clearly articulate to clients each concern held by the Department, even those concerns that differ from other professionals, such as the treating psychologists or therapist commissioned to undertake a social assessment.