QCPCI Tendered in chambers

Date: 17.12.2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Exhibit number: 135

STATEMENT OF DR MAREE GABRIELLE CRAWFORD

I, **Maree Gabrielle Crawford**, of c/- Child Advocacy Service, Royal Children's Hospital (RCH) Herston in the state of Queensland,solemnly and sincerely affirm and declare:

1. I am aStaff Medical Officer in Child Advocacy and General Paediatrics, Royal Children's Hospital, Herston.

2. I have been appointed to this position since 2002.

3. When planning and reviewing my work and seeking approval for decisions, when required, I report to Mr Tim Wood Director of Child Advocacy Service and Associate Professor Neil Wigg, Senior Director Child and Youth Community Health Service (Central), St Paul's Terrace, Brisbane.This service is part of the Children's Health Queensland Hospital & Health Service.

4. Prior to this appointment I was a Visiting Medical Officer in Child Protection at RCH from 1994to 2002 and in General Paediatrics at RCH from 1995 to 2002. I was a Visiting Medical Officer in Child Protection at Mater Children's Hospital from 1987 to 2002. I was also in private Paediatric practice from 1986 to 2002.

5. I hold a M.B., B.S. (Class II Honours) from University of Queensland 1978 and FRACP 1984.I am registered as a Specialist Paediatrician in Queensland.

6. **ROLE**

7. The purpose of my role, as a Staff Medical Officer based in the Child Advocacy Service is to provide Paediatric expertise for the Children's Health Queensland Hospital and Health Service in the area of Child Protection.

8. My duties and activities include:

    - Acting as Child Protection Advisor for Queensland Health (QH)encompassing roles of
        1. QH core representation in interagency Suspected Child Abuse And Neglect (SCAN) team
        2. Review of mandatory reporting from QH staff within Children's Health Service H& HS
    - Acting as Designated Medical Officer within the Royal Children's Hospital with responsibilities to enact Care and treatment Orders under the Public Health Act 2005
    - Provision of forensic medical assessments for children suffering or at risk of abuse and attendant report preparation and court attendance.
    - Provision of health assessment and medical management for children in the child protection system including children in Out of Home Care (OOHC)
    - Supervision and training of other doctors, medical students and health professionals in paediatrics and child protection
    - Quality assurance activities and research in area of child protection

9. As part of my role I have had a specific interest in the health of children in Out of Home Care and chaired the working group of to develop the Royal Australasian College of Physicians policy on *Health of Children in OOHC 2006*

10. As part of my role I have contact with Department of Communities Child Safety Officers, Officers of Queensland Police Service particularly CSIU and CPIU branches, senior guidance officers from Education Queensland, representatives from Indigenous support agencies, and a range of professionals in Queensland Health. Over the years I have had working relationships with non-government providers e.g. ACT for Kids. I have had involvement with judiciary in all jurisdictions within Queensland and in the criminal courts in NSW.

11. As a result of my clinical work in Paediatrics and Child Protection I seek to make the following comments regarding the current child protection response in Queensland.

12. **Mandatory reporting responses and child protection notifications**

Mandatory reports from QH staff made under the Public Health Act 2005 are reviewed by Child Safety Services (CSS) utilising the Structured Decision Making (SDM) tool to determine if CSS will raise a notification and have direct family involvement to assess concerns or whether concerns will be recorded on the Information System as a Child Concern report (CCR).

A significant role of Child Protection Advisors is a review of the mandatory reports conducted by QH to obtain feedback regarding CSS response, provide additional information to CSS and family supports if appropriate, refer case to interagency SCAN meeting if matter fulfils criteria for SCAN referral, and if warranted proceed to an Information Coordination Meeting (ICM) if QH believe that the child would be best served by CSS intervention via a notification.

There is a mismatch between the threshold for QH notifications which are based on practitioners belief on reasonable grounds that a child is at risk of or has suffered significant harm, and the threshold of CSS response which requires that the child has suffered or at risk of suffering significant harm AND there is not a parent willing and able to protect the child. Hence there will be clearly some QH reports which will rightly not reach notification level e.g. abuse by a party outside the family or household, or where there is an individual parent able to care.

However, during my career working in child protection I have observed an increasing tolerance to risk and requirements for higher level of proof of harm and in particular a focus on specific events of harm. Justifications for not raising a notification often appear superficial and reliant on hope and optimism rather than evidence of safety. While there are gains for families not to have intrusive intervention and there is benefit for CSS in workload management it is undesirable that children be exposed to ongoing harm. Without a screened-in notification, CSS will not offer formal involvement with a family and or a role in case planning.

There is a significant emphasis placed on providing evidence of specific incidents of harm with less regard to the cumulative impacts or of the totality of the harmful environment. Hence, currently a child may have recorded multiple CCRs with no system to review the child's overall needs and adequacy of care. Many families will not be linked to support services and if they are there is little oversight of this engagement.

For those families who would be receptive to assistance access to family support services designed to reduce risk factors are limited (e.g. Referral for Active Intervention (RAI) services

are not state-wide and have small geographical catchments). Linkage with supports from non-government agencies may not be available without CSS involvement.

In summary there is not a systemised mechanism of assessment of families and children where one or multiple CCRs are indicative of underlying or emerging risk.

I would recommend that the efficacy of the SDM tool be evaluated, that the current benchmark for level of harm to allow intervention be reviewed, and that a mechanism be generated for case review when multiple CCRs are recorded.

Also that CSS role is expanded to provide case management and support work to families in need to allow earlier intervention and prevention of severe or chronic harm to children.

13.**SCAN team functioning**

The 2004 Crime and Misconduct Commission (CMC) report *Protecting children: an inquiry into abuse of children in foster care* placed emphasis on the value of interagency response and interagency input to child protection and from this SCAN teams were legislated. However far from increasing the influence and advocacy of this interagency forum the intervening years have seen a reduction of the role to a forum principally for the sharing of information with CSS (sometimes unidirectional) and a diminution and largely removal of the role of professional advocacy and consultation with senior members of the partner agencies. This has largely arisen from practice guidelines supporting early case closure after information has been shared and even before assessment completed and case plans are developed. This seems to reflect hypersensitivity by CSS to any potential oversight of practice by other agencies.

Associated with these changes has been an increased demand for information sharing even outside the SCAN system (under s159 Child Protection Act 1999). For Qld Health this has placed increased demands for medical chart reviews in what may be "fishing expeditions" or more concerning for copying of whole files to allow interpretation of these documents and contents by Child Safety Officers (CSO) without medical training.

Referral to SCAN by partner agencies has become limited to cases where CSS has raised a notification and hence is dependant on CSS decision making via the SDM tool as discussed in 12 above. The ICM process to allow partner agencies to share additional information with the Regional Intake Team of CSS in order to review notification decisions has been of little value and in practice if CSS has not raised a notification there is little ability for other agencies to provide expert opinion into management.

I would recommend that the procedures of SCAN be reviewed to allow greater emphasis to be placed on professional advocacy from the range of senior professionals involved in this interagency forum.
Secondly, I would recommend that the emphasis on information sharing be shifted to provision of expert opinion on information available and for this to occur within the SCAN system.

14. **Outcomes of CSS Investigation and assessment**

Assessment of harm by CSS is often somewhat superficial and focused on the result of the specific episode leading to notification. Often great weight is placed on parental explanations and responses and workers do not always look broadly at the child's functioning and likely developmental trajectory. Rarely are other professional opinions sought regarding emotional

and behavioural effects of abuse. This approach may arise from the relative inexperience of many CSOs and often reflects a lack of familiarity of the effects of trauma and of disordered attachment on children's behaviour and development and the longer term outcomes of these adversities. In parallel with this Children's Court magistrates should have knowledge and understanding of the adverse developmental effects of trauma and disordered attachment on young children. Their rulings set the tone and level of interventions with the case at hand but also with subsequent children as CSS becoming reluctant to proceed with court application for orders if they expect a negative outcome even when workers themselves believe this would be in the child's best interest.

While a child is normally best cared for by parents or family, if the level of care does not reach "good enough" standards, prompt intervention should be provided either to support families or if not possible or successful, for children to be removed to safeguard them. Least intrusive action needs to be balanced against ongoing harm and cumulative harm. Many young children are left at unacceptable risk until a clear event warrants removal. Given the extensive literature on brain effects from early trauma and poor attachment ongoing exposure should be minimized. This requires a child centred focus on the child's needs versus the parents' needs and requires an experienced and skilled workforce. Late removal will result in more pathology in the child much of which may be irreversible.

I would recommend that all professionals working with children in the child protection system have an in depth knowledge base of the nature of children's development and the impact of trauma and disordered attachment. A child centred response is essential to provide for children's rights.

15. **Children on child protection orders**

While the philosophy of working with families so that children can be reintegrated back into their care is the goal and achievable for a proportion, there are families who are unable to change to meet children's needs and rights. Many children are "tried back" with parents who are not adequately resourced and supported, or who have not addressed their difficulties fully, or may not have the capacity to change. There appears to be a rigidity in planning which again does not place the child's needs to the forefront and can result in children returning only to be removed again (sometimes on multiple occasions) resulting in further abuse, loss of stability, and further disruption in attachment. There are a small group of children who would benefit from early permanency planning and case planning needs to take account of these.

Additionally following children's return to parents' care at completion of orders there will be little if any interagency consultation and input to case planning even for children with chronic health problems, and no medium to longer term support for families who may continue to struggle under the load of parenting one or multiple children. Such children can and do return to the care system at a later date.

I would recommend that there be early permanency planning in appropriate cases so that children can be allowed to develop sound early attachment to a significant adult carer. Children who have been on orders, and their families, should receive extended support. All agencies should be engaged to support families of children on orders.

16. **Children in OOHC**

Those children who are removed into kinship or foster care need to receive nurture, stability of placement and access to therapeutic resources to address the higher prevalence of emotional and behavioural problems, developmental and educational deficits, and health problems associated with their situation.

Instability of placement is a particular difficulty that impacts on many other aspects. Our community struggles to provide foster carers and carers are often under prepared or trained, under resourced and undervalued. Kinship carers and particularly grandparents are often very poorly supported. Respite for carers is infrequently available and hard fought. Provision of such in many cases would prevent placement failure and carer burnout.

Difficulty maintaining children's placements is also linked to timeliness of removal of children who are suffering abuse or neglect. While it is clearly often difficult to judge parents' ability to change and to determine whether care reaches a level of "good enough" it is also imperative to prevent prolonged abuse or neglect which results in behavioural disturbance or emotional harm which may be very difficult to change or irreversible. Such judgements require skill and experience from child safety workers who should be assisted by a range of professionals including educators, psychologists, paediatricians and child psychiatrists.

Children entering OOHC need to be assessed both for their strengths and also for the range of potential difficulties. The current system of Child Health Passports for children entering OOHC is skewed to general practitioner and primary health care assessment and has not been effectively evaluated. Based on our experience seeing children in OOHC in the Child Advocacy Service, a tertiary hospital clinic supported with allied health and access to child psychiatry, it seems unlikely that an isolated primary care model would be able to fully meet children's physical and mental health needs. There is need for a system of coordination of health assessments preferably utilising nurse practitioners within health (similar to the current NSW model) to liaise between primary health providers, facilitate access to paediatric care for those requiring it, coordinate access to therapeutic services and liaise with department of child safety officers.

In addition, given the high frequency of attachment and trauma related emotional problems and developmental difficulties in these children, developmental and mental health screening and access to therapeutic services is essential but not currently readily available.

These difficulties become particularly acute in the adolescent age group when young people may be difficult to place in a safe nurturing environment and are reluctant to engage with therapeutic supports. They may become involved in juvenile justice system, embark on substance abuse and develop mental health problems.

I would recommend that the level of training and support to foster and kinship carers should be strengthened.

Children entering OOHC should have effective assessment for physical, emotional and developmental problems and have timely access to therapeutic supports.

Efficacy of the current Child Health Passport system should be reviewed with consideration given to improved coordination and better access to specialty and therapeutic services.

Timely removal of children into OOHC and practical and therapeutic supports for carers and children are essential to improve stability in placement for children.

Declared before me at Brisbane, Queensland this 16th day of October 2012.

Signature of officer _____ Witness Signature _____ JP Qual 88469 CHASON