The Hon Tim Carmody SC
Commissioner
Queensland Child Protection Commission of Inquiry

Brisbane, 28-09-2012

Dear Commissioner Carmody,

I make this submission to you as a clinician who has worked in child protection for almost 15 years. My experience as a Paediatrician covers the continuum of the perinatal period and childhood to 18 years of age, and includes developmental, behavioural and forensic Paediatrics, from community through to tertiary practice.

In preparing this submission I have consulted with a multidisciplinary team of highly experienced clinicians who also have a depth of knowledge and clinical experience in relation to the health perspective of child protection including, child psychiatry, psychology, nursing and social work.

This submission is made from a clinical perspective and is based heavily on day-to-day experiences in working within the child protection system. This submission identifies areas where changes in child protection practice may improve outcomes for children. While we used an evidence-based approach to substantiate our concerns, we acknowledge that our research is not exhaustive. However, the value of this submission is that it is based on combined, multidisciplinary clinical expertise.

This submission contains 2 documents and an addendum. The first document is an "Issues and Recommendations" paper, outlining concerns about current practice and suggested responses. The included addendum provides 6 case scenarios which set the scene for some of the issues addressed. The second document is a review of the aspects of the 2004 Crime and Misconduct Commission (CMC) inquiry relevant to clinical practice, with comments about how these statements relate to clinical practice today. A bibliography of papers that were drawn on in preparation of this submission is also included.

Family engagement in support services

In writing this submission there are several issues that stand out. There is universal acceptance that primary prevention and early intervention for families in need and under stress is essential. While there is much discussion about what this should look like in practice, it is not debatable that supporting people in need is a good thing. Health practitioners welcome the ability to refer directly to support services.

What is less clear from the literature is how much increased access to support services helps those families who are most likely to significantly harm their children or where children are

being harmed. To improve the current child protection system we need to focus on how to manage those families where a supportive approach is not accepted, or, if accepted, the support is not adequate and successful in effecting sustained change and in meeting a child's needs.

Reporting processes and multiagency collaborative responses

The next issue for consideration is the reporting processes to the Department of Child Safety (DCS) and how reports are managed from intake through to assessment and management. In principle there is a whole of government response to child protection. It is beyond debate that all partner agencies have an individual role to play in keeping children safe. This is done, however, from very different paradigms and professional perspectives. Bringing these perspectives together into one robust multi-agency approach would strengthen the child protection system as a whole. This broad expertise should be better utilised during all aspects of a child protection investigation; from intake through assessment, and into the management phase of an investigation into potential abuse or neglect.

Threshold of raising a child protection notification & deskilling of the child protection workforce

We are frequently dealing with increasingly complex families with multiple child protection risk factors, often on a background of generational dysfunction. At the same time as acknowledging this complexity, the child protection system under DCS seems to be one where notification rates are kept down and where intervention rates are driven by the principle of "least intrusive intervention", which, at times, overrides the best interest of the child. The increasing reliance on tools, such as the *Structured Decision Making* (SDM) tool, seems to be replacing skilled professional judgement.

Professor Eileen Munro's report from the UK[1] gives an excellent overview of the need for a highly developed professional workforce with less reliance on process, speaking of the need to be 'risk sensible' rather than 'risk averse'.

It has been suggested by some that partner agencies such as Health, Education and Police should take on more of an assessment role around risks to a child by sharing the use of the SDM tool. However, this simplistic approach fails to acknowledge that a highly skilled professional workforce is required to make decisions that have enormous impacts on children's and family's lives, and that this is a specialised area that sits within the mandate of DCS.

Out-of-home-care placements

It has been suggested that too many children are in out-of-home care (OOHC), however, it is not clear what the basis is for this. While more recent data is not readily available, data from 2005, comparing OOHC rates in high income countries in the world, shows that Australia has one of the lowest OOHC rates at 49 placements per 10,000 children; this compared to Denmark and France at a rate of 102 per 10,000. Rather than focussing on the rates of

1. Munro, E. (2011). The Munro review of child protection: final report. A child-centred system. London, Department for education. *Accessed from:* https://www.education.gov.uk/publications/standard/AllPublicationsNoRsg/Page1/CM%208062

OOHC, the timing and quality of OOHC needs to be considered as well as the need for permanency placement for some children.

There is an extensive body of literature which strongly supports the need for positive nurturing environments for children - especially for those under three years of age, with clear evidence of detrimental neurological effects if fundamental human needs are not met in the critical early years. Early intervention and prevention as a public health measure is essential for many families. However, at an individual case level there needs to be multi-agency expert assessment of the family capacity to change in cases where children are (at risk of) being harmed. Appropriate decisions need to be made that eliminate the 'roller coaster' of recurrent DCS involvement and repeated episodes of OOHC, causing disrupted attachment and its long term sequelae.

SCAN

The 2004 CMC inquiry held multi-agency collaboration in high regard and enshrined SCAN teams in legislation in an attempt to strengthen the child protection system. Unfortunately, under the stewardship of the DCS, a deterioration of the SCAN teams has occurred to the point that it is almost unrecognisable from the previous SCAN teams of the Mater Children's and Royal Brisbane and Women's Hospitals, which in 2004 were described as the model for interagency team work to be established across the state.

At present a SCAN team Policy and Procedures (P&P) exists which, if adhered to with rigor, results in discussion being 'gagged'. Non-DCS core members are told that their opinions of ongoing safety of a child are not required. DCS holds most of the information about a family and are reluctant to share this with the other core members.

Yet, some SCAN teams have continued to work well with the current SCAN P&P by being flexible with, or ignoring the P&P rules. Much can be done to improve interagency collaboration, both within and outside SCAN teams, for better outcomes for children and their families.

As previously mentioned, included in this submission is an "Issues and Recommendations" document (Document 1) with associated case scenarios (Addendum). I ask that these cases **not be published** as, whilst de-identified, they may be recognisable to some readers.

Yours sincerely,

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ABBREVIATIONS

ACT	Abused Child Trust
AM team	Assessment and Management team
CCR	Child Concern Report
CCYP	Commission for Children and Young People
CDRC	Child Death Review Committee
CI team	Community Implementation team
CMC	Crime and Misconduct Commission
CPA	Child Protection Act
CPN	Child Protection Notification
CPO	Child Protection Order
CSO	Child Safety Officer
CSSC	Child Safety Service Centre
CSAHS	Child Safety After Hours Service
CTO	Care and Treatment Order
DCS	Department of Child Safety
DGCC	Director General Coordinating Committee
DoC	Department of Communities
DoF	Department of Families
EQ	Education Queensland
ICM	Information Coordination Meeting
IPA	Intervention with Parental Agreement
LAQ	Legal Aid Queensland
LSCB	Local Safeguarding Children's Board
MFYCS	Mater Family and Youth Counselling Services
NGO	Non-Government Organisation
NICHD	National Institute of Child Health and Human Development
OOHC	Out-of-home care
P&P manual	Policy and Procedure manual
QH	Queensland Health
QPS	Queensland Police Service
RAI	Referral for Active Intervention
RIS	Regional Intake Service
SCAN	Suspicion of Child Abuse and Neglect
SDM	Structured Decision Making tool
STSDU	SCAN Team Support and Development Unit
TAO	Temporary Assessment Order
YPSO	Young Person who has Sexually Offended

DOCUMENT 1: ISSUES AND RECOMMENDATIONS

Dr Jan Connors - *MBBS, FRACP, MPH*

Director

Mater Child Protection Unit

Mater Children's Hospital

In this paper, reference will be made to cases which are outlined in the included addendum. I do **NOT** wish for these cases **TO BE PUBLISHED** in case they may be identified by some readers.

INTRODUCTION

There is no doubt that primary and early intervention for families in need of support is essential. What can be questioned is how effective these services are at reducing significant child abuse and neglect.

Children are best placed with their own family, *if* that family can provide physical and emotional nurturing as well as a sense of belonging and self-esteem. As this can't be measured in an absolute sense, it requires the effective collaboration of the Department of Child Safety (DCS), Health (Paediatric & Mental Health), Education and Police, to take into account the intersection of the child's history, and their current situation and trajectory. The challenge of ensuring an appropriate response lies in the application of current knowledge to individual presentations and making a judgement about what level of care and nurturing is 'good enough'.

When the care of a child is not 'good enough', the child protection system is needed for the best outcome for children. The current system is under review and there are areas of practice that need to be addressed.

There are many professionals from a range of agencies who are dedicated to securing the wellbeing of children. Comments and issues raised throughout this submission regarding the perceived failures of the current child protection system are directed to the system; not to individuals within the system.

Until prevention can be fully effective, there are families where children's needs are not being met to the extent that this has a long-term, negative impact on their wellbeing that is often irreversible. It is essential that interventions, which range from family support services to out-of-home care (OOHC), need to occur at the right time and in the right way. To achieve this, comprehensive assessment of the complexity of issues surrounding these families urgently needs to take place. Optimal use of multi-agency collaboration is essential for this.

1. DESKILLING OF THE CHILD PROTECTION WORKFORCE

In the writing of this submission many aspects of the child protection system have been considered. Yet, a general oversimplification of what are very complex issues addressed with a 'tick-box' mentality seems to be a trend that runs throughout the child protection continuum from intake to assessment, through to meeting the child's future needs. This has been demonstrated by an increasing reliance on the 'Structured Decision Making' (SDM) tool and de-skilling of the professional workforce within the Department of Child Safety (DCS).

Professor Eileen Munro's report from the UK *(Munro 2011)* highlights the value of a highly trained professional workforce. While there are many individuals within DCS who are highly skilled in the work they do, this is not supported by a structure that recruits staff with no human services qualifications.

This tendency to assess child protection cases with a superficiality which does not match the complexity of the issues under consideration can be seen at many levels. For example, in cases where children are found in houses with no food, animal excrement and rotten food scraps etc.; parents are asked to clean up the house and when they do, the children are returned with little done to remedy why the parents allowed the house to get to that unsanitary state in the first place (e.g. possible mental health, substance abuse or intellectual concerns).

Children where harm is substantiated and in need of protection, are left at home under an Intervention with Parental Agreement (IPA). Alternatively, families may be linked in with a support service through a Referral for Active Intervention (RAI) but with very little (if any) assessment around the capacity of the parents to engage with services and to make sustained changes, and with any further assessment of demonstrated change over time. Rather than waiting for evidence of change before placing a child back at home, support occurs while the child - sometimes only a newborn, is being fully cared for by parents with a chronic problem. At times it seems that the current policy of 'least intrusiveness' overrides the best interest of the child.

Short term 'band aid' approaches occur for complex generational dysfunction with the expectation that a period of 3 - 6 months with a support service will lead to sustained change. Children are repeatedly re-exposed to neglect and emotional harm over time, as the same pathway of short term support is retried. As a result, the system is left to manage children with extreme behaviours who require medication and for whom it is difficult, if not impossible, to find appropriate out-of-home care (OOHC). Having seen these families return to SCAN team meetings over and over, it is easy to predict the poor outcome. Nevertheless, the system continues to fail to intervene with these cases. Often the need for 'least intrusiveness' intervention is given for the reason.

Assessment will often focus on a specific event or point in time. Taking the further steps of understanding the present in the context of the past and the current developmental trajectory of the child is often left aside. It is therefore essential that the key factors likely to bring about positive change are identified and addressed.

Similarly, for children who are entering OOHC, there only seems to be superficial consideration, instead of a comprehensive assessment and overarching aim to meet their true needs. While Education Queensland (EQ) has a well organised assessment of education needs for these children,

the same cannot be said for their health and emotional needs. The current primary care model adopted by Queensland Health (QH) is rarely well utilised.

Recommendation 1.1

That support is given to the establishment and retention of a highly skilled child protection workforce where clinical judgment based on this expertise is valued over screening tools.

Recommendation 1.2

That assessment is done in a way that acknowledges the complexity of underlying child protection issues.

2. THE THRESHOLD OF RAISING A CHILD PROTECTION NOTIFICATION

Following the 2004 Crime and Misconduct Commission (CMC) inquiry, the Department of Child Safety (DCS) was given jurisdiction of the tertiary end of the child protection system, with responsibility for early intervention and prevention remaining with the Department of Communities. In order to have a manageable workload, DCS raised the threshold of raising a notification to one where it was likely that statutory intervention would be needed; i.e. where there has been demonstrated harm, or very high risk of significant harm.

Unfortunately, it is often the case that without the powers of investigation, partner agencies such as Health are only in a position to identify risk factors that we as professionals know are often linked to significant harm. While we may hold grave concerns for a child, we are unable to explore the full implications of what we know or suspect. By the time clear demonstrable harm has occurred, the opportunity for intervention is lost and the harm may have long term negative implications which are often irreversible.

For Queensland Health (QH), reporting to DCS is on the background of often having already exhausted all support services. This is either due to unavailability or to the reluctance of the family to engage.

It might not be a coincidence that with the decreasing number of notifications there has been an increase in the number of children going into out-of-home care (OOHC). This may suggest that early targeted intervention opportunities have been missed.

Along with the rise in children needing OOHC, there has also been a substantial rise in the number of children with extreme behaviours who need expensive OOHC placement options such as residential care and motels with 24 hours carers. Beyond that group, we have those adolescents who will not accept either of those options. These extremely challenging children are getting younger, with children as young as 8 year who are currently entering residential care.

As mentioned previously in this submission, the 'Structured Decision Making' (SDM) tool - although meant to be a guide, is frequently followed 'religiously', with outcomes that are difficult to understand. Further, comments have been made along the lines that the worker would like to come up with another outcome, but the tool says 'no' **(CASE 1)**.

Recommendation 2

That consideration is given to review of the high threshold DCS have for investigating child protection concerns, with acknowledgment of the limitations other professionals have in being able to identify risk and protective factors and demonstrable harm.

3. PLACEMENT OPTIONS FOR OUT-OF-HOME CARE, INCLUDING CONSIDERATION OF PERMANENCY PLANNING

There are significant numbers of children who are in need of out-of-home care (OOHC) and where placement options are limited or not available. Children as young as 8 years of age are in residential facilities (often residing with older children with challenging behaviours), or in motels with 24 hour carers. It is hard to imagine that this can provide a nurturing and therapeutic setting. After many years of being exposed to neglect and abuse, a number of these children have developed high risk behaviours. When a decision is finally made for OOHC, these children cannot be placed. A number of children will not have had opportunity to develop healthy early attachment and their development has been compromised.

There is ample evidence of the irreversible physical changes which occur during the brain development in children who have been exposed to abuse and neglect in the critical early years (under 5 years of age), especially for those children who are under 3 years of age.

The importance of developing a sound early attachment is well described in the literature. Attachment security is not something that can be judged during a fleeting home visit by staff not adequately trained in the area. For at-risk families, potential attachment issues need to be assessed appropriately and thoroughly by professionals with the appropriate training and clinical experience.

Consideration needs to be given to the role of permanency planning, especially for very young children in need of OOHC. These children require an in-depth assessment of infant attachment, in addition to a comprehensive evaluation of the capacity for sustained change of the parents.

Recommendation 3

There needs to be a review of available OOHC placement options with consideration of permanency planning with the option in some select cases for adoption. This may require re-consideration of the principle of 'least intrusive' intervention with perhaps stronger emphasis on the needs of the child, not just physically, but emotionally.

4. MEDICAL NEEDS OF CHILDREN IN NEED OF PROTECTION

Much is written about the increased physical and emotional health needs of children who are in out-of-home care (OOHC). Far less is said about those children who remain in their home but have also been assessed as being in need of protection. It could be argued that children who remain at home are in need of more, or at least the same level of support as children in OOHC who have moved to a safer and more supportive environment.

Health assessments of both groups of children are likely to be more effective and meaningful if done by health professionals who have a sound understanding of child protection, the implications of past abuse and neglect and knowledge of how to negotiate what can be a complex child protection system.

Recommendation 4

That further consideration is given to a cost effective model of medical care for children assessed as suffering harm, including those in need of protection. This might involve specialist staff supporting primary care physicians in the community.

5. ADOLESCENTS

The current child protection system seems to have very little 'place' for adolescents and young people. Significant concerns about the welfare of these groups seem to get the regular response of a Child Concern Report (CCR) from the Regional Intake Service (RIS). The rationale behind this response is that these older children are able to make their own decisions and/ or that the report is a result of parent-adolescent conflict. This approach attempts to normalise the behaviour and does not take into account the true nature of the conflict which, not infrequently, is one based in abuse and neglect. **CASES 2 & 3** are examples of such reports. Children in this group are getting younger, with children as young as 13 years or less.

As well as those who are not taken up by the Child Protection system, there are many children under Child Protection Orders (CPO) who display extremely high-risk behaviours that could end in their harm or death through accident or deliberate means. These young people have significant emotional and behavioural disturbances and are difficult to engage with. They often self-medicate with drugs and/ or alcohol, develop inappropriate, at times, violent emotional attachments and often refuse supports with accommodation and health services. This group does not fit well in the child protection service model and often all services, including the Department of Child Safety (DCS), the Queensland Police Service (QPS), Health (QH) and Education (EQ), are at a loss as to how to help these children.

Recommendation 5.1

That consideration is given to adolescent specialist teams.

Recommendation 5.2

That multiagency consideration is given to how to best manage high-risk young people.

6. NEWBORN AND PERINATAL PERIOD

Following the 2004 Crime and Misconduct Commission (CMC) inquiry, it is now possible to raise a notification for an unborn baby with the hope that intervention during the pregnancy will mitigate common risk factors such as substance abuse, parental mental health and domestic violence, and less common risk factors such as intellectual disability. In some cases it is very clear that the risk to the newborn is unacceptable and a Temporary Assessment Order (TAO) will be taken once the child is born.

The immediate risk of someone fleeing with a newborn baby can be quite high at times. Especially, as hospital staff have no legal right to remove babies from their mother's care. Babies now room in immediately with their mothers after birth, unless they have a medical concern. Further, most maternity hospitals have single rooms where observation and surveillance is limited. This means that a baby at high-risk, where a TAO will be sort, could be removed by the parents with little opportunity for hospital staff to intervene. While designated medical officers can take a Care and Treatment Order (CTO), prohibiting the parents from leaving with the baby if they believe a baby is at risk of immediate and significant harm, they cannot issue the order on the *chance* the parents will try to leave. This is therefore not an ideal option for securing the safety of the baby. However, if a TAO was issued prior to birth, the baby could be removed to a nursery and parental contact could happen with supervision if that was deemed appropriate.

Another issue that can arise in the newborn period is when mothers are under the care of an adult guardian because of e.g. intellectual impairment. While these women cannot make decisions for themselves, they remain the guardian of their newborn baby unless the Department of Child Safety (DCS) intervenes. There are clearly time delays in such a process.

Recommendation 6.1

That consideration is given to the possibility of being able to issue a TAO prior to the birth of a baby, where it has been assessed that the baby is in need of protection after birth, and/ or that there may be a 'flight risk' that would place the baby at significant risk.

Recommendation 6.2

That consideration is given to the issue of guardianship for babies of mothers who are under the care of an adult guardian.

7. ATTACHMENT

Throughout evolution, babies have needed to stay close and attached to their primary carers for safety. Infants are born ready or 'hard wired' for social relationships. It is through repeated attuned interactions with a familiar caregiver that physiological regulation and secure attachment develop. Attachment is crucial to all aspects of infant (and later) development:

- It effects brain development
- It influences ongoing social and emotional development
- The infant develops models of relationships from the quality and nature of early experience with caregivers
- It helps the child to regulate their own emotions
- It acts as a secure base for exploration and learning about the world
- It promotes resilience and good mental health

Securely attached infants have an advantage in the development of social intelligence, regulation of emotions and stress and self-reflective functioning. Insecurely attached infants have an increased risk of developing behavioural and learning difficulties. Particularly, disorganised attachment, which is a common form of insecure attachment in children with abusive backgrounds, is directly linked to the development of emotional and behavioural disturbances, and externalising disorders.

The foundations for secure attachment are laid in the first 3 years of life. It is essential that infants and parents in high-risk situations are identified early, so that support and intervention can be provided to strengthen the attachment relationship. Evidence-based interventions exist for working with this population.

When harm persists and an infant or young child is removed, developmentally informed foster care is the goal *(Zeanah, Shauffer & Dozier, 2011)*:

- A child's need for forming attachments to their caregivers is critical for their development
- The foster parent must become the primary attachment figure for the young child. This requires substantial emotional investment in the child by the foster parent
- Special training may be required to assist foster parents in learning how to respond effectively to a child's challenging behaviours, and to help them become more securely attached
- Stability of placements must be valued and maintained
- Visits between biological parents and young children should be seen as collaborations between biological parents, foster parents and the child protection system. Foster parents should be present, if possible. Biological parents may need support as they face the realization that their child is attached to someone else
- Transitions – gradually build attachments to the new caregivers and maintain contact with the former caregivers - when possible, even after transition

Recommendation 7.1

That, in any child protection investigation, an infant's need for a secure attachment relationship is appropriately assessed and considered. This requires adequate training of child protection workers to conduct this assessment, or to interpret and act on the findings of assessments performed by other suitably qualified clinicians.

Recommendation 7.2

That attachment-informed interventions are provided to families at-risk.

Recommendation 7.3

That out-of-home care (OOHC) placement should be informed by attachment principles, including the importance of foster carers as primary attachment figures, the stability of placement to allow such attachments to form, and the training and support of foster carers to provide the specialised care OOHC children need.

Recommendation 7.4

That it is recognised that infants and very young children who are hospitalised for extended periods in the absence of a primary carer are at high risk of developing attachment disorders and other adverse sequelae resulting from the absence of a buffer against the challenges of a hospital environment. These situations should be seen as urgent and when child protection services become involved, a foster carer should be identified as soon as possible to allow the child to attach to a single carer.

8. MULTIAGENCY COLLABORATION

8.1 SCAN

On reviewing the 2004 Crime and Misconduct Commission (CMC) report, it is clear that much weight was put on the protection of children through a robust and accountable multi-agency approach. The SCAN teams at both the Mater Children's and the Royal and Brisbane and Children's Hospitals were used as an example of a positive model of collaboration. Lord Lamming, in his report into the case of Victoria Climbie in the UK, made comment about the need for such a structure. The 2004 CMC report agreed with his comment and indeed enshrined SCAN teams in legislation.

Also in the 2004 CMC report, Child Safety (DCS) was deemed the lead agency for child protection, as compared to the Department of Communities (DoC) which took on the role of the other parts of the old Department of Families (DoF) no longer covered by DCS. As the lead agency, DCS were vested with the role of coordinating SCAN teams.

Soon after the 2004 CMC report, a Policy and Procedure (P&P) manual was written by all core member agencies, providing a guide to SCAN teams to promote consistency which had been missing previously. This manual, agreed to by all partner SCAN team agencies, provided guidelines for cases that should be referred to SCAN teams , with Assessment and Management teams (AM teams) and Community Implementation teams (CI teams). This allowed for the input and utilisation of the broad expertise of all core member agencies into the assessment and management of children who had been harmed, or who were at risk of significant harm. It also allowed for community groups, both within and outside government, to come together for support plans for the child and their family.

DCS appointed coordinators for all SCAN teams across Queensland. Unfortunately, the new model was not fully embraced by the new DCS, and to some, the idea that DCS was the 'lead agency' meant that they, alone, were to make decisions about the safety of children; according to DCS, the other core agencies were at the SCAN team table only to provide information and services. This situation led to tensions in some teams where DCS were reluctant to explain how they reached their outcomes, or to give details of their assessment. This led to limitations of the role other core members could play, as they were limited in the information they were given by DCS.

At that stage, any core agency representative could refer cases to SCAN if they were concerned about the safety of a child. This meant that some cases, screened as a Child Concern Report (CCR), could be discussed. At times, following full information sharing, these cases were upgraded to Child Protection Notifications (CPN).

The other opportunity that the team had was to refuse to close a case where the core member agencies felt that the child's protective needs had not been met. At that time there was the option that a concerned SCAN team member could refer the case to a more highly qualified member of their own department before the case progressed to being referred to the SCAN Team Support and Development Unit (STSDU).

Unfortunately, this model of SCAN, at times, was met with hostility from the DCS, with the stance that because they were the lead agency, they did not have to explain their decisions nor did they feel they had to share information with the other core members. This attitude created a shift in

practice to one with a lack of acknowledgement by DCS that other core members did indeed also hold child protection expertise and were also able to add quality professional opinions about the safety and wellbeing of a child.

Over the years that followed this issue remained a major sticking point, with DCS frequently stating that, as the lead agency, they did not have to provide outcomes or information to the other core members who, in their opinion, were only there to provide information and services.

At some sites, however, SCAN did continue to run effectively due to the good working relationships within the teams and the support from the manager and staff of the CSSC supporting that team – not because of the system (!).

Finally, after a number of years of tensions within, and limitations to SCAN teams, the DCS then argued that SCAN teams were not functional and approached the Department of Premier and Cabinet, asking that SCAN teams be disbanded. This reflected clearly the lack of support given to SCAN teams at a systemic level. After robust argument against this proposal by the other core agencies, SCAN teams continued. However, this was under a new P&P manual written by DCS alone - the *one* agency that had just tried to have SCAN stopped.

While there was input from the other core agencies via the SCAN sub-committee, the agenda was clearly set by DCS. The current P&P was written. Many SCAN teams are now functioning very differently from what was described in the 2004 CMC report and enshrined in the legislation. The following points can be made about the current SCAN P&P:

- There is now a division into SCAN team meeting and ICM meetings
- Information Coordination Meetings (ICM) are for cases that have not reached a level of Child Protection Notification (CPN), but where a core member is concerned about the case and thinks there may be something to be gained by a multi-agency discussion. Unfortunately, there are delays in getting these cases tabled, and when they do, there is only one chance to discuss the case. If this occurs while schools are on holidays, no school information can be tabled. Before referring a case to an ICM, the core member must discuss the case with the Regional Intake Service (RIS) that made the Child Concern Report (CCR) decision. If, following this discussion, the core representative still wants a multiagency discussion, they can refer the case for an ICM discussion. However, this is often not supported by the RIS. For many reasons this achieves very little and there is effectively no way of having meaningful discussions about cases that are not CPNs. Previously, it was not uncommon for some CCRs discussed at SCAN to be upgraded to a CPN when all the facts were known **(CASE 4)**.
- Under the current SCAN P&P, once core members have tabled their information, if all that is outstanding is an assessment by DCS, the case closes to SCAN. The outcome of the assessment is to be supplied when completed. However, this gives no option for input from other core agencies as the investigation unfolds. SCAN teams that are functioning well essentially work outside the P&P for effective sharing of information and expertise. Other SCAN teams are less effective, with DCS being the only agency that holds all the information.
- The effectiveness of multiagency collaboration is limited by the inherent delays in the referral of a case to SCAN or ICM, as a case cannot be referred until the intake outcome is known (expected within 5 working days, but this can currently take up to 5 weeks). Then there is a need to wait for the next meeting which may only occur fortnightly. By that time

DCS may have completed their assessment and the information from other agencies is not utilised. Referral from DCS themselves is not common. At other times the case has been finalised while the SCAN team is still collecting information, making the new information meaningless, devaluing the work done by core members.

- SCAN team discussions are limited to a brief time period around the assessment and initial plan for a child. The plan may be that the family will be supported through an Intervention with parental agreement (IPA). The case will close at that point, with no option for monitoring progress of the family or for the other agencies to inform the case plan. Other models for multiagency support, such as the UK's Local Safeguarding Children's Boards (LSCB), have the capacity to provide review over a longer period of time. There are some very complex cases where this could be of benefit.

Recommendation 8.1.1

That the current SCAN team structure is reviewed, with consideration of the scope and the function of the team.

Recommendation 8.1.2

That SCAN team representatives come together as equal partners, each with their own area of expertise.

Recommendation 8.1.3

That SCAN meetings are coordinated and chaired by an independent body.

8.2 OTHER COLLABORATION

As mentioned under the previous section on 'SCAN', sharing of information currently often occurs in such a way that Child Safety (DCS) is the only agency to know all the information about a child (CASE 5). In a case such as this, the case would have previously been referred to SCAN and a comprehensive multi-agency consideration of all the issues would have occurred, with all parties being fully informed.

There is also a decrease in information sharing when Health has concern about a family and wishes to know if a child or family has a past or current child protection history. Regional Intake Services (RIS) not uncommonly inform us that they cannot tell us if there is information about a child held by DCS, unless we are making a report. There is no other way to get this information as we can no longer obtain this information from Child Safety Service Centres (CSSC).

Sharing health information through the SCAN team provides a proper interpretation and meaning within a child protection framework by the SCAN core health representative. However, some CSSCs prefer to access health information directly from health services and have asked for entire health

records under section 159 of the Child Protection Act (CPA). Apart from the fact that the release of full medical records would often be in breach of privacy regulations, it is not clear how the records could be meaningfully interpreted.

Another example of poor quality information sharing involves referrals for medial assessments. The quality of a medical assessment is dependent on the quality of the information provided at the time of the assessment. When SCAN teams operated effectively prior to 2004, Health would have known the background of the child and the family and would have been provided with other important information from Education. This is essential to a full and meaningful assessment of the child and the child's needs. We are now asked to see children with very limited background information, or at times misleading information.

Recommendation 8.2

That there is improved sharing of information, enabling health workers to be effective in their care of vulnerable children, and acknowledging that sound child protection assessments and decision-making can only happen when the present is understood in the context of the past and the trajectory of the child and their family.

9. CHILD SAFETY – AFTER HOURS SERVICE

The Department of Child Safety (DCS), as a statutory authority, has a central role in the investigation of child abuse and neglect. Cases of significant abuse and neglect can occur at any time, yet after hours child safety services are very limited.

While limited by resourcing, DCS are the investigatory agency for child protection and have an obligation to assess and respond to allegations of abuse and neglect in a timely manner. At times, these allegations require an immediate response, e.g. in cases of significant injury to a young child. It is not uncommon that this is needed outside working hours.

The Child Safety After Hours Service (CSAHS) has limited resources to respond to this need, which results in questionable practice. For example, a decision to remove a new born baby is made following a phone interview and the parent is informed of this outcome over the phone. It is not uncommon that children who are hospitalised with an injury have no assessment commenced by DCS until the Monday after a weekend. This lack of timeliness can interfere with the effectiveness of an investigation.

While the Queensland Police Service (QPS), as another statutory authority, can assist DCS, it is not appropriate for Health staff to act on behalf of DCS.

Recommendation 9

That the resourcing of CSAHS is reviewed, with view to expansion of the service to allow for best practice standards at all times, including after hours.

10. NON-ATTENDANCE AT SCHOOL NEEDS TO BE SEEN AS A CHILD PROTECTION MATTER

While acknowledging that being in school is a protective factor, Child Safety (DCS) in Queensland considers that non-attendance at school is not a child protection matter. The DCS position is that not attending education is a matter for schools and police, without acknowledging that lack of school attendance is often a strong link to family dysfunction.

The link between educational neglect and other forms of neglect is common. Hence, it is concerning when DCS indicate that reports of potential harm do not reach the level of a Child Protection Notification (CPN) because there is no demonstrated harm, even though the report includes the fact that a child is not attending school. **CASE 6** describes a child whose medical management was severely compromised because of neglect, with numerous (missed) opportunities for DCS to investigate and intervene with this case.

A recent positive initiative of introducing a reporter's guide to assist Queensland Health (QH) workers in reaching a reasonable suspicion of abuse was based on a similar tool in New South Wales (NSW). The NSW tool, however, included educational neglect, a concept well reported in child protection literature. DCS however, chose to remove the educational neglect pathway.

Recommendation 10

That lack of school attendance is considered to be a sign of educational neglect and should be considered a matter that may require a child protection investigation.

11. MULITAGENCY INVESTIGATIONS

The investigation of allegations of suspected abuse and neglect frequently involve Child Safety (DCS), the Queensland Police Service (QPS) and Queensland Health (QH). While at times this can run very smoothly, there is often frustration around the timeliness and quality of information gathering and sharing. The quality of these investigations can ensure that a child is protected and just as importantly, that parents are not falsely accused.

There is lack of consistency around multiagency investigations, with no guidelines for best practice. Hence, there is currently no way of assessing if appropriate standards are being reached.

Part of this process includes skills in interviewing children. Interviewing children after allegations of abuse and neglect clearly needs to be done in a developmentally appropriate way. Current training in this area is done through a one-week ICARE course for DCS and QPS staff.

There are various models used by Child Protection units across the world, with many relying on specialty interviewer positions with high level interviewing skills. Many studies throughout the 1990s indicate that despite the recommendations of professionals and researchers, most investigative interviews of children do not follow 'best practice' guidelines put out by researchers and professional bodies.

However, there are several research-based interview protocols which are used in the UK, Sweden, Canada, Israel, and the United States for example, that provide a standardised format for well-trained interviewers to elicit information from children. Furthermore, it has been shown that an intensive 1-2 week training in the use of, for example, the National Institute of Child Health and Human Development (NICHD) protocol, together with ongoing detailed feedback and group training sessions for up to one year on trainee's interviews with children, is required in order to best potentiate 'best practice' interviewing guidelines for the use with young people *(Lamb et al 2008)*. This improves the format and style of the interview, the information elicited, and the interviewers themselves.

Recently, Western Australia brought together a Child Advocacy centre, based on the USA model of addressing child abuse. Within this centre, a specialist child interviewer is employed using a 'best practice' format for interviewing children.

Recommendation 11.1

That there is a working group of DCS, QPS and QH to look at setting best practice guidelines for investigations of abuse and neglect.

Recommendation 11.2

That there is review of best practice standards and processes for interviewing children around allegations of abuse and neglect with better format of interview protocol and appropriate, high-quality training and ongoing review.

12. SEXUAL OFFENDING IN YOUNG PEOPLE

The following comments are made by Ms Judy Fox, Manager of the Mater Family and Youth Counselling Service (MFYCS), which provides therapy to young people who sexually offend and their families.

In our experience over the past 6 years, the major concern has been the gross inconsistencies apparent across different Child Safety Service Centres (CSSC) in response to sexual offending by young people. For example:

In some cases where a young person who has sexually offended (YPSO) is living in the family home with the child or children that were harmed, Child Safety (DCS) becomes actively involved and will allow the YPSO to remain in the home. In other cases, however, DCS will become involved but will remove the YPSO from the home immediately.

Further, there appears to be no consistency in regards to whether or not the carer(s)/ parent(s) have been assessed as 'acting protectively'. In some cases, DCS is not involved at all or have only made phone assessments with parents which form the basis of the decision to allow the YPSO to remain in the home.

Recommendation 12.1

That thorough, face-to-face assessments are undertaken for each case involving an YPSO who lives with the child/ children that has/ have been harmed, and that the decisions regarding placement of the YPSO are made on a case-by-case basis, determined by these thorough assessments.

Recommendation 12.2

That DCS ensures that the file remains open while legal proceedings are continuing for the YPSO (this should include the Youth Justice conferencing process until end of the conference agreement).

It has been noted that there is considerable variation across CSSC in the way the processes of family reunification is managed after a YPSO has been removed from the family home. In some cases, our service has been invited to attend family group meetings and stakeholder meetings in order to assist in the careful planning of gradual reunification. Our input has been welcomed and taken into consideration in some cases, yet, there are times that we have not been consulted or included in the process at all, despite contact from us offering vital information about the YPSO and/ or the harmed sibling. In this case, there is often a lack of liaison and communication between DCS and other agencies involved with the YPSO, such as residential care agencies, other counselling services and schools etc.

Recommendation 12.3

That DCS ensures that there is a carefully planned and collaborative approach (involving all agencies engaged with the YPSO) to the process of gradual family reunification in cases where a YPSO has been removed from the family home.

It appears that active, effective involvement and interest by DCS begins to wane in the lives of some YPSOs involved with DCS, when they reach the age of around 15 years. Again, there is variation across CSCCs and between DCS workers. Although there have been some exceptions, these appear to be due mainly to the attitude and practice of the individual DCS officer involved, rather than to any consistent application of DCS policy or procedure. While there may be transition processes and even teams in place to monitor this period in a YPSOs life (approx. 16 years), this approach appears to be inconsistent and, at times, ineffective.

Recommendation 12.4

That transition issues are considered from the early teen years (12/13 years) if YPSOs are involved with DCS at that point. A DCS team approach should be implemented to monitor and address this early period.

A separate team could be responsible for particular attention to the vital 'transition to adulthood' process when YPSOs reach 15/16 years. Focus from early to late teen years should include:

- Assisting young people to engage in pro-social activities
- Life skill training (including interpersonal communication skills, sexual ethics and psycho education)
- Educational and employment/ training opportunities which are achievable and appropriate for each individual young person.

All this is often ineffectual if it does not begin well before age 16 years.

On occasions, DCS officers have requested that Mater Family and Youth Counselling Services (MFYCS) provide long term risk assessments of YPSOs or for MFYCS to be held responsible for monitoring the risk for sexually reoffending, both of which would appear to be the responsibility of DCS.

It appears that many front line DCS officers assigned to complex cases which involve extremely vulnerable children and often chaotic families, may be the most inexperienced and possibly lowest qualified workers. Not surprisingly, staff turnover appears to be a major issue within DCS. Some YPSOs who have attended our service have experienced multiple changes of their allocated Child Safety Officer (CSO). Many YPSOs have already experienced abuse, trauma, and early attachment disruption; developing trust through consistency and stability is paramount to their healing and future safety. Evidence indicates that risk for sexual re-offending is also related to these factors.

We have further found that effective communication with DCS officers is extremely difficult at times, that is: lack of consultation and inclusion, not having calls returned, being difficult to engage with and resisting the sharing of information, even when families have provided authorisation to release information.

Recommendation 12.5

That DCS front line workers have appropriate tertiary qualifications and, prior to commencing work, are trained sufficiently to gain a solid understanding of infant, child and adolescent development, and of other vital and relevant areas such as different types of abuse and subsequent trauma, and the short and long term impacts different forms of abuse.

Recommendation 12.6

That appropriate support for front line workers is provided to minimize the impact of vicarious trauma. There is strong evidence suggesting that vicarious trauma is a normal and expected outcome for those working with traumatised people and traumatising material. Consequently, there is an onus on organisations to support front line workers in this area and to encourage a work environment and culture that recognises and normalises this phenomena. Appropriate and effective supervision, opportunities for de-briefing and appropriate and diverse caseloads are paramount to this support *(Morrison, 2007)*.

Recommendation 12.7

In general, that a more effective approach to child protection in Queensland might encompass a philosophy where children/ young person's permanency, safety and stability take precedence over all else once early intervention practice with families has been tried and failed.

A systemic, multiagency approach similar to the old SCAN model, might attempt to play the role of a 'separate, independent body' which could overview and ensure that each child at-risk is receiving the appropriate response in a timely and appropriate manner.

Alongside this model, there should be organisational structures and policies in place to provide and maintain greater care, support and training for frontline staff.

RECOMMENDATIONS SUMMARY

DESKILLING OF THE CHILD PROTECTION WORKFORCE	
Recommendation 1.1	That support is given to the establishment and retention of a highly skilled child protection workforce where clinical judgment based on this expertise is valued over screening tools.
Recommendation 1.2	That assessment is done in a way that acknowledges the complexity of underlying child protection issues.
THE THRESHOLD OF RAISING A CHILD PROTECTION NOTIFICATION	
Recommendation 2	That consideration is given to review of the high threshold DCS have for investigating child protection concerns, with acknowledgment of the limitations other professionals have in being able to identify risk and protective factors and demonstrable harm.
PLACEMENT OPTIONS FOR OUT-OF-HOME CARE, INCLUDING CONSIDERATION OF PERMANENCY PLANNING	
Recommendation 3	There needs to be a review of available OOHC placement options with consideration of permanency planning with the option in some select cases for adoption. This may require re-consideration of the principle of 'least intrusive' intervention with perhaps stronger emphasis on the needs of the child, not just physically, but emotionally.
MEDICAL NEEDS OF CHILDREN IN NEED OF PROTECTION	
Recommendation 4	That further consideration is given to a cost effective model of medical care for children assessed as suffering harm, including those in need of protection. This might involve specialist staff supporting primary care physicians in the community.
ADOLESCENTS	
Recommendation 5.1	That consideration is given to adolescent specialist teams.
Recommendation 5.2	That multiagency consideration is given to how to best manage high-risk young people.

NEWBORN AND PERINATAL PERIOD	
Recommendation 6.1	That consideration is given to the possibility of being able to issue a TAO prior to the birth of a baby, where it has been assessed that the baby is in need of protection after birth, and/ or that there may be a 'flight risk' that would place the baby at significant risk.
Recommendation 6.2	That consideration is given to the issue of guardianship for babies of mothers who are under the care of an adult guardian.
ATTACHMENT	
Recommendation 7.1	That, in any child protection investigation, an infant's need for a secure attachment relationship is appropriately assessed and considered. This requires adequate training of child protection workers to conduct this assessment, or to interpret and act on the findings of assessments performed by other suitably qualified clinicians.
Recommendation 7.2	That attachment-informed interventions are provided to families at-risk.
Recommendation 7.3	That out-of-home care (OOHC) placement should be informed by attachment principles, including the importance of foster carers as primary attachment figures, the stability of placement to allow such attachments to form, and the training and support of foster carers to provide the specialised care OOHC children need.
Recommendation 7.4	That it is recognised that infants and very young children who are hospitalised for extended periods in the absence of a primary carer are at high risk of developing attachment disorders and other adverse sequelae resulting from the absence of a buffer against the challenges of a hospital environment. These situations should be seen as urgent and when child protection services become involved, a foster carer should be identified as soon as possible to allow the child to attach to a single carer.
SCAN AND OTHER MULTI-AGENCY COLLABORATION	
Recommendation 8.1.1	That the current SCAN team structure is reviewed, with consideration of the scope and the function of the team.
Recommendation 8.1.2	That SCAN team representatives come together as equal partners, each with their own area of expertise.

Recommendation 8.1.3	That SCAN meetings are coordinated and chaired by an independent body.
Recommendation 8.2	That there is improved sharing of information, enabling health workers to be effective in their care of vulnerable children, and acknowledging that sound child protection assessments and decision-making can only happen when the present is understood in the context of the past and the trajectory of the child and their family.
CHILD SAFETY – AFTER HOURS SERVICE	
Recommendation 9	That the resourcing of CSAHS is reviewed, with view to expansion of the service to allow for best practice standards at all times, including after hours.
NON-ATTENDANCE AT SCHOOL NEEDS TO BE SEEN AS A CHILD PROTECTION MATTER	
Recommendation 10	That lack of school attendance is considered to be a sign of educational neglect and should be considered a matter that may require a child protection investigation.
MULITAGENCY INVESTIGATIONS	
Recommendation 11.1	That there is a working group of DCS, QPS and QH to look at setting best practice guidelines for investigations of abuse and neglect.
Recommendation 11.2	That there is review of best practice standards and processes for interviewing children around allegations of abuse and neglect with better format of interview protocol and appropriate, high-quality training and ongoing review.
SEXUAL OFFENDING IN YOUNG PEOPLE	
Recommendation 12.1	That thorough, face-to-face assessments are undertaken for each case involving an YPSO who lives with the child/ children that has/ have been harmed, and that the decisions regarding placement of the YPSO are made on a case-by-case basis, determined by these thorough assessments.
Recommendation 12.2	That DCS ensures that the file remains open while legal proceedings are continuing for the YPSO (this should include the Youth Justice conferencing process until end of the conference agreement).

Recommendation 12.3	That DCS ensures that there is a carefully planned and collaborative approach (involving all agencies engaged with the YPSO) to the process of gradual family reunification in cases where a YPSO has been removed from the family home.
Recommendation 12.4	That transition issues are considered from the early teen years (12/13 years) if YPSOs are involved with DCS at that point. A DCS team approach should be implemented to monitor and address this early period. A separate team could be responsible for particular attention to the vital 'transition to adulthood' process when YPSOs reach 15/16 years. Focus from early to late teen years should include: ▪ Assisting young people to engage in pro-social activities ▪ Life skill training (including interpersonal communication skills, sexual ethics and psycho education) ▪ Educational and employment/ training opportunities which are achievable and appropriate for each individual young person. All this is often ineffectual if it does not begin well before age 16 years.
Recommendation 12.5	That DCS front line workers have appropriate tertiary qualifications and, prior to commencing work, are trained sufficiently to gain a solid understanding of infant, child and adolescent development, and of other vital and relevant areas such as different types of abuse and subsequent trauma, and the short and long term impacts different forms of abuse.
Recommendation 12.6	That appropriate support for front line workers is provided to minimize the impact of vicarious trauma. There is strong evidence suggesting that vicarious trauma is a normal and expected outcome for those working with traumatised people and traumatising material. Consequently, there is an onus on organisations to support front line workers in this area and to encourage a work environment and culture that recognises and normalises this phenomena. Appropriate and effective supervision, opportunities for de-briefing and appropriate and diverse caseloads are paramount to this support *(Morrison, 2007)*.

Recommendation 12.7	In general, that a more effective approach to child protection in Queensland might encompass a philosophy where children/ young person's permanency, safety and stability take precedence over all else once early intervention practice with families has been tried and failed. A systemic, multiagency approach similar to the old SCAN model, might attempt to play the role of a 'separate, independent body' which could overview and ensure that each child at-risk is receiving the appropriate response in a timely and appropriate manner. Alongside this model, there should be organisational structures and policies in place to provide and maintain greater care, support and training for frontline staff.

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DOCUMENT 2: REVIEW OF THE 2004 CRIME AND MISCONDUCT COMMISSION INQUIRY

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INTRODUCTION

This document provides a summary of the issues raised in the 2004 Crime and Misconduct Commission (CMC) Inquiry which remain relevant to the functioning of the current Queensland Child Protection system. Throughout this summary, reflections on child protection matters as they stand today are presented in text boxes below each item.

2004 CMC Inquiry

The aim of the 2004 CMC Inquiry was to review if the Child Protection system:

- Was effective and sufficient to protect children from harm and neglect
- Met the obligations to protect children
- Could be improved in terms of its accountability, compliance and review processes would benefit from, and possibly incorporate alternative care models

Based on the findings of the 20004 CMC Inquiry, the primary recommendation was to employ a specialist agency committed to:

- Addressing the needs of children
- Broadening the range of options for case management
- Being the lead agency in a coordinated government response to child abuse and neglect
- Providing effective and sophisticated intake, assessment and investigative procedures
- Delivering best-practice standards of work
- Being open and accountable

CHAPTER 1: CHILD PROTECTION IN QUEENSLAND

This chapter highlights:

1. The importance of understanding the experiences of children who have been abused, the consequences, and the need for targeted interventions.

2. The subsequent effects of being in care, on children who have been abused

> **Response (re 1-2)**
> The quality of care and the timing of out-of-home care (OOHC) may be just as important, if not more important, than the length of time spent in OOHC. There is a need to avoid the over-simplification that OOHC itself is harmful. Instead, the harm that may have been caused to the child before entering OOHC, or the potential further harm likely to be caused if the child remains at home, should be the platform for OOHC decision making. The correct outcome for a child needs to be based on high quality assessment based around the needs of the child.

3. The longer children are in care the greater the likelihood they will suffer from more serious behavioural, emotional and health concerns

> **Response (re: 3)**
> Again, this is a simplistic statement which does not take into account important factors such as the child's age at entering OOHC, the severity of harm experienced by the child prior to entering care, and the quality of OOHC provided by foster carers and OOHC institutions. The simplified view that OOHC generally causes more harm to a child, poses the risk that care options, such as earlier and better OOHC placements, will be overlooked or will be completely by-passed in the future.

4. The 1999 Child Protection Act lead to emphasis on a multi-disciplinary response in the investigation, assessment and intervention processes The new inter-agency process for coordinating responses to protect children which are now accepted as best practice, are not reflected in the current legislation *(CMC 2004, Chap. 1; p8)*.

   The new Act at that time stated that:
   a. Children's rights to protection was paramount
   b. If intervention was necessary, it was to be the least intrusive

> **Response (re: 4b)**
> In practice, there often is limited assessment of what is an *effective*, least intrusive measure. Therefore there is a prolonged trial process of lower interventions, often with recurrent notifications and the child being continually exposed to harm.

c. The principle of reunification
d. The right to long term alternate care

5. **Regarding notification:** For a concern to be recorded as a notification, that concern must suggest that a child has been harmed or is at risk of harm and does not have a parent willing and able to protect them from harm. (The department) will then only investigate those notifications that reach significance. Significance is defined as serious impairment; is demonstrable or likely to be demonstrable in the child's body, bodily functioning and behaviour *(CMC 2004, Chap. 1; p10).*

Response (re: 5)
Under the current screening criteria, harm is at a level that, even before investigation, is likely to require statutory intervention, i.e. unless the significance of the harm is clearly demonstrated at the time the report is made, there will not be a notification or investigation.

6. There was no way of assessing an unborn

Response (re: 6)
While this has been rectified, it remains impossible to apply for a Temporary Assessment Order (TAO) before the birth of a child, even when the outcome of an investigation is that the child is in need of protection from birth. This places babies at risk as parents can flee with the baby after it is born.

7. Regarding the statement of standards for a child in care *(CMC 2004, Chap. 1; p16)*
   a. *„A child will receive emotional care that allows him or her to experience being cared about and valued and that contributes to the child's positive self-regard."*

Response (re: 7a)
There is ample literature describing the necessity for a child to develop a healthy primary attachment, especially over the first three years of life. Not uncommonly, there appears to be more focus on maintaining contact with the parents at all cost, rather than the promotion of a healthy primary attachment, which then enables further healthy attachment in future years, including with the parents at later date.

   b. „The child will receive dental, medical and therapeutic services".

Response (re: 7b)
There remains no structure or process for timely and meaningful screening and intervention for children in OOHC. It currently occurs in an ad-hoc way.

CHAPTER 2: THE INVESTIGATIONS

Cases that triggered the inquiry:

1. It is of concern that there seems to have been focus on disciplining individuals at a lower level rather than look at the systemic issues.

2. Issue about gonorrhoea /staff accepting the face washer explanation.

> **Response (re: 1-2)**
> There continues to be a lack of departmental awareness that contracting gonorrhoea should be considered harm, even if it is not possible to identify the perpetrator. It is not current practice for DCS to raise a notification on all children who have been sexually abused.

3. Concerns raised that the case was closed too early at SCAN - why SCAN did not pursue the matter was unclear.

> **Response (re: 3)**
> The current SCAN structure does not allow for opinion to be given by other core members – look for information sharing and then close. The role of SCAN is more limited now than in 2004.

4. Brooke Brennan: Ombudsman's recommendations included improved communication between QH, QPS, and DOF; referral of matters to SCAN teams in a timely manner.

> **Response (re: 4)**
> There has been serious deterioration in the use of SCAN, with systemic delays in being able to table a case at SCAN.

5. Baby Kate: issues included ability for DOF to take pre-natal action; transfer of SCAN cases; consideration of welfare of the child; question the ability for the department to scrutinise its own activities

> **Response (re: 5)**
> While assessment can occur prenatally, no action can be taken until the child is born. This leaves a child at risk of being removed from the hospital by the parents, before DCS can act to protect him/ her (see above). Further, SCAN involvement is now very brief and limited and there is no mechanism for reviewing questionable decisions (e.g. no dissension reporting).
> In relation to scrutiny, ability to do Serious Case Reviews (SCR) of avoidable morbidity should be considered.

6. Systemic issues and policy Implications *(CMC 2004, Chap. 2; p91)*
    a. Inconsistency in decision making between officers and offices – systemic
        - Intake and assessment
        - Investigative procedures
        - Accountability
        - The SCAN process
    b. Need for specialist investigators
    c. Need for whole of government approach
    d. Best interests of the child are paramount

Response (re: 6)

Currently, there is little evidence of specialist investigation teams, especially in high risk groups such as infants and adolescents. Outcomes seem to be driven by resources - e.g. the case of a child assessed as being in need of protection (CINOP) was referred to intervention with parental agreement (IPA). When the mother quickly disengaged, the outcome was reviewed and was changed to 'child not in need of protection' after which DCS were no longer engaged with the family.

CHAPTER 3: INQUIRY SUBMISSIONS

Legal Advise Queensland (LAQ): *"Over-emphasis at times on short-term orders and proposals to re-unify a family when re-unification is not a realistic option and the protective needs and welfare of the child would be better served by a* ***long-term stable order.***"

1. Case planning *(CMC 2004, Chap. 3; p100)*
   Abused Child Trust (ACT) - Case planning: *"what...doesn't happen is a full evaluation of that child's needs – medical, education and psychological – and a plan be out in place to support those needs".*
   - Extremely limited long term planning
   - Short term counselling only
   - Need for medical history and records

Response (re: 1)
There is no consistent assessment model from Health at the time a child is placed in OOHC. The current primary care model needs to be assessed as it is inadequate in most cases.

There needs to be a mechanism of ensuring that plans are followed through. CSOs come and go and children move so who should case manage these children long term? Is there a role for the SCAN team multi-agency approach in reviewing case plans every 6 months for children with complex needs?

2. Family contact *(CMC 2004, Chap. 3; p103)*
   a. Inconsistent approach with little individual assessment of appropriateness and if in best interest for the child.

Response (re: 2a)
There is a need for better assessment of the individual child and the relationships that are best for their emotional development. This assessment needs to acknowledge the complexity of family contact within individualised approaches for each case, prioritising the needs of the child.

   b. Comment that parents may take years to resolve their issues and that children do not have 5-6 years to put their lives on hold. Reunification will be pursued despite the child's strong attachment with their foster carer.

3. Placement options *(CMC 2004, Chap.3; p104)*
   Many young people prefer living in a residential setting; do not like conditions placed on them and do not like the 'closeness' of foster homes.

Response (re: 3)
There needs to be a focus on the role of early statutory intervention within the first three years, with the aim of minimising the number of young people who are unable to form meaningful relationships and trust others. For those who are unable to be readily placed, there needs to be consideration of the use of a specialist teams.

4. Communication and information sharing *(CMC 2004, Chap. 3; p106)*

There was a perception that DOF were reluctant to work collaboratively.

- Delays in making referrals to the SCAN team
- Timing to SCAN – well after the assessment was completed therefore cases were referred and recommended close at same meeting
- Request to close when there were still outstanding issues
- Delays in referring cases to QPS
- Need for DOF to fully share information about tissues relating to the physical and mental health of children in care.
- Communication with the DOF is often a one-way-process.

Response (re: 4)
All of the above issues are worse now than in 2004, e.g.:

- Current process for referral to SCAN has inherent delays, making tabling of a referral likely to take at least 3 weeks.
- Cases are tabled at SCAN *after* DCS has closed or has finalised their investigation, before other agencies have returned their information. This limits the role of other core agencies.

Outside the SCAN team process, referrals from DCS for health assessments often lack information, causing assessments to be incomplete.

- When we are considering if the report to DCS is needed, there is no longer a pathway for QH to ask if there are child safety concerns about a family. RIS say we can only discuss a case with them if we are making a report of suspicion of harm or abuse and we cannot ask CSSCs anymore.
- Present structure means that DCS is often the only agency that holds all the information about a family or child.

5. Foster care *(p115)*
   a. Programs aimed at supporting families through NGOs rather than by CSOs.

Response (re: 5a)
This is a good idea but often the reality is that these services happen briefly, i.e. 3-6 months, to support families with generational abuse & multiple risk factors and with instability. If improvement occurs, it can often not be sustained when services withdraw and before too long a new notification is raised. This subjects children to recurrent neglect and abuse. There rarely seems to be adequate assessment of 'capacity to change' or acknowledgment of the need for long term support.

b. Use of intensive family support to keep children safely in the home.

Response (re: 5b)
Again, a good concept *if* for a duration and intensity that allows for sustainable change. Also, there is a need to think differently about supports for infants and older children, i.e. the need for a range of responses.

c. Foster carers not paid enough.

Response (re: 5c)
There is a need to look at models elsewhere, e.g. salaried foster carers, given the cost of raising a child and the demands of these children, and the fact that most households these days have dual incomes.

d. Robust case management system

Response (re 5d)
Consideration is needed as to who should have the responsibility for this role as DCS is often the more inconsistent contact given the high turnover of staff. Education, Health or a multiagency approach are examples of alternate options.

e. Many children in need of protection would benefit from specialist medical, psychiatric, allied health and education services... but there was not routine multidisciplinary assessments done... simplest way...would be to enhance the role of SCAN teams.

Response (re: 5e)
There is extensive literature on the expectations of health screening of children in out of home care. QH has adopted an approach of a primary care model which relies on the foster carer taking the child to a GP. There has never been any assessment of the effectiveness of this model but it is unlikely that GPs, who have not been supported in this model, will be able to effectively provide this service. Some Paediatric services have been able to incorporate these assessments but this is by no means widespread. The quality of information from DCS is often of poor quality and the medical officer seeing the child is making a limited snap shot assessment. This is in contrast to SCAN team meetings held at MCH prior to 2004 when the doctors seeing the children would know the background and complexities of the children and families they are seeing, allowing for more meaningful assessments and more realistic plans for their wellbeing.

6. Enhanced accountability *(page 121)*
    a. Internal accountability for clinical aspects of decisions
    b. Unless the child dies or suffers some other significant adverse consequence.
    c. External review can occur via:
        - Presiding Children's Court magistrate – not trained in child welfare
        - SCAN team – limited referrals. 'For the SCAN team to function properly it needs good coordination, respect for the opinions of the various members and a team commitment to promoting the best interests of the children under consideration in an open and accountable manner.'
        - Commission for Children and Young People (CCYP) – only act with respect to complaints
        - Children's Services Tribunal – jurisdictional limits.

Response (re: 6)

The current functioning of SCAN teams depends largely on the good will of the core members who, in some sites, work around the P&P in order to continue to work collaboratively and who utilise the expertise of the core members and value everyone's opinions. This, however, is not supported structurally, with SCAN officially no longer having the above function. Following the 2004 CMC report, DCS became the lead agency and, over the years, has progressively restricted the role of the other core agencies to simply that of information provision. DCS has argued that information can be provided under section 159 of the CPA, and therefore the role of SCAN has become more and more limited. Discussion of referrals from core agencies has become very restricted, with no ability for other agencies to comment on the safety of a child, and being told the case must be closed when DCS is the only agency actively involved with their assessment yet to occur.

CHAPTER 4: THE FUTURE

1. A new department with the following core functions:
   - Intake, assessment and investigations of notifications
   - Targeted support for children identified as being at risk
   - Provision of alternate care

2. Parallel to this is a need for primary and secondary prevention programs

3. Whole of government approach
   - Co-ordinated multi-agency service delivery

4. Causes and consequences of child abuse are highly complex and require interventions which are equally complex.

5. Child protection needs *(p135)*
   - Some children have little opportunity of growing up in a safe and supportive environment
   - Need to identify this earlier and provided with targeted services
   - commitment to the prevention of future harm
   - response to the needs of children already abused or at risk of abuse

Response (re: 5)
The above principles need to be achieved while maintaining focus on the protective needs of the child as the most important overriding principle.

6. DCS Jurisdiction *(p138)*
   Any at risk child formally brought to the attention of the department by way of notification or any other means

Response (re: 6)
- Post the 2004 CMC, the new DCS has jurisdiction for those cases likely to need statutory intervention. For many less clear cases of abuse it is no longer possible to be investigated, limiting contact with families where targeted services could be utilised.
- The SDM tool has been used quite rigidly, e.g. emotional abuse is a 10 day response even if there are concerns about acute risk of suicide.
- It appears that to limit the work load of DCS, the threshold for raising a notification rose with the following observations:
  - Need for demonstrated harm in many cases
  - While being in education is seen as a safety factor, *not* being in education is not a risk factor
  - There appears to be almost no response for adolescents, who are deemed to be able to 'make their own decisions'

Response continued (re:6):

- Referral to a support agency is deemed to be protective, without any ability of a reporting agency to demonstrate engagement with the service
- Families who do not know a report has been made will be deemed safe on the basis that a support agency referral will be made without the family's knowledge and that they are likely to respond to a cold call offering support

7. Maintaining focus on prevention *(p139)*

Commitment to primary and secondary abuse prevention. 'Clearly likely to be sometime before the benefits of such expenditure become apparent'

Response *(re: 7)*

- The change to the new focus where DCS is only involved with children where statutory intervention is likely to occur, meant that families who previously had assessment and a support plan developed by the department were no longer reaching the threshold for DCS services. There was some time before agencies such as Education and QH could refer to support services and even now these services are not universally available. This means that families now need to wait until they are on the brink for statutory intervention before assessment occurs: this may be too late, with children already irreparably emotionally harmed and by this stage and are difficult to place because of their challenging behaviours. As notification rates have dropped, the number of children going into care has increased.

- The families who end up with their children needing OOHC are often highly dysfunctional, not likely to voluntarily engage in services, have multiple risk factors including mental health, substance abuse and domestic violence and primary and secondary interventions are not likely to be successful without clear case planning through a statutory agency. There is a need to do accurate assessments of likelihood of sustained change to allow for consideration of permanency planning before emotional harm as occurred.

CHAPTER 5: DEPARTMENT OF CHILD SAFETY

1. New organisational culture *(page 143)*
    a. *Open and supportive*
    Open, respectful, professional and responsive communication and decision making processes

Response (re: 1a)
There are currently issues with DCS not wanting to share the outcomes of assessments, thus limiting the ability of the other SCAN core representatives to contribute to assessment and management of child protection cases. Cases are often discussed after DCS have finalised their assessment; under the current system it is not uncommon that the only agency that holds all the information about is DCS, limiting the role that other team members can play.

    b. Decision making to be a cooperative and consultative one, promoting transparency and accountability

Response (re: 1b)
As above – it is frequently made clear that other agencies are there to provide information *only* and not for their opinion about the safety of the child. There is little to no acknowledgement of the child protection expertise held by other agencies.

    c. Accepts clinical accountability
    d. Effective communication with external agencies

2. Intake and assessment
    a. Dedicated officers
    b. Consistency

Response (re: 2a-b)
The current intake process now utilises the Regional Intake Services (RIS). Decision making about raising a notification following a report relies heavily on the SDM tool, with the threshold being elevated.

    c. *"The commission recommends....positions to work with biological parents of children residing at home who have been the subject of low level notifications"*
    (CMC 2004, Chapt. 5; **p155**)

Response (re: 2c)
It is not clear what is referred to here as a low level notification. Within DCS at present, the only option for the department to work with parents is under an Intervention with parental agreement (IPA), where the child has been assessed as having suffered significant harm or is at significant risk and is a child in need of protection (which is not a low level notification). As the threshold of Child Safety raising a notification is on the basis that the information received, on face value and with no further investigation, is likely to mean that statutory intervention is likely to occur, there is really no such thing as a low level notification now.

3. Accountability
    a. Role of senior practitioners
    b. *'In addition, and effectively constituting a further sign-off mechanism, there should be an enhanced SCAN process'*

Response (re: 3a-b)
See comments under next chapter. Essentially DCS have made it very clear that SCAN is not about accountability

    c. That DCS establish a unit and clear procedures for receiving, assessing and responding to complaints.

    d. Child Death Review Committee (CDRC)

Response (re: 3d)
This has been developed but there is no process for reviewing avoidable morbidity in the way of Serious Case Reviews (SCRs) i.e. where a child has been injured rather than killed, especially if that morbidity was preventable.

CHAPTER 6: MULTIAGENCY RELATIONSHIPS

1. DCS to serve as lead agency for a whole -of-government approach to child protection. *(p169)*

Response (re: 1)
Since the 2004 CMC report there has been a progressive isolation of DCS in their management of children, with selective sharing of information, and often being the only agency to know all the available information about a child and their family. The option for full and open SCAN team discussion is not often used.

2. To exhibit strong leadership and flexibility in the exercise of its functions
3. Multi-agency approach requires a paradigm shift on behalf of all agencies

Response (re: 2-3)
The current paradigm is one where DCS has placed restrictions on the operating of SCAN teams, which has significantly limited their usefulness.

4. Director General Coordinating Committee (DGCC) to ensure that partisan orientations towards the process are not permitted if a genuinely whole –of-government approach is to be achieved.

Response (re: 4)
From soon after the 2004 CMC report, DCS held strongly to the principle of being the lead agency and that their assessments and plans were not to be challenged. Despite that, the initial SCAN team policy and procedure manual allowed for a reasonably functional SCAN team. Many SCAN teams function because of the good will and team work of the team. This is particularly the case where SCAN teams are supported by the CSSC manager. In approximately 2009, DCS made a request to the Department of Premiers and Cabinet to abolish SCAN teams. This was strongly resisted by QH and other core SCAN team members. SCAN teams were allowed to continue, but DCS was to re-write the P&P manual with limited input from the other core agencies. The result was a SCAN team system which is highly restrictive.

5. A model of such a process exists in the form of SCAN teams
    a. *"When those teams work effectively, the sharing of information and the adoption of a true multi-agency approach facilitates outcomes in the best interest of children".*

Response (re: 5a)
As above; not happening now as a general rule and certainly not supported systematically.

b. The function of SCAN teams as of 2004:
    - Coordinate a multidisciplinary response to cases of child abuse and neglect referred for assessment.

Response (re: 5b)
This rarely happens now.

6. Referral from DCS if:
    - Initial assessment with QPS
    - Use of health workers or services is required as part of initial assessment
    - Severe harm has been caused
    - Sexual abuse
    - Notification of a child in alternate care.
    - Child in custody
    - CPO is being considered
    - Child under three years of age
    - A number of agencies are involved.

Response (re: 6)
DCS rarely now refers at some SCAN Teams

7. It was acknowledged that 'a properly functioning SCAN team (such as Mater Children's Hospital and the Royal Brisbane Hospital) assist with child protection by promoting coordination, planning and support

8. Concerns about the then current SCAN team system:
    - Quality of teams was extremely variable
    - Role of coordinator was pivotal
    - Inherent tensions
    - Conduct of the 'lead agency' with appropriate referrals not always made or made late after the direction of the case had already been decided.
    - Department was dominant and may not fully consider the views of other agencies
    - Medical practitioners were felt by some to dominate.

9. Comments by Lord Laming in relation to the Victoria Climbie case: *"It is clear that if there is not an open exchange of information and a willingness to embrace a multidisciplinary framework then concepts such as SCAN will fail to deliver"*

Response (re: 9)
Under DCS, there is currently not an open exchange of information or a willingness by DCS to embrace a multidisciplinary framework.

10. At the time of the inquiry commitment had been given to fund a number of full time coordinators

Response (re: 10)
This coordinator role is not always filled and if it is, in many cases it has been made part time. The coordinator needs to be impartial and over time, in some SCAN teams, there has become an imbalance of roles between the core representatives, with Child Safety deciding what will be discussed. Ideally, all core representatives should be at the SCAN table as equal players, with acknowledgment of not only their discipline specific expertise but of their child protection expertise as well. This expertise needs to be utilised from the time assessment is commenced, to the development of a case plan and potentially review of that case plan.

11. SCAN and DCS: the new model:
"Child protection can best be delivered by effective case planning and management in a multidisciplinary inter-agency configuration. An invigorated SCAN framework should be the foundation of this process"

a. Core members could be expanded

Response (re: 11a)
Occasionally includes invited stakeholders.

b. Case planning for children placed in care

Response (re: 11b)
Rarely.

c. All cases of alleged abuse and neglect of children in alternate care or under formal orders should be referred.

Response (re: 11c)
Rarely.

d. Senior staff member with ability to commit resources

e. Case planning framework should encompass the formulation of the case plan and agreement of all members in a truly multi-disciplinary manner.

Response (re: 11e)
Rarely.

f. Six monthly case reviews for some cases.

Response (re: 11f)
Never.

g. Need detailed records

h. "Exception reporting" if agreed to plan is not followed

i. Resources for training and team building

Response (re: 11i)
Rarely now, but mainly because SCAN has been too unstable

j. Effective functioning should be a performance indicator for DCS.

k. Multi-agency SCAN teams are a core means of officially responding to cases of suspected child abuse in Queensland.

Response (re: 11k)
Rarely

CHAPTER 7: THE FOSTER CARE SYSTEM

1. There is a shortage of placement options for children. *(p187)*

> **Response (re: 1)**
> Significant numbers of children as young as 8 years old are in motels with 24 hour carers at high cost.

2. Few opportunities to match the child's needs with the appropriate service
3. Insufficient foster care or residential facilities
4. Children homeless and in at risk situations
5. Temporary accommodation
6. Diverse needs of children coming into care
7. Children with severe behavioural and mental health problems needing independent living arrangements or therapeutic placements.
8. Challenge of placing sibling groups
9. Respite care – conceptualise as respite for the child
10. Carers have no leave entitlements and there is no provision for regular holidays or access for respite at times of crisis.
11. Regular planned respite to improve the child's wellbeing.
12. Planned respite with camps etc.
13. Adverse behavioural, emotional and developmental effects of abuse are well documented.
14. Abusive early parenting partially ameliorated by stable nurturing and responsive environment.
15. Difficulties in forming attachments.
16. Remuneration: volunteer carers as opposed to salaried carers
17. Casework and planning

Response (re: 17)
There is no mention of the need for comprehensive assessment of the child's medical, psychological and education needs

18. Biological parents role 'currently the aim of the department is to reunify children' therefore need to be involved in case plan.

19. Reunification versus permanency planning to avoid having children experiencing indeterminate periods in care oscillating between reunification and placements in care causing serious risk to the child's long term wellbeing and specifically places children at risk of behavioural and emotional problems and ongoing difficulties forming stable, positive, relationships with others.

20. US and UK

21. NSW has permanency planning legislation.

22. Concerns about another stolen generation

23. Query too much weight to the principle of least intrusive and to reunification.

24. Need to give appropriate weight to the safety of the child

25. Relationships with biological parents should be maintained - if in the best interest in the child.

Response (re: 25)
There are increasing numbers of children with significant behavioural and emotional problems who are difficult to place, break down placements and engage in extremely high-risk behaviours, and, in some cases, will die by accident or suicide. Once these children have suffered significant emotional harm, it may not be possible to turn their negative trajectory around. More needs to happen to stop this generational abuse. Consideration needs to be given to adequate intervention in the critical years of a child's development - i.e. under 5 years of age. Often, attempts to place the child in OOHC occur after many failed interventions and once there is demonstrated harm, as that is the standard that DCS has set. There needs to be better assessment of capacity for change for parents who have high risk indicators such as substance abuse, mental health and domestic violence. Consideration needs to be given to permanency placement. At present, children who enter care at a young age will most likely have a short-term CPO with the plan for reunification. This does not always promote full and healthy primary attachment. In some select cases adoption may need to be considered as an alternative for young children.

CHAPTER 9: LEGISLATIVE CHANGE

1. Importance of SCAN teams enshrined in legislation. *(p244)*

Response (re: 1)
While this did occur, there has been a progressive erosion of the expectations of SCAN teams and the role of the core representatives. Where SCAN teams remain effective this is because of the good will and history of the team who choose to ignore the current P&P manual.

2. Ability to raise a notification before the birth of a child to allow assistance and support to the pregnant women.

Response (re: 2)
While this is now possible and an assessment can be done, there is a lack of ability to take further action until the child is born. In a number of cases an outcome of a 'child in need of protection' is made, and it is clear that it will be very risky for the child to go home. However, there is no ability to any further assessment so that a TAO will be taken as soon as possible after the birth of the child. There can be an inherent delay in getting the TAO where there is no power for the hospital to remove the child from the mother's care, leaving the possibility that the mother could abscond with the baby. A care and treatment order does not help in this situation.