QCPCI Tendered in chambers

Date: 17.10.2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Exhibit number: 132

STATEMENT OF Queensland Health witness Timothy Wood

I, **Timothy Wood**, of Children's Health Service Queensland, Child Youth Community Health Service, 184 St Paul's Terrace, Spring Hill Qld 4006, Director Child Advocacy Service, solemnly and sincerely affirm and declare:

1. I am Director for the Child Advocacy Service, Children's Health Queensland, Child Youth Community Health Service.

2. I was appointed to this position in October 2010. I live and work in Brisbane and greater metropolitan area.

3. When planning and reviewing my work and seeking approval for decisions, when required, I report to Dr Neil Wigg, Senior Director Child Youth Community Health Service who is also based in Brisbane. This service is part of the Children's Health Queensland Hospital & Health Service.

4. Prior to this appointment I have held the following positions:
   - Team Leader, Queensland Hearing Loss Family Support Service, Child Youth Community Health Service, (Sept 2008- Sept 2010); providing clinical leadership and operational management in a state-wide service for children diagnosed with permanent hearing loss.
   - Acting Principal Therapeutic Programs Officer, Program Management Branch, Policy and Programs Division, Department of Child Safety, Queensland Government (Jan 2008- Sept 2008); Assisting the development of partnerships for therapeutic programs for children in out of home care.
   - Acting Principal Program Officer , Policy and Programs Division, Department of Child Safety, Queensland Government (July 2006- Jan 2008); with portfolio for Evolve and Referral for Active Intervention services.
   - Project Officer Quality Standards Assessment Branch, Department of Child Safety, Queensland Government, (Nov 2005-July 2006); assisting development of "Operational Framework for the Regulation of Child Protection Care Services" in Queensland
   - Independent Reviewing Officer, Review and Quality Assurance Unit, London Borough of Hammersmith and Fulham, UK (June 2004 to Oct 2005); supporting statutory review and quality assurance systems within the Local Authority, including chairing Child Protection Conferences and Child 'Looked After' reviews.
   - I have also held a range management and clinical roles in government and non-government agencies in the UK, across a spectrum of tertiary, secondary, primary services.

5. I hold a Master of Arts in Applied Social Studies, (Brunel University, England, conferred 1998), Diploma in Social Work, (Brunel University, England, conferred 1997) and Bachelor of Arts Honours (*Economics of Government and Social Industrial Studies*) (University of Wales, UK, conferred 1992). I am currently a member of the Australian Association of Social Workers.

6. Please refer to the witness statement by Corelle Davis, Child Safety Director, Department of Health for context of health service delivery systems in child protection, legal and policy frame work, including *Role and purpose of Suspected Child Abuse and Neglect*, paragraphs 17-28 *and Legislation regarding mandatory reporting*, paragraphs 29- 37.

JP Qual 88469.

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DIRECTOR, CHILD ADVOCACY SERVICE (CAS) ROLE

7. The CAS Director is responsible for the provision of specialist clinical and managerial leadership, strategic direction and advocacy in child protection services in Children's Health Queensland (CHQ), including Royal Children's Hospital and Child Youth Community Health Services.

8. My duties and activities include:
   - Accountability for operational, financial, asset and administrative management of the service.
   - Supporting development of integrated model of care for child protection services, in preparation for Queensland Children's Hospital due to become operational in late 2014.
   - Providing leadership and strategic direction for clinical service integration for community health child protection services in the region.
   - Applying clinical and managerial experience to develop strategies to manage complex issues impacting upon service delivery.
   - Provision of advice and direction on clinical child protection services at a statewide policy level.
   - Provide professional advice in relation to standards of practice and clinical need.
   - Accountability for the integration of QH Statewide and Whole of Government Child Protection initiatives into Children's Health Queensland policy, practices and clinical quality and safety, including the accountability for all policy development and reviews related to child protection across region.
   - Providing the lead contact for RCH in systems and practice review following death of a child known to Child Safety Service in the last three years.

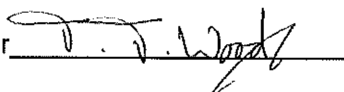
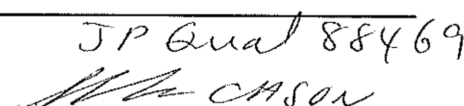
9. As part of my role I participate in a range of intra-service network meetings, community health management meeting, child protection reference group, Strategic Directions Group (now State-wide Child Protection Clinical Partnership steering group), SCAN Business Meetings and north metro Medi-Care local meetings. I also chair weekly service clinical intake meetings; provide weekly intake duties delivering clinical consultation to health staff and lead CHQ child protection (district orientation) education sessions each month.

10. As part of my role I have contact with a broad range of health staff including paediatric nursing and allied health management, clinical leaders and frontline health staff. The role has also required regular contact with systems and policy managers for Queensland Health and Child Safety Services (CSS). I have occasional meetings with local CSS Regional Intake Service managers to review systems and communication needs. I also liaise with Queensland Police Service, Child Protection Investigation Units and non-government agencies such as Act for Kids and NAPCAN.

Child Advocacy Service role and functions

11. The Child Advocacy Service (CAS) commenced in July 1999 becoming a single point of contact for tertiary level assessment and consultation-liaison advice on cases of suspected harm and abuse for the Royal Children's Hospital and Children's Health Services. (As of July 1st 2012, Children's Health Services become Children's Health Queensland, Hospital and Health Service).

12. The CAS team consists of multi-disciplinary clinical specialists including paediatricians, nursing staff and social worker delivering:
    - Initial assessment and long term follow up and treatment for identified clients.
    - Ambulatory clinics for children with medical concerns relating to their child protection history.

Signature of officer  Witness Signature 

- 24 hour (Child Protection Advisor) paediatric consultation.
- Inpatient and other patient consultation and case management where child protections concerns are identified, such as non-accidental injuries, neglect of medical care and complex case management.
- Core member representation at (ten per month) Suspected Child Abuse and Neglect (SCAN) meetings and provision of written health information.
- Education and training at both district and community health service level.
- Forensic assessments, report writing and court attendance as expert witnesses.
- Completion of Child Health Passports for children entering out-of-home care.
- Receipt of all mandatory reports (SW010) from CHQ and other hospitals and facilitation of consultation and management process.
- Provision of intake and consultation services for CHQ health staff. Also as a tertiary hospital providing state-wide consultation.
- Provision of relevant child protection information (under information sharing legislation) and consultation and advice with CHQ Health Information medico- legal team as required
- Management of service based statistical data systems.

13. A significant cohort of children accessing these clinics are referred through SCAN or Department of Communities, Child Safety Services with current or recent child protection concerns. In 2010 -11 over 90% of referrals occurred through this pathway. These clinics also provide significant medical follow up for children in out of home care. The focus on this cohort is consistent with contemporary research which identifies heightened health risks for children residing in out of home care[1]. A study of 63 children in out-of-home care accessing these clinics, found that 70% of these children required multiple referrals to various health services including paediatric follow-up (41%), immunisations (32%), counselling services (30%) and audiology (26%).[2] Kaltner and Rissel's study support evidence of need for children in care requiring multi-disciplinary health screens to detect child health issues in this population.

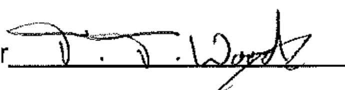
14. CAS delivers nine outpatient clinics per fortnight which are targeted toward children whose medical concerns relate to their child protection history. Clinics provide initial assessment and long term follow up and treatment for identified clients. Between 2009-11, 1635 child protection outpatient clinic bookings were made with attendance reaching 76%, which is remarkable for this cohort of children.

15. CAS has a leading role in promoting education and training activities that support the responsibility of health staff in recognition, reporting and responding to concerns of child abuse and neglect. In 2011 paediatric, nursing and social work staff delivered 294 hours formal education activities promoting skills and knowledge in this area.

16. **The following statements have been developed in consultation with CAS clinical team, including Dr Catherine Skellern (Senior Medical Officer, CPA), Dr Otilie Tork (Senior Medical Officer, CPA), Dr Maree Crawford (Senior Medical Officer, CPA), Dr Geoffrey Pearce (Senior Medical-Registrar), Colleen Cox (Child Protection Liaison Officer (CPLO)- Clinical Consultant Nurse), Karin Rissel (Clinical Nurse- CPLO) and Julie Broadhurst (Senior Social Worker- CPLO).**

[1] Nathanson D, Tzoumi D. *Health Needs of children living in out of home care.* J Paediatrics and Child Health 2007

[2] Kaltner, M, Rissel, K. *Health of Australian children in out-of-home care: Needs and carer recognition.* J Paediatrics and Child Health, 2010

Signature of officer  Witness Signature

Mandatory reporting responses

17. Receipt and oversight of mandatory reports generated by health staff, is an important function of the service. In 2011 CAS received and triaged 2064 mandatory reports. Clinical staff routinely provided feedback to reporters within the CHQ catchment. Some challenges occurred for the service in attaining outcome advice within a five day time frame.

18. The roll out of Child Safety Services -Regional Intake Services (RIS) in 2010 has provided improved pathways for co-ordination and simplified reporting. The capacity to raise issues through RIS Team Leaders and participate in localised discussions has in principle promoted collaborative intents. For example, periodic challenges for RIS in delivering outcome reports within designated time frames have been addressed through local dialogue and ongoing communication about any missing information.

19. There is a challenge for health child protection services in operating across different legislative frame works. Mandatory reporting under *Public Health Act 2005* offers a disparity between reporting thresholds contained in the Child Protection Act 1999. In practice, this point may arguably be reflected in CAS data and RIS review data. In 2011 intake staff triaged 15% of intake reports within category of "Significant Harm or Risk of Harm- *Expeditious Response within 24 hours*"[3]. The Regional Intake Service Post-Implementation Practice Review, 2011 identified in October 2010 to June 2011, 3.3% of health professional reports required a 24 hour notification response.[4]

20. It is perhaps unsurprising that health services that deliver across primary and secondary interventions will contain lower thresholds than a statutory tertiary service. Given the complexities of child protection, an intervention system that can utilise principles articulated in *National Framework for Protecting Children 2009-20* initiative, may achieve a balanced approach to population health that can enhance a continuum of care. In short, the structure of delivery of services to vulnerable children and families should be strengthened to encompass programs that combine primary and secondary, or secondary and tertiary levels.

System's and practice review mechanisms

21. The *Child Protection Act 1999* requires Child Safety Services to review its involvement with a child where the child was known to the Department in the last three years prior to their death. Whilst cases involving child fatalities are heavily scrutinised through the Child Death Review Committee, there is no parallel system to allow similar scrutiny in cases that constitute a 'near-miss'.

22. Revision of the SCAN team system included capacity to provide core members with opportunity to table cases that have been *screened out* by intake processes through Information Co-ordination Meetings (ICM). The intention is to provide a mechanism for key agencies to offer further information that will be relevant to risk for the subject child/ren.

23. In cases that are tabled at ICMs there is no further provision to review or re-table. In practice the ICM system impairs collaborative intents placing a significant tension and adversarial dynamic between agencies. For example, any new relevant information must

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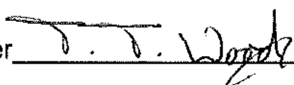
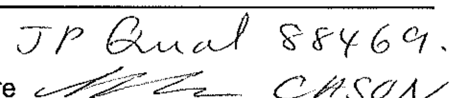
[3] *Intake and Service Eligibility- Child Safety*, CHQ Procedure Document doc 02650

[4] *Regional Intake Service, Post-Implementation Practice Review, State-wide Report* Queensland, Department of Communities, August 2011

Signature of officer  Witness Signature 

be communicated back to RIS (even if it has been tabled in the ICM already). RIS will then consider the information in the context of what is already known about the case.

24. Given the intent of the ICM system is to provide a capacity for agencies to share information, any agency/ core representative referring to this meeting is likely to believe that this information has significant value in informing appropriate decision-making. Any change of decision will require the RIS representative attending this meeting to reverse their original screening decision.

25. The framework governing ICM and SCAN functions are defined in the SCAN manual. In practice, there are few ICM's held (9 in Brisbane area 2011. This figure may be indicative of agreement at an earlier level before resulting in ICM or interagency reluctance to utilise this mechanism).

26. A recent survey of eleven Queensland Health Child Protection services in the greater Brisbane metropolitan area conducted in March 2012, included feedback from services identifying increased demand for information sharing under, The *Child Protection Act, 1999*, S159.[5] An internal CAS audit conducted in early 2012 recorded that CPLO staff, utilised an average of 33% of working hours to meet SCAN and information requests. CAS medical CPAs and CPLO staff attending SCAN meetings have observed emphasis on retrieving information for these meetings without any apparent bearing on quality of decision making.

Children in Out of home care

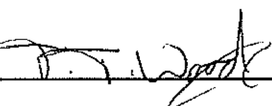
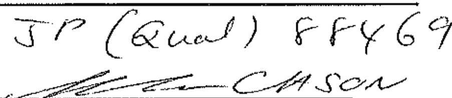
27. I make the following comment based on my professional experience as a former *Independent Reviewing Officer (*IRO*)* in the UK for "Looked after children". I acknowledge different legal jurisdictions; traditions and social contexts may influence the total value of this approach but respectfully recommend consideration of how similar principles may benefit the Queensland child protection systems.

28. While the role of CCYPCG, community visitor program offers oversight for a cohort of children in out-of-home care, IRO tasks are underpinned through statutory requirement to[6]:

- *Monitor the local authority's performance of their functions in relation to the child's case*
- *Participate in any review of the child's case*
- *Ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the appropriate authority*
- *Ensure that plans for looked after children are based on a detailed and informed assessment, are up-to-date, effective and provide a real and genuine response to each child's needs*
- *Identifying any gaps in the assessment process or provision of service*
- *Making sure that the child understands how an advocate could help and his/her entitlement to one*
- *Offering a safeguard to prevent any 'drift' in care planning for looked after children and the delivery of services to them*

[5] Survey conducted by Child Protection Clinical Services Integration team (Children's Health Queensland) to map Child Protection Service Delivery across the Greater Brisbane Metropolitan Area, March 2012

[6] The appointment of an independent reviewing officer (IRO) is a legal requirement under Section 118 of the Adoption and Children Act 2002, UK. (See: http://www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/iro)

Signature of officer  Witness Signature 

- *Monitoring the activity of the responsible authority as a corporate parent in ensuring that care plans have given proper consideration and weight to the child's wishes and feelings and that, where appropriate, the child fully understands the implications of any changes made to his/her care plan.*

29. I commend the value of the IRO system in supporting placement stability, providing advocacy and continuity of care centred on the needs of the child.

Declared before me at Brisbane, Queensland this ~~10th~~ 16th day of October 2012.

JP Qual 88469.

Signature of officer ________ Witness Signature ________