STATEMENT of Queensland Health witness Peter Clifton Roper

I, Peter Clifton Roper, of Rockhampton Hospital, Canning Street, Rockhampton, solemnly and sincerely affirm and declare:

1. I am the Director of Paediatrics for Rockhampton Hospital and the Central Queensland Health Services District.

2. I have held this position and the position of Senior Staff Specialist in Paediatrics for the Rockhampton Hospital since January, 1999.

3. I am also a part-time Senior Lecturer in Paediatrics with the Rural Clinical School in Rockhampton, which is attached to the University of Queensland.

4. I was a Paediatric Consultant in private practice with visiting rights to Rockhampton Hospital between January 1981 and December 1998.

5. I am the designated Paediatrician to the Rockhampton S.C.A.N. (Suspected Child Abuse and Neglect) team.

6. I have held this position since 1982.

7. I am also the Medical Child Protection Advisor to the Central Queensland Health Service District.

8. I have been appointed to this position since 2005.

9. I have the qualifications of:-
   a. Batchelor of Medicine, Batchelor of Surgery, M.B.B.S., University of Queensland, 1971.
   b. Fellow of the Royal Australasian College o Physicians, F.R.A.C.P. (Paediatrics) 1981.

10. Since 1981, I have regularly attended conferences and workshops on Child Protection.

ROLE

11. The purpose of my role as the designated Paediatrician to the Rockhampton S.C.A.N, team includes –
    a. Assessment of the child for signs of abuse. This involves taking a history, including the story of the injury in detail; assessing the developmental age of the child; a thorough examination of the child or signs of abuse; and undertaking relevant investigations.
    b. Reporting of suspected abuse to the Department of Child Safety (Department of Communities D.O.C.S.) as mandated under legislation,

and to the Queensland Police Service if sexual abuse or criminal behaviour is suspected.

c. Attend S.C.A.N. team meetings regularly and for emergency meetings to discuss management of cases of child abuse. The regular meetings are held weekly on Wednesday mornings.
d. Attend court as required to present medical evidence in cases of child abuse, and an expert medical opinion when required.
e. Ongoing review of the abused child as required to monitor response to management.
f. Participation in conferences and workshops on Child Protection to keep abreast of new developments in this complex area.
g. Providing ongoing education in Child Protection to junior resident medical officers working under my supervision at Rockhampton Hospital.
h. Act as an advocate for the rights of children.

12. The purpose of the role of the Medical Child Protection Advisor is outlined in Attachment A. This role was created in 2005. There is no formal allocation of F.T.E. of this role by Queensland Health.

13. I am assisted in my role by Child Protection Liaison Officers (C.P.L.O.'s).

14. The Rockhampton S.C.A.N. team consists of-
    a. Queensland Health represented by the designated Paediatrics and Child Protection Liaison Officer from the relevant area.
    b. Queensland Police Service represented by a police officer from the local Child Protection Investigation Unit.
    c. Queensland Education Department represented by a Senior Guidance Officer.
    d. Department of Child Safety (Communities) represented by the S.C.A.N. Coordinator, the Team Leader from the relevant area (North Rockhampton, South Rockhampton, Gladstone or Emerald) and an administrative assistant who documents the minutes.
    e. A representative from the Recognised Entity to represent the interests of Indigenous children when discussed at a S.C.A.N. team meeting.

15. The Rockhampton S.C.A.N. team covers an area from St Lawrence (to the north) to Agnes Water (south of Gladstone), and from Yeppoon (to the east) to the border between Queensland and the Northern Territory (past Winton and south including Birdsville).

16. There are four Department of Communities Centres covering areas as follows-
    a. North Rockhampton including the Capricorn Coast
    b. South Rockhampton including Mt Morgan and Woorabinda
    c. Gladstone including Biloela and Moura
    d. Emerald including Blackwater, Longreach, Winton and Birdsville.

17. The weekly S.C.A.N. meetings are arranged so that teleconferences are held with Gladstone on the second and fourth Wednesdays of each month followed

by South Rockhampton; and a teleconference with Emerald on the first and third Wednesday followed by North Rockhampton.

18. The teleconference S.C.A.N. meetings are attended by the Child Care Officer from D.O.C.S. (in Gladstone or Emerald), the Child Protection Liaison Officer from Queensland Heath (in Gladstone, Biloela, Emerald or Longreach), the S.C.A.N. Coordinator (DOCS Rockhampton), Police representative (Rockhampton), S.C.A.N. Paediatrician (Rockhampton), Education representative (Rockhampton) and Recognised Entity (Rockhampton).

KEY ISSUES AND CHALLENGES

19. The S.C.A.N. Paediatrician does not have an allocation of F.T.E. for this role, and is expected to undertake other clinical and administrative duties as part of the role of Staff Paediatrician and Director of Paediatrics.

20. The S.C.A.N. Paediatrician does not have time available to review all the reports of suspected child abuse and neglect with the C.P.L.O's, although reports with significant concern are discussed.

21. The current S.C.A.N. Paediatrician is retiring in the near future. There is no formal training process for new Paediatricians in Rockhampton, particularly in the area of examination of sexual abuse.

22. With the recent loss of key personnel from the Queensland Health Child Safety Unit in Brisbane, there is currently no support or education process for a S.C.A.N. Paediatrician, particularly in regional areas.

23. Child Protection cover is provided for 24 hours 7 days a week by the S.C.A.N. Paediatrician and the Paediatrician on call at the hospital after hours.

24. Statistics for the Rockhampton area (Rockhampton, Capricorn Coast, Mt Morgan and Woorabinda; Gladstone and Emerald not included show an increase in the number of Q.H. reports of a reasonable suspicion of Child Abuse and neglect. Over 50% of reports are from nursing staff.

25. The legislation to include reporting of mothers-to-be with risk factors including use of drugs and alcohol has contributed to the increase.

26. The Unborn Child High Risk Alert has variable outcomes. The Department of Child Safety are reluctant to formulate a plan of action for when the baby is born, either in-house or through the S.C.A.N. process. This results in confusion for the parents and hospital staff, particularly on weekends and after hours. It is inappropriate for police to issue a TAO, or Paediatric Staff a Care and Treatment Order for these situations. Confrontation between parents and hospital staff occurs particularly if the baby is separated from the mother. It is inappropriate for busy nursing staff to be given the task and responsibility for continual observation of mother infant interaction.

27. The response of the Crisis Care Centre in Brisbane to after hours reports is often inappropriate, revealing a lack of knowledge of the geography and resources available in Central Queensland. Often local Q.H. staff or police are asked to manage the situation without support from D.Ch.S.

28. The Regional Intake Service (R.I.S.) was relocated to Hervey Bay and similarly has a lack of knowledge of local geography and resources. The R.I.S. often disregards the opinion and recommendations of senior clinicians including the S.C.A.N. Paediatrician. This can involve a lack of understanding of injuries and the mechanism. Eg a newborn baby with significant risk factors was discharged home with the mother to Marlborough, a small village, 1 hour north of Rockhampton. The following day, 2 Child Care Officers drove there to remove the baby under a court order.

29. The R.I.S. team is often late in notifying the local team of the outcome of their assessment. This delays action by the local team.

30. The R.I.S. and the Crisis Care Centre are reluctant to refer complex cases, particularly medical, to S.C.A.N. These cases are discussed in an I.C.M. meeting with the same S.C.A.N. participants, often resulting in a change to a child notification.

31. Indigenous cases often involving neglect and emotional abuse are complex and difficult to manage. These cases often invoke a long discussion and repeat presentations at S.C.A.N. Often there are no suitable carers due to domestic violence, substance abuse, unemployment and poverty.

32. Many indigenous youth are involved in volatile substance use and criminal activity, and are homeless.

33. There is no rehabilitation centre for these youth in Central Queensland. Some after repeated offences are sent to detention in Brisbane, or to rehabilitation programs in the Northern Territory. This dislocates the youth from their family causing further problems.

34. There are a limited number of carers available for children in care who often have difficult behaviours due to previous emotional abuse or post traumatic stress disorder. These children are reviewed by the local EVOLVE team under the supervision of a Child Psychiatrist, but are often difficult to engage.

35. Non government agencies perform a valuable service, but their skills, resources and services are variable with different levels of commitment. Engagement with these agencies often means D.Ch.S. are not involved with direct care, and the agencies do not report engagement or outcome back to S.C.A.N.

36. Care and treatment orders are rarely involved, with either D.Ch.S or Police taking out T.A.O's instead.

Section B: Role Description – Medical Child Protection Advisor

A designated Health Service District (HSD) Medical Child Protection Advisor (CPA) should:

- Demonstrate relevant clinical qualifications.
- Demonstrate clinical experience child protection.
- Be clinically active in the field of child protection. .
- Demonstrated experience in child protection forensic and legal matters.
- Demonstrated negotiation and leadership skills.

RESPONSIBILITIES

The CPA will:

1. Work closely with other CPA's, the Child Protection Clinical Chair and Queensland Health Child Health and Safety Unit (Policy, Strategy and Resourcing Division) in supporting all activities necessary to ensure all Health Service Districts (HSD) staff meet their responsibilities in safeguarding children.

2. Be responsible and accountable within the managerial framework of their employer HSD.

3. Interagency responsibilities
    a. Participate as required on the relevant Information Coordination Meeting and Suspected Child Abuse and Neglect team forums
    b. Where necessary participate on one or more HSD or state-wide committees concerned with child protection policy and planning, governance/improvement and training
    c. Advise other statutory and voluntary agencies (particularly Department of Communities Child Safety Services and Queensland Police Service) on health matters relevant to safeguarding children (to include policy as well as individual cases).

4. Advisory
    a. Advise the [HSD Manager/Clinical CEO] on questions of local planning and strategy with regard to safeguarding children (including ensuring performance indicators are in place where child protection is concerned)
    b. Advise and input into practice guidance development and policies for all those working within the HSD and ensure they are appropriately audited
    c. Contribute to the planning and strategic organisation of Queensland Health responses to child protection matters
    d. Ensure expert health advice on child protection is available to other agencies
    e. Ensure advice to all specialities (including but not limited to primary health care, Accident and Emergency, orthopaedics, obstetrics, gynaecology, child and adult psychiatry) is available on the day-to-day management of children and families where there are child protection concerns

f. Advise on appropriate training for all health personnel.

5. Clinical
    a. Take an active role in seeing children where there are child protection concerns. This should include all aspects of child abuse, including sexual abuse and neglect
    b. Support and advise other professionals on the management of all types of child maltreatment
    c. Have skills in the gathering and evaluation of evidence in order to safeguard children and young people
    d. Have appropriate skills in writing reports and presenting information to case conferences and related meetings
    e. Have knowledge and experience of court processes relating to child protection

6. Policy and Procedures
    a. In conjunction with other CPA's, ensure the HSD has appropriate child protection policies and procedures/guidelines/standards in line with Queensland Health policy and legislation.
    b. Participate in ensuring child protection procedures/guidelines/standards are distributed, understood and implemented by alerting colleagues to any changes made in the light of new developments.

7. Training
    a. Liaise with relevant staff about assessment and priorities for training for health professionals
    b. Ensure the HSD has an appropriate training strategy for safeguarding children, in line with Queensland Health policy
    c. Play an active role in the delivery of training to health personnel and multi-agency and multidisciplinary groups.

8. Monitoring
    a. Assist with the collection of data in serious case reviews and developing the chronology of such children and families (unless directly involved with the case)
    b. Assist with monitoring the quality, acceptability and effectiveness of service provision and training
    c. Advise on the implementation and recommendations from serious case reviews and child death reviews.
    d. Where necessary and appropriate, contribute to the implementation of recommendations from serious case reviews and child death reviews.

9. Supervision
    a. Advise on appropriate systems for child protection case supervision
    b. Support other professionals in developing their skills where child protection matters are concerned.

10. Professional Development
    a. Attend relevant HSD and state-wide continuing professional development activities in order to maintain up to date skills in the area. This includes meeting professional organisation requirements as a minimum in addition to specific training related to specialist activities
    b. Complete the Self-Assessment of Capability on an annual basis, and undertake additional training as identified by their line manager.

11. Accountability
    a. Be accountable to the employer [HSD Manager/Clinical CEO].
    b. The Medical Director within the HSD with primary responsibility for children's services will relate directly to and supervise the CPA, or as per district / health service organisational process.

The CPA will have the authority to carry out all of the above duties on behalf of the HSD and be supported in doing so by HSD management.

Resources required for the role:

- The CPA role should be explicitly defined in HSD job descriptions.
- There should be a minimum of one CPA (Medical/Non-Medical) in each HSD at all times.
- The HSD will ensure that sufficient resourcing is available to enable the CPA to fulfil their role and responsibilities effectively, including participation in case reviews and critical incident reviews. Support should include dedicated administrative assistance and be based on the size and needs of the population, the number of staff and the degree of development of local child protection structures, processes and functions.
- The HSD will provide appropriate professional and personal support and supervision for the CPA in recognition of the stressful nature of the role.