Crown Law
Queensland Government

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

VOLUME 1 of 1

ORIGINAL - QCPCI - STATE OF QUEENSLAND
(DEPARTMENT OF HEALTH – Davies, Corelle)

FILE FOLDER : 545781/2 Covering ltr # 1976422
Statement #1976424 Attach - VOLUME 1 OF 1
#1976428 to 1976442

DEPARTMENT OF HEALTH

STATEMENT OF CORELLE DAVIES

QCPCI

Date: 21.8.2012

Exhibit number: 26

QUEENSLAND CHILD PROTECTION
COMMISSION OF INQUIRY

STATEMENT OF Queensland Health witness Corelle Davies

I, Corelle **Davies**, of Level 5, Queensland Health Building, 147-163 Charlotte Street, Brisbane 4001 in the State of Queensland, Child Safety Director, Office of the Director-General, Department of Health, solemnly and sincerely affirm and declare:

1. I make this statement pursuant to a request to provide information to the Queensland Child Protection Commission of Inquiry (the Requirement).

2. I have held the position of Queensland Health Child Safety Director since 2005, and represent Queensland Health on behalf of the Director-General of Queensland Health.

3. My qualifications include registration as a general nurse and midwife and a post graduate degree in Health Administration.

Background

Health System in Queensland:

4. Queensland Health is the provider of public hospital and health services for more than four (4) million Queenslanders.
5. Queensland's children (0 – 18 years of age) currently make up a little more than a quarter of the state's population and there are approximately 62,000 babies born every year.
6. Children are a generally well population with the majority of their health care needs provided through primary care services such as general practitioners and community health services.
7. Approximately six percent of the child population will have health conditions requiring secondary or tertiary intervention provided through hospital and health services.

8. The mission of Queensland Health is to create dependable health care and better health for all Queenslanders.
9. Queensland Health recognises that Queenslanders trust the department to act in their interests at all times. To fulfil the mission and sustain this trust the department has four core values:
    a) Caring for people
    b) Leadership
    c) Respect
    d) Integrity
10. Queensland Health is working towards the implementation of reforms that change the way hospital and health services are managed through the National Health Reform Agreement. The objective of the National Health Reform Agreement is to improve health outcomes for all Australians, and to ensure a responsive and enduring Australian health system.
11. Changes from 1 July 2012, in Queensland are:
    a) Establishment of 17 Hospital and Health Services (HHSs) **(Attachment 1 : New Queensland Health Structure)**
    b) HHSs are statutory bodies with Hospital and Health Boards, accountable to the local community and the Queensland Parliament
    c) The Boards will have expertise to manage large, complex healthcare organisations
    d) HHSs, Medicare Locals and other health service providers will work together to better integrate local services and drive improvements in health outcomes
    e) Queensland Health 'Corporate Office" is transitioning to the role of System Manager and will focus on system-wide policy, planning and service purchasing in addition to well established functions such as supporting system-wide quality and safety and service innovation.

12. Benefits of the reform are:
    a) Focus on patient centred care

b) Clinicians, consumers and community are more engaged at a local level
c) HHS flexibility to innovate and address local priorities
d) HHSs held accountable for performance
e) Role clarity between system manager and service providers

Health System and applicability to child protection

13. HHSs undertake an extensive range of services and programs for children, young people and families, across the child protection continuum, and collaborate with other government agencies to ensure a coordinated response to child protection.
14. The range of services and programs provided by HHSs include primary, secondary and tertiary health services.
15. Approximately 65,000 staff are employed across Queensland Health facilities to provide these services.
16. Current services and programs across HHSs include:
    a) Community Child Health Services:
        - provide a range of child health services of varying levels including primary and secondary prevention and treatment;
        - deliver prevention, promotion and early intervention programs such as Positive Parenting Programs (Triple P) and Family CARE including ICARE for Indigenous families, including universal and targeted programs for vulnerable children.
    b) Universal Postnatal Contact Service Initiative has an overarching goal of ensuring all mothers receive a follow up contact from a health professional after the birth of a baby, that encompass prevention and early intervention services. The Universal Postnatal Contact Service Initiative has:
        - implemented universal antenatal assessment and screening for key risk factors that impact on the health and wellbeing of both mother and baby – tobacco, drug and alcohol use, psychosocial wellbeing, domestic violence and maternal mood disorders including depression

- developed and enhanced community partnerships and service networks to ensure appropriate referral for families identified at risk
- established Newborn and Family Drop-In Services to ensure families have access to local, flexible health care options after the birth of a baby
- improved integration of maternity and child health services and information sharing, for enhanced continuity of care between hospital and community settings.

c) the provision of extensive clinical treatment of children and young people with injuries as a result of non-intentional injuries or abuse and neglect;

d) participation as a core member of Suspected Child Abuse and Neglect (SCAN) teams, since the 1980's., including:
   - medical treatment, management, assessment and referral that occurs as a recommendation / action of these interagency meetings;

e) key positions in all HHSs to provide child protection advice and support to frontline staff, and to work in close collaboration with other key government departments and entities to ensure there is a whole-of-government response to children who are at risk, or who have been, harmed. **(Attachment 2 QH Child Protection Roles)** These positions include:
   - Child Protection Liaison Officers
   - Child Protection Advisors
   - SCAN core member representatives
   - Designated Medical Officer

f) All Queensland Health staff have a duty of care through policy to identify children as risk of harm and responding accordingly.

Role and purpose of Suspected Child Abuse and Neglect (SCAN) team

17. SCAN teams were initiated in 1980 by the Coordinating Committee on Child Abuse (CCOCA) to ensure an effective and coordinated, multidisciplinary response to notifications of suspected child abuse and neglect.
18. CCOCA was established in 1978 to provide a formal mechanism to coordinate the activities of various government departments in relation to child abuse. CCOCA was comprised of – Queensland Police Service; Queensland Health; the then Department of Families; Education Queensland & the Justice Department. There were 39 SCAN teams at this time.
19. A Queensland Health medical practitioner was one of the three core members of SCAN with the Queensland Police Service and the then Department of Families, Youth and Community Care.
20. The role of the SCAN team is to ensure a coordinated response to the protective needs of children by: assessing information; ensuring coordinated and culturally appropriate responses to the protective needs of children and young people; and formulating and implementing recommendations for action. SCAN teams also provide a forum to share information about children and families and to coordinate actions to meet the protective needs of the children and young people.
21. The Crime and Misconduct Commission (CMC) Report *"Protecting Children: An Inquiry Into Abuse of Children in Foster Care* (March 2004) reflected the important contribution of SCAN teams to the child protection system, and made specific recommendations to relation to SCAN, including:
    a) Enshrining the existence of SCAN in legislation (s159I-159L Child Protection Act 1999)
    b) Development of a standard set of policies and procedures
    c) Appropriate funding
    d) Regular review of SCAN functioning
22. In 2004 - 2005 the new SCAN model comprised:
    a) a core membership of Department of Communities Child Safety; Queensland Police Service; Queensland Health; Department of Education and Employment; and if the child's family is of Aboriginal or Torres Strait Islander origin, a recognised Aboriginal and Torres Strait Islander Entity. Relevant individuals

from other government and non-government agencies may be invited to participate in specific SCAN Team case discussions if that individual is able to provide specific knowledge or expertise which will add value to the case discussion.

b) 21 enhanced SCAN teams were established across Queensland to provide a cross-agency response for children and young people in need of protection.

23. In 2007 – 2008 there was a review of the SCAN model by the agency core member representatives of the Child Safety Director Network SCAN subcommittee. The findings from this review led to a commitment to implement a refined model of service delivery for SCAN teams.

24. In June 2008 Queensland Health endorsed the 'Partnership in Action: a shared vision for the Suspected Child Abuse and Neglect (SCAN) Team System', which committed SCAN team core member agencies to jointly implement a refined model of service delivery for SCAN teams. The refocused SCAN team system has committed all agencies to:

a) a shared focus and purpose aligned with the legislated mandate of Child Safety;

b) an administratively workable SCAN team system;

c) the promotion of joint investigations between Child Safety and the Queensland Police Service into suspected child abuse cases which may constitute a criminal offence;

d) consistent referral criteria, focusing on cases which meet the threshold for statutory intervention by Child Safety (a notification has been recorded);

e) joint professional development for all SCAN team core member agency representatives;

f) a separate mechanism – information coordination meetings (ICM) – to provide a forum for discussion of a matter where a SCAN team core member representative seeks further information regarding the rationale for the Child Safety intake decision (Child Concern Report or notification) and requires the opportunity for multi-agency discussion; and

g) revision of the SCAN team system operational policies and procedures.

25. The refocused ICM and SCAN model was implemented in late 2010, with training provided across the state by representatives of the Child Safety Directors Network SCAN subcommittee to SCAN team core members including Queensland Health SCAN team core member representatives.
26. In November 2011 Queensland Health held a SCAN core member workshop **(Attachment 3)**. The workshop was an opportunity for the Queensland Health SCAN team core representatives to participate in a professional development opportunity, specifically for Queensland Health representatives.
27. The role and responsibilities of the Queensland Health SCAN team core member representative are outlined in:
    a) *Queensland Health Protecting Children and Young People Policy – Implementation Standard for Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team system* **(Attachment 4)**
    b) *Procedure for Referral of an Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team system meeting* **(Attachment 5)**
    c) Fact sheet 3.1-Key District child protection roles **(Attachment 6)**

28. To enable a Queensland Health SCAN team core member representative to decide whether to refer a matter to the SCAN team requires the timely sharing by Child Safety Services of the outcome decision in relation to a report of a reasonable suspicion of child abuse and neglect. Under the refocussed ICM and SCAN team manual, there is a requirement for Child Safety Services to provide feedback to SCAN team core member agencies within five business days. **(Attachment 7, section 1.3)** When the timeframe is not met, this challenges the SCAN teams' ability to meet the purpose of SCAN in terms of timeliness of referrals. **(Attachment 7, section 3.1)**

Legislation regarding mandatory reporting

29. The *Health Act 1937* was amended to make it mandatory for doctors and registered nurses in Queensland to report directly to the Department of Child Safety (now known as the Department of Communities, Child Safety and Disability) any reasonable suspicions of child abuse and neglect. This amendment came into effect 31 August 2005. The mandatory reporting requirement is reflected within sections *191 – 196 Public Health Act 2005*.
30. Section 193 of the *Public Health Act 2005* holds an offence provision that applies if a professional fails to report. It is difficult to ascertain the impact of this provision on a professional's decision-making in regard to reporting child abuse and neglect.
31. Sections 197 – 208 of the *Public Health Act 2005* outline the Care and treatment order for a child legislative provision, which replaced the previous 96 hour hold provisions.
32. In 2005 Queensland Health introduced a number of resources to assist health professionals in recognising, reporting and responding to child abuse and neglect. One of these resources is a standardised form for Queensland Health staff to report a reasonable suspicion of child abuse and neglect to the Department of Child Safety (now the Department of Communities Child Safety and Disability) – 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form SW010. **(Attachment 8)** The SW010 form supports the legislative requirements of mandatory reporting and reporting to the Department of Communities, Child Safety and Disability.
33. Following a comprehensive statewide review of the Queensland Health SW010 form in 2007, a snapshot booklet was developed 'How to complete the Queensland Health 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010)'. This booklet provides a framework and reference for health professionals when they are undertaking their legislative reporting requirements. **(Attachment 9)**
34. Another Queensland Health resource implemented is a phased approach to inform staff of changes to legislation regarding mandatory reporting, including the development of training resources. The resource is based on the three "R's" of child protection – Responsibility, Recognition and Reporting. All health staff

receive introductory information, managed through HHS clinical orientation programs, and health professionals working in child related / child associated service areas complete an annual capability self assessment process. **(Attachment 10)** A self directed education program has been designed by Queensland Health to provide employees with the appropriate skills and knowledge to fulfil their child protection responsibilities. **(Attachment 11)**

35. These resources have been provided to private health service providers and other government and non-government agencies.
36. The Queensland Health Human Resources Policy, 'E7 Child Safety – Health Professionals Capability Requirements and Reporting Responsibilities', applies to all health professionals, and the purpose of this policy is to ensure that all health professionals are aware of their roles and responsibilities in recognising, reporting and responding to child protection concerns. **(Attachment 12)**
37. A Care and Treatment Order for a Child is a very powerful intrusion on the normal decision-making rights of parents or guardians, and needs to be administered with the welfare and best interests of a child as paramount. Sections 187 – 190 of the *Public Health Act 2005* provide the legislative framework for this provision.
38. Queensland Health has implemented:
    a) Queensland Health Protecting Children and Young People Policy – Implementation Standard for a Care and Treatment Order for a Child **(Attachment 13)**
    b) an information booklet to inform HHS staff about their legislative and policy responsibilities, as well as the requirements in appointing a Designated Medical Officer and enacting a Care and Treatment Order for a Child.

<u>Queensland Health child protection budget</u>

39. Following the CMC Queensland Health has implemented key positions and resources across HHSs, including:
    a) $395,000 - Child Safety Unit including Child Safety Director
    b) $1,680,000 ($80,000 per SCAN team, there are 21 SCAN teams)

c) $120,000 to Children's Health Queensland HHS, for the Queensland Child Protection Clinical Partnership
d) Approx $7,120,000 for HHS staff including Child Protection Liaison Officers , Child Protection Advisors and Administration officers

40. The exact quantum of funding for child protection related work in each HHS is difficult to ascertain, as there are many HHS staff who provide support to children and young people across the child protection continuum. These include social workers, community and mental health services. Child safety funding in most instances is incorporated into child health services funding as part of core business.
41. The roles of Child Protection Liaison Officer, Child Protection Advisors and Administration Officer are integrated within HHS services, and may undertake a range of other health service functions.
42. HHSs receive $18, 925,000 for the Evolve Therapeutic Services program from the Department of Communities, Child Safety and Disability Services. This funding supports ten (10) EVOLVE therapeutic services teams across the state.

Child protection policies

43. In consultation with key stakeholders throughout Queensland Health, the Child Safety Unit has revised and implemented Queensland Health Protecting Queensland Children Policy Statement and Guidelines in 2005, 2009 and 2012. These reviews have occurred to ensure that the policy reflects current legislation and evidence based child protection practice. The Queensland Health policy and resources have been shared with non-Queensland Health health services, for their information. (For example private hospitals, general practitioners)
44. The work of the Queensland Health Child Safety Unit is guided by The Queensland Health Statewide Child Safety Reference Group (now known as the Statewide Child Protection Clinical Partnership). Membership includes:
    a) three child safety clinical chairs – senior paediatricians – from Northern, Central and Southern Queensland
    b) the Northern and Southern Child Safety Network Coordinator's

c) a representative of Child Advocacy Services, Royal Children's Hospital

45. An initial Queensland Health child protection 'policy statement and guidelines on the treatment and management of abuse and neglect of children and young people (0 – 18 years)' was implemented in 2003.
46. Following the CMC Inquiry, the policy was revised in August 2005, to include the recommendations of the CMC. A significant inclusion was the duty of care reporting requirement for all Queensland Health 'health professionals'.
47. In 2008 there was a major revision of the policy document; and it was renamed 'Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0 – 18 years)'. This version was more comprehensive as it provided guideline information for staff and was aimed at addressing frequently asked questions from child protection staff or clinical situations requiring advise.
48. Queensland Health has undertaken a further review of the policy in 2011, and has implemented the latest version in June 2012. This review was guided by the Queensland Health Policy Management Framework. The Protecting Children and Young People Policy document is supported by Implementation Standards and Protocol that cover the following areas:

    a) Reporting and responding to a reasonable suspicion of child abuse and neglect
    b) Care and Treatment Order for a Child
    c) Information sharing in child protection
    d) ICM and SCAN team meetings
    e) Conducting child sexual assault examinations
    f) Responding to 'Unborn Child High Risk Alert'

49. The Human Resources Policies G6 'Orientation and Induction' and E7 'Child Safety - Health Professionals Capability Requirements and Reporting Responsibilities' ensure that all clinical staff at induction view a child abuse and neglect orientation DVD that outlines their responsibilities in relation to child protection, as well as providing the relevant contacts within their health service to support them in meeting this responsibility.

Child protection case management

50. Queensland Health's responsibilities and responses to child protection extend beyond the reporting of a reasonable suspicion of child abuse and neglect. Presentations to health that require a response may include:

    a) A presentation where there is some concern about safety and wellbeing of a child or young person. While the presentation may not meet the threshold for a reasonable suspicion of abuse and neglect, it may raise sufficient concern that a child's health, safety and wellbeing may presently be, is likely to be or may have been compromised. This may require the provision of additional health and other community services to the child and their family.

    b) A presentation where there is uncertainty as to whether the assessed concern meets the threshold for a reasonable suspicion of child abuse and neglect. These are situations which may require the provision of additional health and other community services plus a degree of support and follow-up by health services.

    c) A presentation where the health professional makes a report of a reasonable suspicion of child abuse and neglect to Child Safety Services, but the report does not result in a notification response.

        - This often necessitates the ongoing provision of health and other services to the child and family to prevent the risk of harm escalating or the harm from occurring. This reflects the essential early intervention function that health professionals have in the prevention of child abuse and neglect.
        - The Queensland Health SCAN core representative is able to refer this case to the ICM for further multi agency discussion.

    d) A presentation where reports of significant harm result in a statutory response from Child Safety Services and possibly the Queensland Police Service. The provision of health and other

services at this point may increase significantly as an assessment and investigation of the concerns is undertaken.

- Some of these cases will be reviewed by the Queensland Health child protection team and referred by the SCAN core member representative to the SCAN team system and may result in a multiagency response.
- These are the cases that result in intensive service delivery from a variety of agencies including health services.

e) Children who have been subjected to statutory intervention and may, as a result, have been removed from their parents or carers; may have been severely impacted by their experience of abuse, their separation from their family and adjustment to a new family or care environment and context. They may subsequently require intensive involvement from a variety of services within health.

Frontline Queensland Health staffing

51. The legal and duty of care reporting requirements represent an acknowledgement of the crucial role health professionals play in matters of child protection. It is recognised that many Queensland Health staff may have limited experience in:
    a) Recognising indicators of abuse and neglect
    b) Providing an appropriate response to the presenting indicators
    c) Reporting concerns to Department of Communities, Child Safety and Disability Services
52. Queensland Health has a responsibility to provide staff with relevant information and training, and has met this obligation through the provision of information to staff. This information:
    a) Builds on existing Queensland Health strategies, models of care and guidelines
    b) Is disseminated through the child protection liaison officers, child protection advisors and all health professionals involved in child protection activities
53. Challenges for health professionals include the differences in the legislative requirements of mandatory reporting under the *Public Health Act 2005*, and the

statutory agency threshold in the *Child Protection Act 1999*, that underpins the intake decisions of Child Safety Services. The differences in the thresholds between the two Acts reflect the professional responsibilities and scope of practice for health professionals. An investigation is a function of Child Safety Services and is not within the scope of the health role. This results in many health professionals reporting concerns which may not further investigated by the Department of Communities, Child Safety and Disability Services.

Decision-making frameworks

54. There are numerous factors that can contribute to and influence the range of actions and behaviours which constitute child abuse and neglect. When determining if a suspicion is reasonable, it is important for health professionals to consider all of these factors, or as many of them as possible, in order to develop a comprehensive understanding of the issues.
55. The identification of any child protection concern rests in the presentation of signs, clues, disclosures, behaviours, symptoms or injuries. These are known and categorised as child protection risk factors.
56. The identification of risk factors cannot be done in isolation. They must be considered in the context of the child's circumstances and family situation. They must also be measured against the presence of other factors known as protective factors or indicators.
57. To support Queensland Health staff in their knowledge and decision-making in relation to child protection there are a range of accessible resources, including:
    a) Key human resources in HHSs, including Child Protection Liaison Officers, Child Protection Advisors and other staff with relevant child protection expertise
    b) The '*Report of a Reasonable Suspicion of Child Abuse and Neglect (SW010)*' form has been developed to mirror the Child Safety Service 'intake' process and questions.
    c) The Queensland Health policy and reporting snapshot booklets is a handy and concise guide for clinical staff.
    d) A suite of fact sheets are available to staff.

e) Queensland Health has developed both internal and external web sites to provide a range of information to support staff to meet their legislative and policy requirements in relation to child protection. Information provided on these sites includes access to an education tool, fact sheets and relevant contacts across government.

f) The Queensland Child Protection Guide is being trialled in the Gold Coast Hospital and Health Service.

58. Queensland Health has provided these resources to non-government health service providers, including general practitioners.

Analysis of last reporting year

59. Queensland Health does not centrally collect state-wide child protection reporting data. HHSs collect child protection data at a local level that is relevant to their service reporting requirements and to guide clinical service planning and provision.

60. In 2009 - 10, Queensland Health undertook a comprehensive statewide review of the Queensland Health 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010). Recommendations from the review led to amendments to the report form and the development of specific resources to support health professionals to improve recognising, reporting and responding to child abuse and neglect. The review had two components:

a) A reporting profile: information was sought as to populations of children (0-17 years) across the state and in each district. These were then compared with the number of reports made by Queensland Health staff from within that district to establish a reporting trend.

b) A retrospective review of the quality of written reports was undertaken using an audit tool specifically developed for the review.

61. Queensland Health Child Protection Liaison Officers working across the then fourteen health service districts plus the Children's Health Service, were asked to provide the following:

a) The number of reports made in that service by Queensland Health staff for the period 1 January 2009 to 30 June 2009
b) 15 written reports (SW010s) in sequence, and
c) The intake screening outcomes of these reports as determined by Child Safety Services.

62. Key findings of the 2009 – 10 audit were:

a) Fifty percent (50%) of reports came from hospital presentations with the remainder from Community and other sources, for example the Youth Detention Centre.
b) Significant numbers of reports were received from the following services Accident and Emergency departments, Adult Mental Health and Maternity Services, with smaller numbers of reports from eight other services including Paediatrics, Child and Youth Mental Health Services, Child Health, School Based Youth Health Nurses.
c) Reports were made by the following professional streams; nursing, allied health, medical officers, Child Protection Liaison Officers and others.
d) Findings form the review were provided to Child Protection Liaison Officers and Child Protection Advisors for consideration with HHS education and training, and resources were developed for staff including a 'Six Simple Steps' to reporting pocket guide and the 'How to complete a report of a reasonable suspicion of child abuse and neglect form' snapshot booklet.

Flowchart interface health/child protection **(Attachment 14)**

63. As outlined in legislation (s191 – 194 Public Health Act 2005, registered nurses and doctors) and policy, Queensland Health health professionals are required to undertake the following process once they have formulated a reasonable suspicion of child abuse and neglect:

a) When a Queensland Health staff member formulates a reasonable suspicion of child abuse and neglect, this staff member is required to immediately verbally report their concerns directly to

an authorised officer of Department of Communities Child Safety Services: Regional Intake Service or Child Safety Services After Hours Service.

b) Additionally, all verbal reports shall be followed up with a written report to Department of Communities Child Safety Services Regional Intake Service within seven days on the Queensland Health 'report of a reasonable suspicion of child abuse and neglect' (SW010) form.

c) The staff member making the report shall:

- fax a copy of the SW010 form to the Department of Communities Child Safety Services Regional Intake Service that received the verbal report
- file the original copy of the SW010 form in the correspondence section of the individuals clinical record
- forward the yellow carbonated copy of the SW010 form to their district Child Protection Unit.

64. *S188 Public Health Act 2005* may by written instrument appoint a doctor to be a designated medical officer. The role of the designated medical officer is to administer the provisions of a 'Care and Treatment Order for a child'.(*ss197-207 Public Health Act 2005*)

65. Under the provisions of *Chapter 5A Service delivery coordination and information exchange Child Protection Act 1999* Queensland Health shares information to coordinate and effectively meet the protection and care needs of children and young people.

66. To support the understanding by Queensland Health staff of the information sharing provisions there are a number of resources available, including:

a) Queensland Health Legal Unit
b) HHS medico-legal services
c) Child Protection Liaison Officers
d) Child Protection Advisors
e) QH child safety unit fact sheets
f) QH information sharing presentations 2008

67. Information sharing requests to Queensland Health, predominately from the Department of Communities, Child Safety and Disabilities, have significantly

increased since the legislation was implemented and places a high demand on services and staff in HHS, for example:

a) Approximately 6,000 Queensland Health reports of a reasonable suspicion of child abuse and neglect per year
b) Approximately 24,000 cases discussed at SCAN in 2007
c) EVOLVE Therapeutic services
d) Evidence for court proceedings
e) Child safety case planning
f) Information for Child Safety Child Health Passport initiative

68. The exchange of information presents challenges to Queensland Health services, including:

a) A shared understanding of the intention of the legislation between agencies (for example a shared understanding of the term 'relevant information')
b) The heavily regulated privacy context of health information
c) Lack of a Queensland Health centralised patient information system
d) Information requested & presented at SCAN, then requested outside of SCAN
e) Experience and training of staff across the child protection workforce

Statistical Information:

Child protection presentations at health services

69. Queensland Health does not centrally collect information on child protection presentations at health services.
70. Child safety services data identifies that in 2010-2011 health professionals were responsible for approximately twelve percent of the total number of intakes to Child Safety Services per annum. This data includes all health professionals from both public and private sectors in Queensland. This reporting rate has remained constant since data has been available from 2007.

71. Hospital records are routinely coded both nationally and internationally according to the International Statistical Classification of Diseases and Related Health Problems (ICD) system developed by the World Health Organisation

    a) Rigid coding rules around the use of maltreatment codes coupled with limited clinical documentation regarding maltreatment, results in ICD codes that are highly specific, but not very sensitive indicators of maltreatment.

72. HHS may collect some information in regard to key activities of child protection units, such as numbers of reports of a reasonable suspicion of child abuse and neglect; ICM and SCAN activities; information sharing requests; medical examinations. Each HHS collects information relevant to their local requirements.

Demographics of child protection issues at QH

73. Queensland Health does not capture data with regard to the demographics of child protection presentations to health services.
74. Parenting skill and ability is the most significant variable factor in a child or young person's life. The ability of a parent to respond to the needs of their child can be impacted by:

    a) social isolation
    b) poverty
    c) negative childhood experience
    d) childhood abuse
    e) substance abuse
    f) domestic and family violence
    g) age of parent - very young parent
    h) mental illness
    i) learning difficulties
    j) physical disabilities
    k) chronic medical conditions
    l) homelessness
    m) no or little commitment to parenting
    n) relationship difficulties
    o) multiple relationships

p) lack of community support

q) poor engagement with professional services

75. Queensland Health has a range of mechanisms to identify and support parents who are facing these challenges and to assist parents to exhibit more appropriate parenting practices, including:

a) ante-natal assessment and screening for risk factors ie drug and alcohol use, maternal mood disorders, domestic and family violence

b) universal and targeted child health services

c) early intervention services designed to address the needs of children with (or at risk of developing) identified behavioural and emotional problems (including the behavioural and emotional components of disabilities and developmental problems)

d) parent education, often delivered in group format and particularly supporting parents in caring for their new baby, caring for themselves as parents and (as their children grow) how to assist the behavioural and emotional development of their children

e) postnatal primary health care, in the form of Newborn and Family Drop in Clinics for the first 8 weeks of life and child and family health clinics that assess the health and development of the child and parent and provide information to guide and support them through common concerns including sleeping, settling, feeding, growth, safety and other health and development issues

f) free parenting programs i.e. Triple P-Positive Parenting Program

g) Family CARE Nurse Home Visiting Program to at-risk families with a newborn child. To be considered for the program families must have one or more of the following risk factors present: exposure to family violence, maternal mood disorder and/or financial stress.

h) Queensland Health is funded to provide a universal service for families with children 0 to 3 years under the Helping Out Families program at the Gold Coast HHS and parts of Children's Health Queensland (South) , an initiative of the Queensland Government that aims to enhance the child protection system and

the community-based services sector to improve support for 'vulnerable families'.

Comparison interstate / international models to include similarities / differences with policy/practice in Queensland

76. The legal requirement to report suspected cases of child abuse and neglect is known as mandatory reporting. All jurisdictions possess mandatory reporting requirements of some description. However, the people mandated to report and the abuse types for which it is mandatory to report and the penalties applied for not reporting vary across Australian states and territories.
77. The relevant Acts and Regulations in the Australian Capital Territory, New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia contain lists of particular occupations that are mandated to report.
78. Some states have a limited number of occupations listed, such as Queensland (doctors, departmental officers, and employees of licensed residential care services) and Victoria (police, doctors, nurses and teachers). Other jurisdictions have more extensive lists (Australian Capital Territory, South Australia, and Tasmania) or use generic descriptions such as "professionals working with children".
79. In addition to differences across jurisdictions in the people who are mandated to report abuse concerns, there are also differences across jurisdictions in the abuse types for which it is mandatory to report.
80. In most jurisdictions (Australian Capital Territory, New South Wales, Northern Territory, South Australia, Victoria, Western Australia, Tasmania), the identity of notifiers - whether mandated or not - is explicitly protected. However, in some jurisdictions there are limits to this protection. For example, in the Northern Territory, the identity of reporters is not disclosed to families, but may be disclosed to the Family Court upon request.
81. Legislation in all jurisdictions except New South Wales requires mandatory reporting in relation for all young people up to the age of 18 (whether they use the terms "children" or "children and young people"). In New South Wales, the legislative grounds for intervention cover young people up to 18 years of age, but

it is not mandatory to report suspicions of risk of harm in relation to young people aged 16 and 17.

Recent inquiries / responses

82. Recommendations from the CMC Inquiry 2004 required the following responses from Queensland Health:

    a) the establishment of a Child Safety Director
    b) implementation of legislation and training for mandatory reporting by registered nurses
    c) enhanced SCAN team participation
    d) support for the review of deaths of children in care
    e) provision of tertiary therapeutic support services
    f) contribution towards an integrated service system.

83. Queensland Health has implemented all of the recommendations.

Indigenous overrepresentation in child protection and health

84. In the Queensland Health 2009 – 2010 Report form audit **(Attachment 15)**, Aboriginal and Torres Strait Islander children were reflected in the data collated in the following areas:

    a) Aboriginal and Torres Strait Islander children represented 23% of total reports made by Queensland Health professionals to Child Safety Services. This demonstrates little variation since the 2007 review.
    b) Some sites had variable proportions of Aboriginal and Torres Strait Islander children represented between the 2007 and the 2009 audit, including:
        - Charleville: In 2009 – 60% of reports in Charleville were Aboriginal and Torres Strait Islander as compared to 40% in 2007.
        - Roma: In 2009 – 33% of reports in Roma were Aboriginal and Torres Strait Islander as compared to fifty-three per cent (53%) in 2007.

- Other districts demonstrated only minor variations in Aboriginal and Torres Strait Islander reporting.

85. Indigenous Child Health Workers have been employed within community child health services, primary health care services and the non-government health sector to promote increased access to Aboriginal and Torres Strait Islander families to child health programs including, child health checks such as growth and developmental screening, infant care, breastfeeding support, increased immunisation rates, strategies to strengthen parenting skills and education in infant care, implementation of the Positive Parenting –An Indigenous Guide to Positive Parenting, and health promotion and education.
86. Young Parent Support Program - Young Parents Support workers have been recruited in Townsville, Cairns, Toowoomba, Woorabinda, Palm Island, Cherbourg, to increase support for young pregnant Indigenous women in the antenatal and postnatal periods. Young Parents Support Workers provide support to young Indigenous women and their partners through pregnancy, birthing and well into the postnatal period. Workers work in partnership with communities and families to increase access for young parents to health and other support services.

Interagency Cooperation/Collaboration

87. **The Child Safety Directors Network** was established following the CMC report in 2004 to ensure coordinated responses to child safety across Government. Child Safety Directors represent human services agencies with a key role in the promotion of child protection. The role of the Network is to provide leadership, coordination and direction by operating at the strategic whole-of-government level.
88. **Interagency SCAN teams**: SCAN teams are a multi agency vehicle for responding to the needs of children in the child protection system who require a multi agency response. To enable a Queensland Health SCAN team core member representative to decide whether to refer a matter to a SCAN team requires the timely sharing of information by Child Safety Services of the outcome decision in relation to a report of a reasonable suspicion of child abuse and neglect. Under the refocussed ICM and SCAN team manual, there is a requirement for Child Safety

Services to provide feedback to SCAN team core member agencies within five business days. **(Attachment 7, section 1.3)** When the timeframe is not met, this challenges the SCAN teams' ability to meet the purpose of SCAN in terms of timeliness of referrals. **(Attachment 7, section 3.1)**

89. **Evolve Therapeutic Services** (ETS) is the Queensland Health component of Evolve Interagency Services funded by the Department of Communities which provides intensive mental health, disability and behaviour support services for children and young people in care with severe emotional and behavioural problems. The program was developed in response to recommendations of the CMC report in 2004. Evolve is an interagency partnership between the Department of Communities Child Safety and Disability Services, Queensland Health and the Department of Education, Training and Employment.
90. To inform the health needs of children in out of home care, Queensland Health has collaborated with Child Safety Services in the development of a child health assessment framework.
91. Challenges for interagency collaboration include the differences in the legislative requirements of mandatory reporting under the *Public Health Act 2005*, and the statutory agency threshold in the *Child Protection Act 1999*, that underpins the intake decisions of Child Safety Services. The differences in the thresholds between the two Acts reflect the professional responsibilities and scope of practice for health professionals. An investigation is a function of Child Safety Services and is not within the scope of the health professional's role. Therefore many health professionals may report concerns which may not be further investigated by the Department of Communities.

Factors that should guide system improvement recommendations

92. Raising a child and supporting them to reach their full potential is the responsibility of the child's family. Parents, as the legal guardians for their children, are responsible for protecting their children and keeping them safe. The role of the child protection system is to intervene when parent's are unable or have failed to protect their children.
93. The preferred way of ensuring a child's safety and wellbeing is through supporting a child's family. Services that support families early, before issues

escalate and require a child protection intervention, are provided by government and non-government service providers. These services and supports for families are community based, and are a part of what is known as a public health and wellbeing model.

94. It is acknowledged in the National Framework for Protecting Australia's Children 2009-2020, of which Queensland is a signatory, that a public health and wellbeing model for care and protection will deliver better outcomes for children and young people.
95. Under a public health and wellbeing model a priority is placed on the availability of universal support services for families, with more intensive support available to families identified with greater need.
96. Universal, child and family services, including maternal and child health, general practice, early childhood education and care services and schools, need to identify and target vulnerable children as early as possible, which means the provision of targeted support for "at risk" children and sharing information with other services relevant to supporting families with identified needs in the best interests of the child.
97. Improved coordination and engagement of families to a range of government and non-government support services earlier may change the trajectory of children into the tertiary child protection system.
98. In local areas there are a range of services available to families across the government and non-government sectors; however knowledge of these services, and the seamless and efficient linking of families to these services, is not always available at the points where families interface with services.

I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the *Oaths Act 1867.*

Signed .....

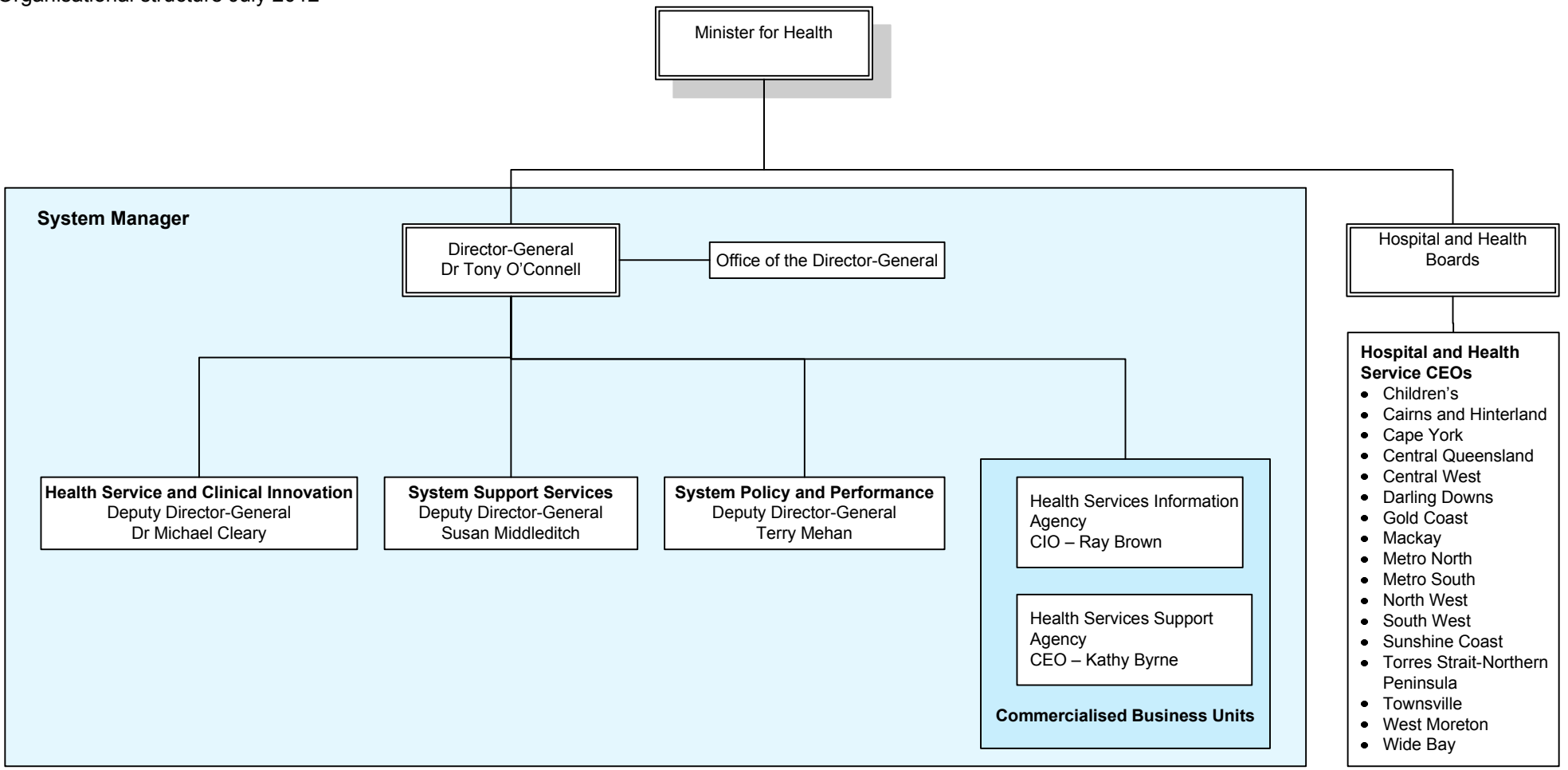
Taken and declared before me, at Brisbane this 7th day of August, 2012

Witness. .....
(Solomon Rowland)

Solicitor/Barrister/Justice of the
Peace/Commission for Declarations

Queensland Health

Organisational structure July 2012



4. Roles

This section of the Policy Statement and Guidelines:

- Details key Queensland Health professionals who have a role in the health response to abuse and neglect of children and young people
- Outlines the role of key Queensland Health units in providing support to frontline professionals
- Summarises the role of other government departments and entities in the protection of children and young people
- Describes the key inter-departmental groups who set the direction for a whole-of-government response to child protection.

4. Roles

The responsibility for the protection of children and young people from abuse and neglect belongs to everyone. Families, the general community, community agencies, police and government, all play a part. Roles may differ but working in partnership, with a shared understanding of the rights of children, the need to support vulnerable families and take protective action when necessary can help build a safety net for children and young people[1].

An awareness and appreciation of the roles and responsibilities within Queensland Health and other Government Departments and entities is essential for effective collaboration regarding child protection.

Queensland Health's commitment to effective collaboration in the protection of children and young people is demonstrated through the appointment of key positions across the Department. These positions provide support to front line staff who may identify concerns regarding a child or young person's presentation for health services. They also work in close collaboration with other key government departments and entities to ensure that there is a whole of system response to children who are at risk or who have been harmed.

[1] Department for Community Development, Government of Western Australia 2005, *Identifying and responding to child abuse and neglect – A Guide for Professionals*, [Online] Available at: http://www.community.wa.gov.au/NR/rdonlyres/4DOAEO58-4835-4AAO-A6CD-566OF7OA1126/O/11711PotectingChildrenweb.pdf

4.1 Key Queensland Health Roles

4.1.1 Clinical Chief Executive Officers / District Managers

Are responsible for:

- Formally designating the following child protection positions in the Health Service District;

  • Child Protection Advisor – in smaller Health Service Districts, District Managers may, in consultation with their neighbouring District Manager, nominate the Child Protection Advisor of an adjoining larger district as their advisor

  • Designated Medical Officer – under section 188 of the *Public Health Act 2005*, the person in charge of the health service facility may, by written instrument, appoint a doctor to be a Designated Medical Officer if they have the necessary expertise or experience to be a Designated Medical Officer. That is the expertise to identify and interpret signs of harm in children

  • Nominated positions for receiving and responding to Unborn Child High Risk Alerts issued by the Department of Child Safety

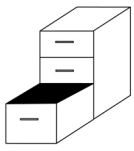
- Ensuring the use of the Queensland Health Policy; '*Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0-18 years)'* as a minimum standard in the development of locally relevant clinical pathways, protocols and procedures in relation to child abuse and neglect. Local protocols should include the contact details of the formally designated Child Protection Advisor, and the Child Protection Liaison Officer for each Health Service District
- Compliance by all staff within the Health Service District with the Queensland Health Policy; '*Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0-18 years)'*
- Ensuring that key processes and protocols for inter-agency collaboration are developed for:
  - Information sharing
  - Queensland Health's representation at SCAN Teams. This includes raising staff awareness of the role, location and membership of SCAN teams
  - Formal reporting to the Department of Child Safety regarding reasonable suspicions of child abuse and neglect
  - Workforce development addressing the provision of child protection training and support to staff

- Ensuring adequate resources, eg. staff, equipment and facilities
- Facilitating action regarding any unresolved child abuse and neglect issues.

4.1.2 Child Protection Advisor – CPA

The Child Protection Advisor is a nominated Health Service District position. The position plays a key role in the provision of child safety/protection services both at a District and interagency level. The role of the Child Protection Advisor is to;

- Assist staff with the formulation of a reasonable suspicion of child abuse and neglect and the subsequent report to the Department of Child Safety
- Receive 'Report of a Reasonable Suspicion of Child Abuse and Neglect' forms for review
- Liaise with the Suspected Child Abuse and Neglect (SCAN) Assessment and Management system core representative (if they are not the same person) to decide if a reported case meets the criteria for referral to the SCAN system
- Act as a resource person in child safety/protection for Queensland Health staff
- Communicate effectively with the Queensland Police Service and provide advice to staff about child protection criminal matters that need to be reported immediately to the Queensland Police Service and/or the Department of Child Safety
- Contribute to the improvement of health, development and wellbeing of children and young people and their families; and
- Advocate for the rights of children and young people to be safe.



Resource

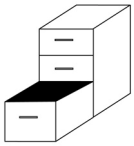
- A list of all District Child Protection Advisors is available on the Child Safety Unit QHEPS site:

  http://qheps.health.qld.gov.au/csu

4.1.3 Child Protection Liaison Officer – CPLO

The role of 'Child Protection Liaison Officer' (doctor, nurse, social worker, psychologist) has been implemented within Health Service Districts to provide a single point of contact for child protection issues. The role of Child Protection Liaison Officers include;

- Facilitating liaison communication and information sharing implemented by Queensland Health and other government agencies, community organisations and non-government service providers
- Supporting frontline staff in determining whether a suspicion of child abuse and neglect is reasonable through the provision of timely and relevant clinical advice
- Contributing to the development, implementation and review of child protection local policies and procedures
- Facilitating education and training of district staff around child protection issues
- Contributing to strategic child health workforce planning and development with an emphasis on child protection requirements
- Providing support to the Child Protection Advisor in activities related to QH involvement in the SCAN system
- Contributing to the effective and efficient financial management of child protection related services
- Ensuring that data reflecting QH staff reports to the Department of Child Safety is collected and forwarded to the appropriate local staff and the Child Health and Safety Branch
- Contributing to the improvement of health, development and wellbeing of children and young people and their families
- Advocating for the rights of children and young people to be safe.



Resource

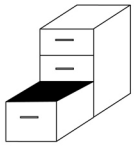
- A list of all District Child Protection Liaison Officers is available on the Child Safety Unit QHEPS site:

  http://qheps.health.qld.gov.au/csu

4.1.4 Designated Medical Officer - DMO

The role of the District Designated Medical Officer is to:

- Make and/or extend a Care and Treatment Order for a Child under the *Public Health Act 2005*.



Resource

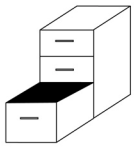
- A list of all District Designated Medical Officers is available on the Child Safety Unit QHEPS site:

  http://qheps.health.qld.gov.au/csu

4.1.5 Nominated Position for Unborn Child High Risk Alert (UCHRA) Notifications

The nominated position for the UCHRA notifications is responsible for;

- Receiving the form *HRA Form 1 – Unborn Child High Risk Alert – Request for Immediate Notification when Pregnant Woman Presents for Delivery* from the Department of Child Safety and then ensuring there is a hospital process using *HRA Form 2 – Unborn Child High Risk Alert - Notification that a Pregnant Woman has Presented for Delivery* for notifying the Department of Child Safety immediately if the woman presents to deliver
- Ensuring an appropriate process is in place to identify the pregnant woman if she presents to deliver in accordance with the Queensland Health Policy Statement; *'Unborn Child High Risk Alerts - From the Department of Child Safety to Queensland Health'* – QHEPS No: 25322
- Acknowledging receipt of the alert to the Department of Child Safety
- Ensuring the forms are appropriately filed in the *Unborn Child High Risk Alert Tool Kit* and then retained or disposed of according to district retention and disposal policies.



Resource

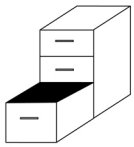
- A list of all District Child Nominated Positions for Unborn Child High Risk Alerts is available on the Child Safety Unit QHEPS site:

http://qheps.health.qld.gov.au/csu

4.1.6 Suspected Child Abuse and Neglect (SCAN) System Core Member Representative

The QH core member representative will work co-operatively with other SCAN team representatives to provide relevant information and expertise to ensure the planning for and delivery of coordinated child protection services to children and young people who have been harmed or who are at risk of harm. Their principal responsibilities are to:

- Provide relevant health opinion/information about the child or young person based on direct assessment, available health records and liaison with other health providers
- Provide expert health opinion about the diagnosis and impact of the alleged abuse and neglect and appropriate differential diagnoses that should be considered
- Contribute forensic medical knowledge on mechanisms of injuries from abuse
- Supply expert knowledge on the health symptoms and conditions associated with child neglect (physical, psychological and developmental)
- Recommend and facilitate appropriate physical, psychological and developmental investigations and assessments required for health evaluation of the allegations and impact of child abuse and neglect
- Actively participate in initial case assessment and the development of case management recommendations for implementation within the SCAN system
- Provide advice, support and consultancy services to QH employees to facilitate the effective functioning of the SCAN system
- Recommend appropriate physical, psychological and developmental assessment and treatment services required for a child or young person's ongoing health needs
- Provide relevant advice and assistance to SCAN Team members in relation to health matters and relevant Queensland Health legislation, policies and procedures
- Participate in interdepartmental development and delivery of training and information relating to the SCAN system.



Resource

- A list of all Queensland Health Suspected Child Abuse and Neglect (SCAN) System Core Member Representatives is available on the Child Safety Unit QHEPS site:

http://qheps.health.qld.gov.au/csu

4.1.7 Information Sharing Delegated Positions

The Director General has delegated the power to provide "relevant information" to any "service provider" or receive "relevant information" from any "service provider" under sections 159M and 159N of the *Child Protection Act 1999* to the following Queensland Health positions:

- District Managers
- Medical Staff
- Superintendents/Directors of Medical Services
- Child Safety Director
- Medical Specialists
- Medical Officers
- Child Protection Advisors
- Child Protection Liaison Officers
- School Based Youth Health Nurses
- Health Information Managers
- Medico-Legal Officers
- Allied Health Workers including Social Workers, Occupational Therapists, Physiotherapists, Dieticians, Speech Therapists, Audiologists, Psychologists
- Directors of Nursing
- Registered Nurses
- Oral Health Nurses
- Nurse Managers
- Direct Entry Midwife's
- Radiographers
- Indigenous Health Workers
- Indigenous Patient Liaison Officers
- Patient Liaison Officers
- Pharmacists
- Dentists
- Suspected Child Abuse and Neglect (SCAN) team representatives
- Any other officer who has a clinical role.

To determine what is "relevant information", delegates must refer to the definition in section 159C of the *Child Protection Act 1999*.

To determine what a "service provider" is, delegates must refer to the definition in section 159D of the *Child Protection Act 1999*.

4.1.8 Line Managers

Line managers are responsible for:

- Ensuring staff are aware of and comply with all legal and policy obligations in accordance with this policy
- Ensuring staff participate in training related to child protection issues as required
- Ensuring that staff comply with the 'self assessment of capability' requirements contained within IRM 3.19; which can be viewed at:

  http://www.health.qld.gov.au/industrial_relations
- Ensuring staff are aware of the positions of District Child Protection Advisor/s and Child Protection Liaison Officer and who the present nominated incumbents are
- Ensuring staff are aware of the after hours on call Child Protection Advisor and of how to make contact with them
- Ensuring that cases brought to their attention by staff are communicated to the Child Protection Advisor or Child Protection Liaison Officer (this may include cases that did not reach the threshold and therefore did not require a report to the Department of Child Safety)
- Ensuring staff receive professional support, debriefing and supervision as required. This may include facilitating access for individual Queensland Health staff to the Employee Assistance Service
- Ensuring there is an effective system for reviewing the management of child protection cases with staff
- Ensuring staff are trained in using appropriate documentation processes
- Ensuring that the details of all child protection cases comply with QH documentation standards
- Ensuring 'self assessment of capability' is entered on to the LATTICE system.

4.1.9 Individual Staff

All Queensland Health staff are responsible for;

- Being aware of and complying with legislation, local clinical pathways, protocols and procedures in relation to child protection matters
- Immediately reporting all reasonable suspicions of child abuse and neglect directly to the Department of Child Safety using the procedure set out in this policy

- Comprehensively and accurately documenting all issues considered and discussed in association with a suspicion of harm or risk of harm including:
    - When and to whom the case has been reported
    - Decisions made
    - The basis for decisions
    - Action taken (when, how and to whom) including clinical service responses regarding the child and family
    - All subsequent contact and communication that Queensland Health staff have with Officers of the Department of Child Safety and / or the Queensland Police Service.

4.1 Queensland Health Child Health and Safety Unit

The Child Health and Safety Unit (CH&SU) is located within the System Policy and Performance Division. The CH&SU provides policy, direction, strategic leadership, advice and support for child health and safety planning, service development and quality management initiatives to the Senior Executive Directorate, other areas of Queensland Health (QH) and other key partners. This includes those related to Aboriginal and Torres Strait Islander children and youth.

The role of the Branch is to:

- Provide leadership, strategic direction and advice, consultation and negotiation regarding health services for children, young people and their families
- Identify priorities for policy development which inform best practice in the delivery of child health and safety services·
- Build effective and collaborative relationships within the Commonwealth, other state government departments and non-government organisations regarding child and youth health.
- Represent QH in advocating for the health and wellbeing of children in national and state policy, planning and service development initiatives.· Contribute to the identification, development and periodic review of child health & safety services and related strategies, programs, research, performance indicators and benchmarks.·
- Support and develop collaborative partnerships with other parts of QH, the broader health system, the university sector and other sectors to promote effective public health action, workforce development and dissemination of best practice.
- Develop and maintain partnerships with service providers whose business impacts on the health and safety of Queensland children and young people. These include other parts of QH (particularly Hospital and Health Services) local government, other state government departments, relevant health professional organisations, the private sector, non-government and community based organisations.

The Queensland Health Child Health and Safety Unit has participated in the implementation of the Queensland Health specific recommendations of the Crime and Misconduct Commission report 'Protecting children – an inquiry into abuse of children in foster care, January 2004'. Since the Child Health and Safety Unit's development, its role has evolved into a strategic policy and advisory unit for child safety issues across Queensland Health.

Queensland Health SCAN core member Workshop

Thursday 3rd & Friday 4th November 2011

DAY ONE – Thursday 3rd November 2011

Venue – The Sebel, Cnr Charlotte and Albert Street, Brisbane

TIME	TOPIC	FACILITATOR - comments
9am – 9.20 am	Registration & coffee	
9.20 – 10.30 am	Introduction & overview • Role of the QH SCAN core representative	Jo Gurd to lead The QH core representative role & the scope of their role. Questions to be addressed in this session could be: • What do you think the role is? • What does the legislation say? • What does QH policy say? • What are the skills required in the role??
10.30 – 11.00 am	**MORNING TEA**	
11.00 – 12.30 am	Referrals to ICM & SCAN	Led by Kerry Sullivan … with Clinical Chairs – large group discussions and / or small group work. Questions to be answered include: • Does QH have to refer? , why can't we just leave it to QPS or Child Safety • What sort of cases should QH refer? • How does QH determine the cases (SW010 reports) to refer - individual, team? • What are the common characteristics of the cases QH refers? • What specific outcomes is QH trying to achieve by referring? • What does the referral really look like - history of presentations only or an assessment of the concerns? • How do existing capacities/resources impact on our referral rates and / or ability to complete the documentation? Use of case scenarios / examples
12.30 – 1.15 pm	**LUNCH**	
1.15 – 2 pm	SCAN Recommendations	Led by Dr Judy Williams & Jan Connors - clinical chairs – large group discussions and / or small group work.

Queensland Health SCAN core member Workshop

Thursday 3rd & Friday 4th November 2011

		Focus on QH role & good practice Questions to be addressed include: • What should a recommendation look like? • Should a recommendation correlate to the assessment of the protective needs of a child? Use of case scenarios / examples

2 – 2.45 pm	SCAN meeting & minutes	Led by Jan Connors clinical chairs – large group discussions and / or small group work
		
		Consensus
		• What would be an issue that we can disagree with in SCAN - what would it look like;
		  ○ can we not agree to close a case because we are unhappy with the response?
		  ○ can we disagree with Child safety's assessment of a situation
		• How does QH respond / manage these areas?

2.45 – 3.15 pm	**AFTERNOON TEA**	
3.15 – 4.00 pm	Case discussion	Led by clinical chairs.
4.00 pm	**SUMMARY & CLOSE**	

Queensland Health SCAN core member Workshop

Thursday 3rd & Friday 4th November 2011

DAY TWO – Friday 4th November 2011

Venue – The Sebel, Cnr Charlotte and Albert Street, Brisbane

TIME	TOPIC	FACILITATOR / PRESENTER
9 – 9.20 am	Registration & coffee	
9.20 – 10.30am	QH SCAN core representative – key performance indicators	Led by Jan Connors - clinical Chairs. • How do you report your activities against your role? • How do you measure – workload changes?
10.30 – 11.00 am	**MORNING TEA**	
11 – 11.45 am	Quarterly reports	Led by Judy Williams - clinical Chairs Quarterly reports: • Why?? • How do we make the most of them??
12 – 12.30pm	Discussion: SCAN core representative training, professional development & succession planning	Led by clinical Chairs
12.30 – 1.15 pm	**LUNCH**	
1.15 – 2.30pm	Case discussion	Led by clinical Chairs
2.30 – 3pm	Summary & where to from here?	
3pm	**Close**	

Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) team shall operate within the legislative requirements of the *Child Protection Act 1999*.

Queensland Health staff shall operate in collaboration with Department of Communities Child Safety Services.

Standard # QH-IMP-078-4:2012

Protecting Children and Young People Policy

Implementation Standard for Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team system

1. Purpose

The purpose of the Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team system is to provide a coordinated response to the protection needs of children. An ICM provides a forum for discussion of a matter where the Queensland Health SCAN team core member seeks further information regarding the rationale for a child safety intake decision and requires the opportunity for a multi-agency discussion.

This Implementation Standard identifies the minimum requirements that evidence the implementation of the ICM and SCAN team system component of the Protecting Children and Young People policy. This Implementation Standard identifies individual position accountabilities and responsibilities in relation to information coordination meetings and suspected child abuse and neglect team systems and SCAN records management.

2. Scope

This Implementation Standard applies to all Queensland Health SCAN team core member representatives or their delegates and district health information officers.

3. Supporting documents

Authorising Policy:

- Protecting Children and Young People Policy

Related standards:

- Implementation Standard ‘Information sharing in child protection’
- Implementation Standard ‘Consent in child protection and management of complex care cases and end of life decision making’
- Implementation Standard ‘Care and Treatment order

for a Child'
- Implementation Standard 'Reporting and responding to a reasonable suspicion of child abuse and neglect'
- Implementation Standard 'Conducting child sexual assault examinations'

Protocols, Procedures, Guidelines

- Procedure for ICM and SCAN referral

Forms and templates

- Attachment 1: ICM and SCAN team request for multi-agency meeting form 1
- Attachment 2: SCAN team additional information form 2
- Attachment 3: SCAN team review form 4
- Attachment 4: SCAN team escalation report form 6

4. Related documents

- Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) Team System Manual
- *Child Protection Act 1999*
- Queensland Health Clinical Records Retention and Disposal Schedule
- Queensland Health Policy Records Management for Administrative, Clinical and Functional records
- General Retention and Disposal Schedule for Administrative Records

5. Requirements

5.1 Participating appropriately in SCAN team system

5.1.1 SCAN team core members representatives shall:

- contribute appropriate knowledge and experience in child protection to the SCAN team system
- contribute to the development of recommendations about assessing and responding to the protection needs of children, and:
  - share relevant information about children, their families and other relevant persons
  - identify relevant resources
- take action as required under the recommendations from SCAN meetings
- monitor the implementation of recommendations and review their effectiveness

- identify other service providers with knowledge, experience or resources that help achieve the purpose of the SCAN system (*Child Protection Act 1999*, *s159 I-L*).

5.1.2 In addition to the above legislative requirements the SCAN team core member representative shall participate in the SCAN team system in the following ways:

- coordinate and undertake health assessments and contribute to multi-disciplinary/multi-agency case assessment
- coordinate, collate and analyse health information and contribute to multi-disciplinary/multi-agency case management and treatment planning
- identify and recommend appropriate physical, psychological and developmental assessment and treatment services required for child or young person's ongoing health needs
- participate in interdepartmental development and delivery of training and information relating to the SCAN system.

5.3 Making a referral to an Information Coordination Meeting (ICM)

5.3.1 To make a referral to an ICM the Queensland Health SCAN team core member representatives shall:

- contact the Department of Communities Child Safety Services Regional Intake Service (http://www.communities.qld.gov.au/childsafety/about-us/contact-us/child-safety-service-centres/regional-intake-services) team leader for further discussion regarding the decision and rationale of the report outcome from Child Safety Services
- complete a request for an ICM using 'Request for a multi-agency meeting form 1' (Attachment 1), if the matter remains a child concern report and the ICM and SCAN core member representative requires the opportunity for a multi-agency discussion.

5.4 Making a referral to a Suspected Child Abuse and Neglect (SCAN) team meeting

5.4.1 To make a referral to the SCAN team system the Queensland Health SCAN team core member representative shall:

- ensure the matter has been assessed by Department of Communities Child Safety Services as meeting the threshold for recording a notification; and/or
- ensure that Department of Communities Child Safety Services is responsible for ongoing intervention with the child through a support service case, intervention with parental agreement or a child protection order; and
- ensure the coordination of multi-agency actions as required to effectively assess and respond to the protection needs of the child.

5.5 Managing ICM and SCAN documentation

5.5.1 All staff filing ICM and SCAN team system forms generated by Queensland Health shall do so in the correspondence section of the individuals' clinical record. These forms include: Request for a multi-agency meeting form 1; SCAN additional information form 2; SCAN review form 4 and SCAN escalation report form 6.

5.5.2 ICM and SCAN documents created by other agencies shall be filed in the SCAN record. These documents include: ICM and SCAN team agendas; minutes; records of decisions; request for a multi-agency meeting; reviews and notations.

5.5.3 The SCAN team core member representative shall:

- ensure ICM and SCAN records are accurate, relevant and complete
- ensure the creation of a SCAN record
- file the ICM and SCAN documents in the SCAN record
- ensure the SCAN record is kept in a secure location in the Child Protection Unit
- maintain restricted access to the SCAN record
- consult with the senior manager of the District Health Information Service or equivalent on matters related to records management
- inform the District Health Information Service of the creation of the SCAN record.

6. Review

This Standard is due for review on: 24/08/2013

Date of Last Review: N/A

Supersedes: N/A

7. Business Area Contact

Child Health and Safety Unit, Primary, Community and Extended Care Branch

8. Responsibilities

Position	Responsibility	Audit criteria
Queensland Health Child Safety Director	Oversighting of implementation of the policy. Review of Policy as per schedule. Provision of information and direction to internal and external stakeholders regarding policy.	Policy review is conducted as per schedule. As required/ requested, record of communication regarding policy and inclusions are maintained.
Nursing Directors or delegate	Monitoring and reporting on compliance with policy	Reports are compiled and submitted as requested. Local documents are consistent with this policy. The following are documented and filed: • PRIME Clinical Incident Reports • Patient Complaints • QCMB Patient Satisfaction Survey Reports.
Suspected Child Abuse and Neglect (SCAN) team core member representative	To attend ICM and SCAN meetings and contribute health expertise to interagency discussion.	Review of SCAN records.
Child Protection Advisor	Provision of clinical summaries of information relevant to the SCAN team meeting.	Review of SCAN forms.
Child Protection Liaison Officer	Provision of clinical summaries of information relevant to the SCAN team meeting.	Review of SCAN forms.

9. Definitions of terms used in this policy and supporting documents

Term	Definition / Explanation / Details	Source
Child concern report	A child concern report is recorded when the information received does not suggest a child is in need of protection. A child safety officer may respond to a report by: • providing information and advice to the person reporting the concern • making a referral to another agency • providing information to the police or another state authority.	Department of Communities. *What is a child concern report* www.communities.qld.gov.au/childsafety/about-us/our-performance/intake-phase/child-concern-reports#what-is-a-child-concern-report
Child protection order	Child protection orders are court orders for the protection of children aged up to 18 years, which are made under the *Child Protection Act 1999*. Child protection orders are made where it has been assessed that the child is in need of protection and does not have a parent willing and able to protect the child from harm.	*Child Protection Act 1999*
Clinical record	A collection of data and information gathered or generated to record the clinical care and health status of an individual or group	Australian Standard AS2828 Health Records
Harm	Harm, to a child, is any detrimental effect on the child's physical, psychological or emotional wellbeing, 1. that is of a significant nature; and 2. that has been caused by - • physical, psychological or emotional abuse or neglect; or • sexual abuse or exploitation	S158 *Public Health Act 2005*
Information Coordination Meeting	An Information Coordination Meeting (ICM) provides a forum for discussion of a matter where a SCAN team core member representative seeks further information regarding the rationale for a child safety intake decision and requires the opportunity for multi-agency discussion.	Information Coordination Meeting(ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual

Term	Definition / Explanation / Details	Source
Notification	A notification is recorded when child protection information received suggests a child needs protection. Children and young people in need of protection are those who have suffered significant harm, are suffering significant harm, or are at unacceptable risk of suffering harm and do not have a parent able and willing to protect them from the harm.	Department of Communities http://www.communities.qld.gov.au/resources/childsafety/child-protection/notification-387.pdf
Recognised entity	The *Child Protection Act 1999* states that a recognised entity may be an individual or organisation that is appropriate to be consulted about an Aboriginal or Torres Strait Islander child's protection and care. If the entity is an individual, he or she must be an Aboriginal person or a Torres Strait Islander with appropriate knowledge of or expertise in child protection. The individual must not be an officer or employee of Child Safety Services. When the recognised entity is an organisation, its members must include individuals who fulfil the previously stated criteria and the organisation must provide services to Aboriginal people or Torres Strait Islanders. The recognised entity (whether an individual or organisation) must have been approved by the chief executive to undertake the role of the recognised entity and be named on the list of approved recognised entities required under *Child Protection Act 1999, section 246I.*	Department of Communities www.communities.qld.gov.au/resources/childsafety/practice-manual/pr-working-with-the-recognised-entity.pdf
SCAN record	Contains SCAN information generated by other government departments or service providers.	
Suspected Child Abuse and Neglect (SCAN) team	A SCAN team is a group of people who meet on a regular basis to formally discuss the protective needs of children who have been harmed or who are at risk of harm. SCAN teams consider whether protective intervention should occur. SCAN teams include core representatives from the Department of Child Safety, Queensland Health, the Queensland Police Service, Education Queensland and the Recognised Entity for Aboriginal and Torres Strait Islander child referrals.	Information Coordination Meeting(ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual

Term	Definition / Explanation / Details	Source
Suspected Child Abuse and Neglect (SCAN) team core member agencies	Child Safety is recognised within legislation as the lead agency for the SCAN team system. Core member agencies are the Queensland Police Service, Queensland Health, the Department of Education and Training and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited representing recognised entities when an Aboriginal or Torres Strait Islander child is being discussed.	Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual
Queensland Health Suspected Child Abuse and Neglect (SCAN) team core member representative	Queensland Health SCAN team core member representatives, usually the Child Protection Advisor, act as consultants to assist local staff in responding to child protection concerns and attend SCAN team meetings.	Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual
ICM and SCAN forms generated by Queensland Health	Queensland Health forms including referrals, reviews, assessment records, examination results and treatment plans. They are to be stored as part of the clinical record of the individual.	
ICM and SCAN documents generated by another agency	Contains documents generated by other agencies and include: SCAN team agendas, minutes, SCAN referrals and reviews compiled by other government departments.	

10. Approval and Implementation

Policy Custodian

Executive Director, Primary, Community and Extended Care Branch

Responsible Executive Team Member:

Deputy Director-General, Policy, Strategy and Resourcing Division

Approving Officer:

Michael Cleary, Deputy Director-General,

Policy, Strategy and Resourcing Division

Approval date: 16 May 2012

Effective from: 14 May 2012

Document Number # QH-PCD-078-4-1:2012

Procedure for Referral of an Information Coordination Meeting or a Suspected Child Abuse and Neglect team system meeting

Custodian/Review Officer:

Queensland Health Child Safety Director

Version no: 1

Applicable To: Queensland Health staff members

Approval Date: 16/05/2012

Effective Date: 14/05/2012

Next Review Date: 14/05/2015

Authority:

Approving Officer

……

Name

Supersedes: nil

Key Words: suspected child abuse and neglect, referral, child protection unit, SW010

Accreditation References:

EQuIP and other criteria and standards

1. Purpose

This procedure describes the processes for referring a Queensland Health report of a reasonable suspicion of child abuse or neglect to an Information Coordination Meeting (ICM) or a Suspected Child Abuse and Neglect (SCAN) team system meeting.

2. Scope

This Procedure relates to all Queensland Health employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

3. Supporting documents

Authorising Policy and Standard/s:

- Protecting Children and Young People Policy
- Implementation Standard 'Reporting and responding to a reasonable suspicion of child abuse and neglect'
- Implementation Standard 'Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team'

Forms and templates

- ICM and SCAN team request for multi agency meeting form 1
- SCAN team additional information form 2
- SCAN team review form 4
- SCAN team Escalation report form 6

4. Related documents

- Information Coordination Meetings (ICM) and

the Suspected Child Abuse and Neglect (SCAN) Team System Manual

- Retention and Disposal Schedule for Clinical Records.
- Department of Communities (Child Safety Services) Child Safety Practice manual http://www.chidsafety.qld.gov.au/practice-manual/introduction/index.html

5. Procedure for referral to an ICM or SCAN team system meeting

On receipt of a yellow copy of a completed 'report of a reasonable suspicion of child abuse and neglect' (SW010) form, relevant representatives of the district Child Protection Unit, including the Queensland Health SCAN core representative shall:

- Undertake a review of the SW010 form to determine if the concerns require the coordination of multi-agency actions to effectively assess and respond to the protection needs of the child
- Obtain from Child Safety Services the outcome and rationale for the decision of the report:
    a. If the matter has been assessed as a child concern report and the SCAN team core representative requires further information regarding the decision and rationale, the SCAN team core representative contacts the Child Safety Services regional intake team leader for further discussion
        i. If the matter remains a child concern report and the SCAN team core member requires the opportunity for a multi-agency discussion the matter is referred to an ICM through the completion of Form 1: request for a multi-agency meeting
        ii. Form 1: request for a multi-agency meeting is then forwarded by the SCAN team core representative to the Child Safety Service SCAN team coordinator
    b. If the matter has been assessed as a notification, the SCAN team core representative completes Form 1: request for a multi-agency meeting and forwards this form to the Child Safety Service SCAN team coordinator.

6. Definition of Terms

Term	Definition / Explanation / Details	Source
Harm	*Harm*, to a child, is any detrimental effect on the child's physical, psychological or emotional wellbeing. 1. That is of a significant nature; and 2. That has been caused by - • Physical, psychological or emotional abuse or neglect; or • Sexual abuse or exploitation *'Harm'* is also defined in s9 of the *Child Protection Act*	S158 *Public Health Act 2005*

	1999 as: • Any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing • Caused by physical, psychological or emotional abuse or neglect, sexual abuse or exploitation • How the 'harm' is caused is considered immaterial.	
Harm/abuse/maltreatment	These terms refer to 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing'	
Information Coordination Meeting	An Information Coordination Meeting (ICM) provides a forum for discussion of a matter where a SCAN team core member representative seeks further information regarding the rationale for a child safety intake decision and requires the opportunity for multi-agency discussion.	Information Coordination Meeting(ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual
Recognised Entity	A recognised entity may be an organisation or individual that is appropriate to be consulted about an Indigenous child's protection and care under an agreement between the department and the entity	
SCAN Core representative agencies	Child Safety is recognised within legislation as the lead agency for the SCAN team system. Core member agencies are the Queensland Police Service, Queensland Health, the Department of Education and Training and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited representing recognised entities when an Aboriginal or Torres Strait Islander child is being discussed.	Information Coordination Meeting(ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual
Suspected Child Abuse and Neglect (SCAN) team	A SCAN team is a group of people who meet on a regular basis to formally discuss the protective needs of children who have been harmed or who are at risk of harm. SCAN teams consider whether protective intervention should occur. SCAN teams include core representatives from the Department of Child Safety, Queensland Health, the Queensland Police Service, Education Queensland and the Recognised Entity for Aboriginal and Torres Strait Islander child referrals.	Information Coordination Meeting(ICM) and Suspected Child Abuse and Neglect (SCAN) team Manual
SCAN internal records	Queensland Health referrals, reviews, assessment records, examination results and treatment plans. They are to be stored as part of the clinical record of the individual.	
SCAN external records	Records generated by other agencies and include: SCAN team agendas, minutes, SCAN referrals and reviews compiled by other government departments.	

7. References and Suggested Reading

- Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) Team System Manual

8. Consultation (optional)

Key stakeholders (position and business area) who reviewed this version are:

- Central and Southern Child Protection Clinical Chairs
- Northern Child Protection Coordinator
- Southern Child Protection Clinical Network Coordinator
- Statewide Child Protection Liaison Officers
- Statewide Child Protections Advisors
- Queensland Health Suspected Child Abuse and Neglect core representatives

9. Procedure Revision and Approval History

Version No.	Modified by	Amendments authorised by	Approved by
1	Sharon McDonald	Joanna Gurd	

3.1 Key District child protection roles

Queensland Health staff have a significant role in recognising and responding to child abuse and neglect. Key district child protection positions have been appointed to assist staff to understand the responsibility of Queensland Health (QH) professionals and their role in the provision of services to children who have been harmed or who are at risk of harm.

District Child Protection Advisor

The District Child Protection Advisor is a nominated Health Service District position. The position plays a key role in the provision of child safety and protection services both at a District and interagency level.

A list of all District Child Protection Advisors is available on the Child Health and Safety Unit QHEPS site http://qheps.health.qld.gov.au/csu.

District Child Protection Liaison Officer

The role of the District Child Protection Liaison Officer is to provide a single point of contact for child protection issues.

A list of all District Child Protection Liaison Officers is available on the Child Health and Safety Unit QHEPS site http://qheps.health.qld.gov.au/csu.

District Designated Medical Officer

The District Manager, under section 188 of the *Public Health Act 2005*, may appoint doctors to act as District Designated Medical Officers due to their expertise or experience in identifying and interpreting signs of child harm. Designated Medical Officers, once appointed, have the authority to make and or extend a Care and Treatment Order for a Child.

A Care and Treatment Order for a Child enables a child to be held at a health service facility initially for up to 48 hours. Under the legislation, only Designated Medical Officers are authorised to issue a Care and Treatment Order for a Child.

A list of all Designated Medical Officer is available on the Child Health and Safety Unit QHEPS site http://qheps.health.qld.gov.au/csu.

Suspected Child Abuse and Neglect (SCAN) Team System core member representative

The QH Suspected Child Abuse and Neglect (SCAN) core member representative will work cooperatively with other government department SCAN team representatives to provide relevant information and expertise to ensure the planning for and delivery of coordinated child protection services to children and young people who have been harmed or who are at risk of harm.

A list of all QH Suspected Child Abuse and Neglect (SCAN) Team System core member representatives is available on the Child Health and Safety Unit QHEPS site http://qheps.health.qld.gov.au/csu .

Further information

Please refer to the *Protecting Queensland Children: Policy Statement and Guidelines for the Management of Child Abuse and Neglect of Children and Young People (0 – 18 years).* Information is available by visiting the Child Health and Safety Unit website at http://qheps.health.qld.gov.au/csu or emailing CSU@health.qld.gov.au

Queensland Government
Queensland Health

Queensland Government

Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) Team System Manual

This Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) Team System Manual has been produced by the Refocused SCAN Team System working group. The working group comprises representatives from each of the SCAN team core member agencies, which are the Department of Communities – Child Safety, the Queensland Police Service, the Department of Education and Training, Queensland Health and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited.

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INTRODUCTION

Keeping children safe and providing opportunities for them to reach their full potential cannot be achieved by one government agency. Responsive service provision to young Queenslanders relies on solid, respectful and trusting partnerships within and across government, non government agencies and local communities. These partnerships are critical to an effective system for protecting children.

In October 2008, *Partnership in Action: a shared vision for the SCAN Team system*, was endorsed by the chief executive of each SCAN team core member agency which includes the Department of Communities – Child Safety (Child Safety), the Queensland Police Service, Queensland Health, the Department of Education and Training and the Aboriginal and Torres Strait Islander Child Protection Peak.

Partnership in Action: a shared vision for the SCAN Team system outlines the agreement and commitment made by each agency to a refocused model of service delivery for the SCAN team system, as well as the introduction of information coordination meetings to provide a separate mechanism for coordinated multi-agency discussion.

The *Information Coordination Meetings (ICM) and the Suspected Child Abuse and Neglect (SCAN) Team System Manual* provides procedures to guide the operation of SCAN teams and information coordination meetings and was developed by an interagency working group comprising members of all SCAN team core member agencies.

The SCAN team system and information coordination meetings operate within the following governance arrangements.

External monitoring

The Commission for Children and Young People and Child Guardian (CCYPCG) is responsible for independently monitoring the Queensland child protection system.

To do this, it is mandated to proactively audit, investigate and review the systems, policies and practices of service providers within the child protection system, including the SCAN team system. On an ongoing basis, the performance of the SCAN team system is reported on in the annual *Child Guardian Report – child protection system*.

The CCYPCG is a member of the Child Safety Directors' Network (CSDN) and is represented on the CSDN SCAN subcommittee.

Child Safety Directors' Network

The Child Safety Directors' Network (CSDN) supports the Queensland Government's child protection system across the continuum from prevention and early intervention to statutory intervention and ensures child protection is a whole-of-Government responsibility. The CSDN leads coordination, communication and strategic planning in the child protection system and has a key role in facilitating service responses, identifying emerging issues and gaps in service delivery and enhancing multi-agency collaboration.

The CSDN includes all appointed Child Safety Directors as well as representatives from Child Safety (Chair), the CCYPCG, and the Department of the Premier and Cabinet. The CSDN reviews information in relation to the SCAN team system.

Child Safety Directors' Network SCAN subcommittee

The CSDN SCAN subcommittee facilitates the operational role of the SCAN team system and comprises key agencies involved in the SCAN team system, including Child Safety, the Queensland Police Service, Queensland Health, the Department of Education and Training, Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited and the CCYPCG. Other Child Safety Directors may also attend subcommittee meetings where appropriate.

CHAPTER ONE

Reporting to Child Safety intake

1.1 Child Safety intake

The Department of Communities – Child Safety (Child Safety) has a legislative responsibility to respond to information received about harm or risk of harm to a child, or an unborn child who may be at risk of harm after he or she is born. The purpose of intake is to:

- receive information about child protection concerns from community members and other agencies
- provide a response to the information in accordance with the responsibilities of Child Safety
- inform the community about the role of Child Safety and provide information about child protection services.

1.2 Reporting child protection concerns to Child Safety

Any person may contact Child Safety as a notifier. All notifiers are subject to the confidentiality provisions of the *Child Protection Act 1999*, section 186.

Information is gathered from the notifier at intake to assess whether a child has been harmed, is being harmed or is at risk of being harmed, and whether they have a parent able and willing to protect them from the harm. When the information relates to an unborn child, the intake decision is whether the unborn child will be at risk of harm after he or she is born.

Completion of the screening criteria assists the decision about whether reported child protection concerns are recorded as a child concern report (CCR) or meet the threshold for recording a notification.

Harm refers to any detrimental effect of a significant nature on the child's physical, psychological or emotional well-being. It is immaterial how the harm is caused. Harm can be caused by physical, psychological or emotional abuse, neglect, sexual abuse or exploitation (*Child Protection Act 1999*, section 9). The threshold for recording a notification requires that there is an allegation of harm or risk of harm to a child, and a reasonable suspicion that the child is in need of protection (*Child Protection Act 1999*, section 14).

Refer to Appendix 1 for related definitions.

1.3 Child Safety feedback to SCAN team core member agencies

When the notifier is from a SCAN team core member agency, Child Safety **must** provide feedback to SCAN team core member agencies through SCAN team core member representatives or approved delegates, of the intended response to the reported child protection concerns, specifically:

- whether a notification or a child concern report has been recorded, and
- the rationale for the decision within **five** business days of the information being received.

If requested by the SCAN team core member representative, Child Safety will provide written advice of the decision and rationale for the decision, to the SCAN team core member representative or approved delegate.

To inform the decision regarding whether a matter constitues a notification or a child concern report, Child Safety may initiate a pre-notification check with one or more SCAN team core member agencies. Pre-notification checks will not be undertaken if the initial information received indicates the matter meets the legislative threshold for a notification.

Where a pre-notification check is to occur, it must be initiated as soon as possible and within 24 hours of receiving the child protection concerns, to allow as much time as possible for SCAN team core member agencies to respond. The decision regarding whether a notification will be recorded **must** be made by Child Safety within 48 hours of receiving the initial information. The timeliness of provision of information by SCAN team core member agencies in relation to pre-notification checks may impact the ability of Child Safety to meet the five day feedback timeframe.

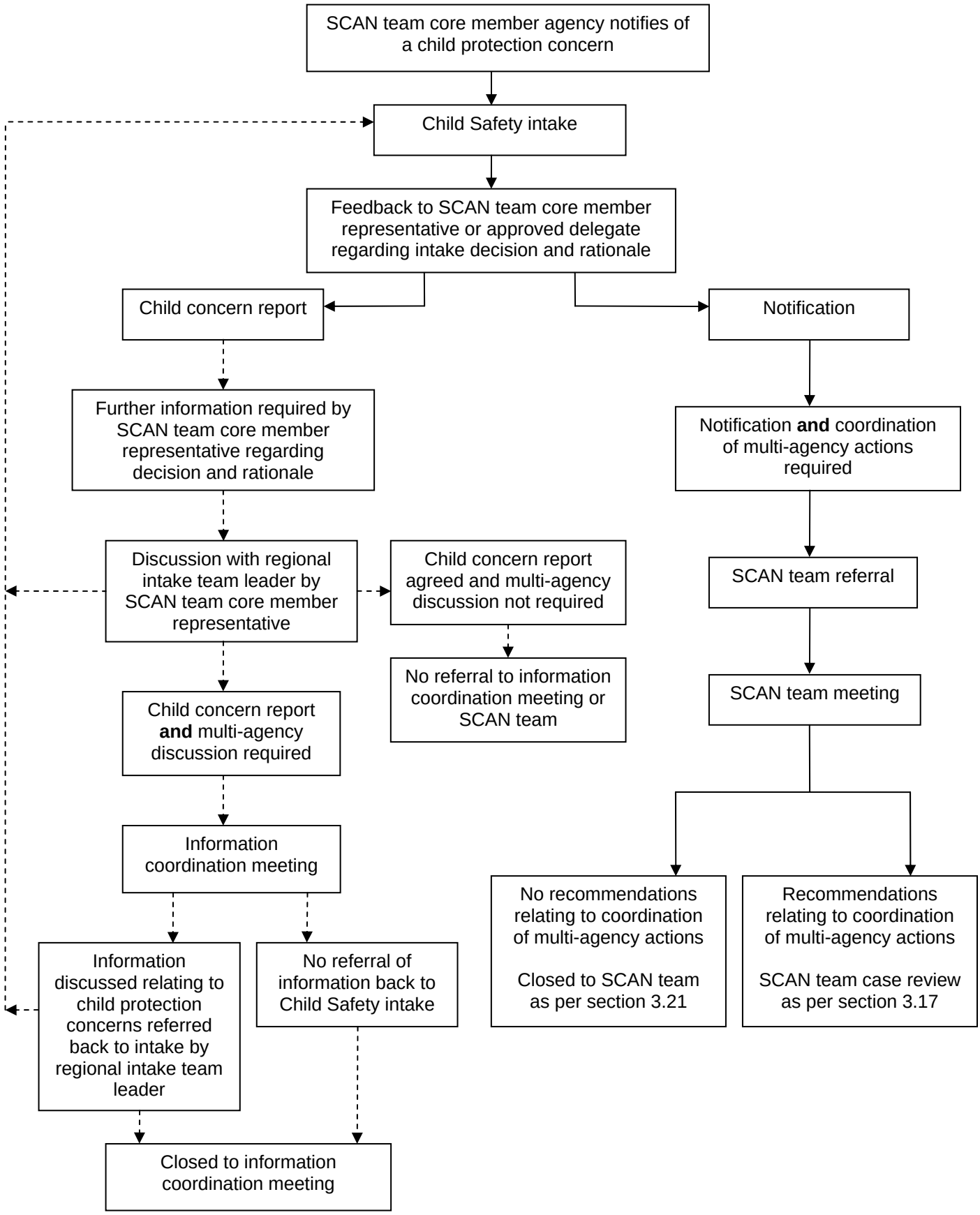
If feedback from Child Safety, both verbal and written where requested, about the decision is not received, the SCAN team core member representative may choose to progress the matter through existing line management processes by contacting the regional intake team leader for further discussion and action if required.

Where a notification has been recorded and coordination of multi-agency actions is required to assess and respond to the protection needs of the child, the SCAN team core member representative may then progress a SCAN team referral via the Request for multi-agency meeting form. Refer to chapter three for further information.

Where a child concern report has been recorded and the SCAN team core member representative requires the opportunity for multi-agency discussion, an information coordination meeting referral may be progressed via the Request for multi-agency meeting form. Refer to chapter two for further information.

This process is represented diagrammatically in Figure 1 Information coordination meetings and SCAN team process flowchart.

Figure 1 Information coordination meetings and SCAN team process flowchart



CHAPTER TWO

Information coordination meetings (ICM)

2.1 Purpose of an ICM

An ICM provides a forum for discussion of a matter where a SCAN team core member representative seeks further information regarding the rationale for a child safety intake decision and requires the opportunity for multi-agency discussion.

2.2 Referral to an ICM

An ICM referral **must** meet **all** the following criteria:

- the matter has been assessed by Child Safety as a child concern report (CCR)
- the SCAN team core member representative has contacted the Child Safety regional intake team leader for further discussion regarding the decision and rationale
- the matter remains a CCR and the SCAN team core member representative requires the opportunity for multi-agency discussion.

Providing these criteria have been met, an ICM referral may be progressed by the SCAN team core member representative. For administrative efficiency, an ICM referral is submitted via the Request for multi-agency meeting form, which is utilised for both ICM and SCAN team referrals.

The SCAN team coordinator **must** ensure the matter is listed on the ICM agenda for discussion within **ten** business days of receipt of the Request for a multi-agency meeting form or as otherwise negotiated where urgent discussion is required.

Once the Request for multi-agency meeting form has been submitted, any SCAN team core member representative who becomes aware of additional information significant to the ICM referral **must** ensure this information is discussed at the ICM.

2.3 Attendance and quorum for an ICM

If required, an ICM **must** be scheduled adjacent to a SCAN team meeting. It will be attended by representatives from SCAN team core member agencies only. A **quorum** is required for the ICM to proceed. An ICM **quorum** comprises a representative from Child Safety, the Queensland Police Service, Queensland Health and the Department of Education and Training. In **all** instances, discussion **must not** delay agency responses or impede a criminal investigation.

The recognised entity representative is considered a SCAN team core member only when an Aboriginal or Torres Strait Islander child is being discussed and, therefore, does not comprise part of the ICM quorum. If the recognised entity is unable to attend, the ICM can proceed.

A regional intake team leader will attend in person or, where the ICM is being held in a different geographical location to the regional intake service, may participate via telephone conference link. The regional intake team leader attends with the requisite decision making authority in relation to the CCR decision.

Inability to attend an ICM

If a representative from any SCAN team core member agency is unable to attend the meeting in person, they **may** participate via telephone or video conference. In these situations a quorum is

still formed and those linking via telephone or video conference **must** ensure compliance with privacy and confidentiality requirements.

2.4 Decisions and Documentation for an ICM

There are two decisions that can occur as part of an ICM. If following discussions at an ICM, the RIS team leader believes the matter should be reassessed, the team leader will refer the matter back to the regional intake service. Otherwise the matter will remain a CCR.

When deciding what information can be brought to an ICM as part of the discussion and what information must be immediately reported to the regional intake service, each core member agency must adhere to their own internal policies, procedures and/or legislation.

The documentation for an ICM will be prepared and distributed by the SCAN team coordinator and will comprise an ICM agenda and ICM record of decision.

The ICM agenda will be distributed to all SCAN team core member representatives prior to the ICM and list in relation to each matter:

- the full name and date of birth for each child
- indigenous status
- school and/or doctor if known
- the referring officer and SCAN team core member agency.

Further contextual information regarding the child and family will be available via the Request for multi-agency meeting form which will be distributed to all SCAN team core member representatives by the SCAN team coordinator prior to the ICM.

The ICM record of decision will document:

- key information from each agency
- a summary of the issues discussed
- decisions made in relation to each matter including referral back to Child Safety intake or no further action.

Following the ICM, the SCAN team coordinator **must** ensure a copy of the ICM record of decision is distributed to all meeting participants within **five** business days.

Providing the matter remains a CCR, the ICM record of decision will also be attached to the intake event within the Child Safety Integrated Client Management System (ICMS). Other SCAN team core member agency representatives will record the information in accordance with respective agency guidelines and requirements.

The escalation process (section 3.20) outlined for the SCAN team does not apply to an ICM. If a core member agency representative has concerns about the decision from an ICM, the standard complaints process is to be applied (refer to section 4.3).

2.5 SCAN team referral following an ICM

Following an ICM discussion which results in the matter being referred back to Child Safety intake by the regional intake team leader and a notification being recorded, Child Safety will advise the

SCAN team core member representative of the decision within **three** business days and attach the ICM record of decision to the intake event within ICMS.

When the SCAN team core member representative progresses a SCAN team referral, the ICM record of decision **must** be attached by the referring officer to the Request for multi-agency meeting form.

CHAPTER THREE

SCAN team system and operational procedures

3.1 Purpose of the SCAN team system

The purpose of the SCAN team system is to enable a coordinated, multi-agency response to children where statutory intervention is required to assess and meet their protection needs. This will be achieved by:

- timely information sharing between SCAN team core members
- planning and coordination of actions to assess and respond to the protection needs of children who have experienced harm or risk of harm
- holistic and culturally responsive assessment of children's protection needs.

3.2 Core members of the SCAN team system

Child Safety is recognised within legislation as the lead agency for the SCAN team system. Core member agencies are the Queensland Police Service, Queensland Health, the Department of Education and Training and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited representing recognised entities when an Aboriginal or Torres Strait Islander child is being discussed.

Refer to Appendix 6 for more detailed information regarding the role of SCAN team system core member agencies.

3.3 Legislative framework

The *Child Protection Act 1999* provides Child Safety with the mandate to investigate allegations of harm or risk of harm to a child where it is assessed the child does not have a parent able and willing to protect the child from the harm and there is a reasonable suspicion the child is in need of protection, and to intervene to ensure the child's ongoing protection.

The *Child Protection Act 1999*, chapter 5A, sections 159I–159L, provides the legislative basis for the establishment of the SCAN team system and activities undertaken by the SCAN team system.

In accordance with the *Child Protection Act 1999*, section 159L, SCAN team core members have a legislative responsibility to "*contribute to the operation of the SCAN system through representatives who have appropriate knowledge and experience in child protection; use their best endeavours to agree on recommendations about assessing and responding to the protection needs of children; share relevant information about the children, their families and other relevant persons; identify relevant resources of members or other entities; take action as required under the recommendations, monitor the implementation of recommendations and review their effectiveness; invite and facilitate contributions from other service providers with knowledge, experience or resources that would help achieve the purpose of the SCAN system*."

SCAN teams will operate in accordance with other relevant legislation as detailed in Appendix 2.

3.4 SCAN team system principles

The following principles inform the operation of the SCAN team system:

- All business conducted through SCAN teams will prioritise consideration of the safety and wellbeing of the child, including the cultural context for the child.
- A coordinated, multi-agency approach results in quality planning, assessment and response to the protection needs of the child.
- Individual SCAN team core member agencies are accountable and retain responsibility for their actions in accordance with their respective legislative authorities.
- SCAN teams do not have distinct decision making authority.
- Recommendations will be developed based on consensus following a critical analysis of the information available to the SCAN team, and will be evidence based.
- SCAN team processes will occur in a timely way and all actions will be consistent with legislative and policy guidelines.
- SCAN teams will attempt to resolve complaints or issues **locally** through existing agency specific line management or complaints mechanisms, with the particular mechanism utilised dependent upon the issue for resolution.
- SCAN team business meetings are the appropriate forum for concerns to be addressed in relation to SCAN team functioning and systemic issues (refer to 4.4 Convening business meetings)
- All participants will:
  - share relevant information to assess and respond to the protection needs of the child in accordance with information sharing provisions
  - ensure relevant information is provided to staff within their own agency in accordance with confidentiality and privacy requirements in a timely way
  - facilitate, as far as possible, access to available resources to assess and respond to the protection needs of the child
  - provide an appropriate level of professional expertise and knowledge
  - support collaboration across agencies by demonstrating professional respect at all times.

3.5 SCAN teams

A SCAN team comprises:

- a SCAN team coordinator (Child Safety)
- a SCAN team administration officer (Child Safety)
- a representative from the SCAN team core member agencies:
  - Child Safety
  - Queensland Police Service
  - Queensland Health
  - Department of Education and Training
  - the recognised entity when an Aboriginal or Torres Strait Islander child is the subject of discussion.

When required, a SCAN team may also comprise relevant stakeholders from SCAN team core member agencies or other agencies who can provide expertise and/or resources to inform discussion and deliberations by the SCAN team core member representatives.

The frequency and duration of SCAN team meetings will be agreed by SCAN team core member representatives in response to operational need and will occur at least once per fortnight. The business of the meeting will focus on case discussions regarding SCAN team referrals, reviews and transfers, formulating recommendations, and decisions regarding closure of cases to the SCAN team.

Refer to Appendix 7 for the current configuration of SCAN teams across Queensland.

3.6 SCAN team referral criteria

All SCAN team core member agencies are able to make a SCAN team referral via their SCAN team core member representative. In accordance with *Partnership in Action: a shared vision for the SCAN Team system*, SCAN team referrals **must** meet the following mandatory criteria:

- the matter has been assessed by Child Safety as meeting the threshold for recording a notification **and/or**
- Child Safety is responsible for ongoing intervention with the child through a support service case, intervention with parental agreement or a child protection order **and**
- coordination of multi-agency actions is required to effectively assess and respond to the protection needs of the child.

3.7 Referring a matter to the SCAN team

Where a matter meets the threshold for a notification and the mandatory criteria for a SCAN team referral, an officer from any of the SCAN team core member agencies intending to refer a matter to SCAN **must** progress the referral through their agency's SCAN team core member representative. Matters which have **not** been through the Child Safety intake process and a notification recorded, **cannot** be referred to the SCAN team, unless the child is subject to ongoing intervention through a support service case, intervention with parental agreement or a child protection order.

To make a referral to the SCAN team, the following steps **must** be undertaken:

- the referring officer completes the Request for multi-agency meeting form for each family where relevant
- the SCAN team core member representative forwards the Request for multi-agency meeting form (hard copy or electronic) to the SCAN team coordinator for inclusion of the matter on the SCAN team meeting agenda
- the SCAN team coordinator ensures the matter is listed on the SCAN team meeting agenda for discussion within **ten** business days of receipt of the SCAN team referral
- the SCAN team coordinator ensures SCAN team core member representatives receive copies of all Request for multi-agency meeting forms no later than **three** business days **prior** to the meeting unless otherwise negotiated
- the SCAN team coordinator ensures a hard copy of the Request for multi-agency meeting form is signed by the referring agency's SCAN team core member representative at the SCAN team meeting for filing

- the referring agency's SCAN team core member representative is well briefed on the case before the SCAN team meeting and has all relevant information to participate fully in the discussion
- if considered necessary prior to the scheduled SCAN team meeting, the SCAN team core member representative **may** request an emergency SCAN team meeting (Refer to 3.10 Requesting and convening an emergency SCAN team meeting).

3.8 Providing additional information for a SCAN team referral

Once the Request for multi-agency meeting form has been submitted, any SCAN team core member representative who becomes aware of additional information significant to the SCAN team referral, **must** provide this via the SCAN team additional information form to the SCAN team coordinator **prior** to the SCAN team meeting unless otherwise negotiated. The SCAN team coordinator will ensure SCAN team core member representatives receive copies of all SCAN team additional information forms no later than **three** business days **prior** to the meeting. If an emergency SCAN team meeting is convened, the SCAN team additional information form should be provided as soon as practicable.

3.9 Convening a SCAN team meeting

Each SCAN team core member agency will have only **one** designated SCAN team core member representative who, wherever possible, should attend every SCAN team meeting. Child Safety will have the SCAN team coordinator and SCAN team administration officer in attendance at each SCAN team meeting as well as the designated SCAN team core member representative. The SCAN team core member representative will have the skills, knowledge and experience to appropriately represent their agency in SCAN team discussions and sufficient authority to commit their agency to SCAN team recommendations relating to the coordination of multi-agency actions.

Each SCAN team core member agency will provide the SCAN team coordinator with contact details of their SCAN team core member representative, including name, position, email address and contact numbers, and details of an appropriate proxy who will attend when the SCAN team core member representative is unavailable. Prior to a SCAN team meeting, details of any additional agency officers attending will also be provided to the SCAN team coordinator by each core member agency.

Ensuring a SCAN team quorum

SCAN team recommendations are valid **only** if a **quorum** is formed for both scheduled and emergency SCAN team meetings. A SCAN team **quorum** comprises a representative from Child Safety who is not the SCAN team coordinator or SCAN team administration officer, the Queensland Police Service, Queensland Health and the Department of Education and Training. The recognised entity representative is considered a SCAN team core member only when an Aboriginal or Torres Strait Islander child is being discussed and, therefore, does not comprise part of the SCAN team quorum.

The immediate safety of a child **must never** be compromised by an inability to form a SCAN team quorum. In some circumstances intervention by one or more agencies may occur prior to or during a SCAN team meeting. Intervention may be required to ensure the immediate safety of a child and/or to meet other legislative requirements. In **all** instances, discussion and planning for cases by the SCAN team **must not** delay statutory responses or impede a criminal investigation.

3.10 Requesting and convening an emergency SCAN team meeting

Emergency SCAN team meetings can **only** be convened on business days and will **not** be convened outside business hours. Information **can** be shared between SCAN team core member agencies outside business hours to ensure the immediate safety of a child and coordinate a response to the protection needs of the child without the need to convene an emergency SCAN team meeting.

Any SCAN team core member representative can request an emergency SCAN team meeting if the matter has been assessed by Child Safety as meeting the threshold for recording a notification and coordination of multi-agency actions is required between scheduled SCAN team meetings. While unanimous agreement from all SCAN team core member representatives to convene an emergency SCAN team meeting is **not** required, all SCAN team core member representatives who comprise the quorum **must** attend for the emergency SCAN team meeting to proceed. If the SCAN team core member representative is unavailable, an appropriate proxy nominated by the agency for SCAN team meetings **must** attend.

The SCAN team core member representative requesting the emergency SCAN team meeting will inform the SCAN team coordinator of the reason for seeking the meeting and arrange for the appropriate Request for multi-agency meeting or SCAN team review form to be completed and submitted as soon as practicable **prior** to the meeting. A copy of the Request for multi-agency meeting or SCAN team review forms will be distributed to all SCAN team core member representatives by the SCAN team coordinator at the meeting or sooner if possible.

The minutes of an emergency SCAN team meeting will be recorded in accordance with SCAN team procedures.

3.11 Representation by the recognised entity

When an Aboriginal or Torres Strait Islander child is being discussed by a SCAN team, every effort **must** be made by the SCAN team coordinator to ensure the nominated representative or proxy from the recognised entity is given sufficient advance notice, to allow for participation in case discussion.

When participating in a SCAN team discussion, the recognised entity representative or proxy has the same status as other SCAN team core member representatives, including receiving copies of all documents in relation to an Aboriginal or Torres Strait Islander child discussed during the meeting. Where necessary, such documents should be forwarded by a secure electronic storage device or secure fax machine if email communication is not secure.

3.12 Inability to attend a scheduled or emergency SCAN team meeting

When the SCAN team coordinator or administration officer is unable to attend the SCAN team meeting, another officer from Child Safety who is not the SCAN team core member representative will chair or minute the meeting (whichever applies). When these substantive officers are on leave or secondment, the CSSC manager will ensure the responsibilities of the officer continue to be fulfilled by an officer who is not the Child Safety SCAN team core member representative.

When any SCAN team core member representative is unable to attend a scheduled or an emergency SCAN team meeting, the relevant agency is responsible for organising an appropriate proxy.

If a representative from any SCAN team core member agency is unable to attend the meeting in person, they **may** participate via telephone or video conference. In these situations a quorum is still formed and those linking via telephone or video conference **must** ensure compliance with privacy and confidentiality requirements. This method should **not** become the standard for participation in SCAN team meetings.

When the recognised entity representative or proxy is not able to participate, the SCAN team coordinator will provide the SCAN team meeting minutes and copies of all documents in relation to an Aboriginal or Torres Strait Islander child discussed, to the representative or proxy as soon as possible after the meeting.

If the recognised entity representative or proxy is unable to attend in person, arrangements can be made for telephone or video conferencing. Although this is not to occur on a regular basis, an exception exists when a recognised entity is located in a remote community or a significant geographical distance from the SCAN team meeting location and cannot physically attend the meeting. Recognised entities can also indirectly contribute to the discussion by providing information through a SCAN team review form or other document. (Refer to 3.17 Conducting SCAN team case reviews.)

3.13 Providing SCAN team information to a child and parents

Prior to or following discussion of a referral or review by the SCAN team, an officer from a core member agency **may**, in consultation with other SCAN team core member representatives and depending on the circumstances of the case, take action to inform the child and at least one parent of the:

- referral to a SCAN team
- purpose and operation of the SCAN team
- review of the case by a SCAN team
- recommendations made by the SCAN team.

If uncertain about whether the child and parents should be informed, the referring officer will raise this as an issue for discussion at the next scheduled SCAN team meeting.

Under **no** circumstances are SCAN team documents (referrals, case reviews or minutes) to be provided or shown to a child, their parents, legal representative or an advocate. Access to these documents can **only** occur if subpoenaed or applied for in accordance with the *Right to Information Act 2009*.

Decision not to provide information to a child and parents

There may be situations when the SCAN team, following a thorough assessment of risk, makes a decision that providing this information to a child and parents may:

- place the child at further risk
- place a member of staff at significant risk
- jeopardise a criminal investigation

- directly or indirectly identify a notifier.

In such situations, a child and parents will **not** be informed unless agreement to do so has been reached by the SCAN team. The rationale for the decision not to inform a child and parents will be documented in the SCAN team minutes.

When the referring officer recommends that a child and parents should **not** be informed, the officer will record this and a rationale for the recommendation on the Request for multi-agency meeting or SCAN team review form.

Decision to provide information to a child and parents

When a decision is made to inform a child and parents, the officer **must** ensure the information provided does not in any way disclose the identity of the notifier. When the parents are separated and residing in different locations and retain joint parenting responsibilities, the officer should, wherever possible, provide this information to both parents.

A decision to provide the child with information **must** be based upon the protection needs of the child, the child's ability to comprehend the information and an assessment of potential emotional and psychological impacts of the nature of the information upon the child.

The decision to inform a child and parents will be recorded by the referring officer on the Request for multi-agency meeting or SCAN team review form and be documented in the SCAN team minutes.

3.14 Identifying and arranging attendance by invited stakeholders

A key responsibility of SCAN team core member representatives is to invite and facilitate contributions from other service providers with knowledge, experience or resources to assist with coordination of multi-agency actions to assess and respond to the protection needs of children. For further information refer to 4.1 Managing occasional attendance by individuals at SCAN team meetings.

To ensure the most appropriate response to the child, SCAN team core member representatives will identify stakeholders who can:

- contribute to discussion in relation to the protection needs of the child
- offer services and/or resources to assist the child and family
- contribute additional expert knowledge to assist with the formulation of recommendations for action.

Invited stakeholders may include other service streams within the Department of Communities and a range of other government and non-government agencies, including Department of Community Safety, domestic and family violence services, drug and alcohol services, child care services, prevention and early intervention services such as Referral for Active Intervention, Family Intervention Service (FIS), family support and reunification services.

The referred child, family members, carers, legal representatives or advocates **cannot** be invited stakeholders. If necessary, these individuals may request information about SCAN team case discussions and recommendations from Child Safety. Refer to 3.13 Providing SCAN team information to a child and parents for further detail regarding access to SCAN team documents.

Notice of invited stakeholders **must** be provided to the SCAN team coordinator **three** business days **prior** to the scheduled case discussion unless otherwise negotiated. If the advice is received by the SCAN team coordinator after this time, the case may be discussed in the absence of the stakeholder. If the invited stakeholder involvement is critical, information can either be gathered outside the SCAN team scheduled meeting, or an emergency SCAN team meeting may be convened. The SCAN team will then determine if the stakeholder attends the next scheduled SCAN team case review.

The SCAN team coordinator will contact the manager of the relevant agency to arrange appropriate representation and obtain details of the invited stakeholder for inclusion on the SCAN team meeting agenda. The invited stakeholder will be advised by the SCAN team coordinator of their role and expectations relating to SCAN team discussions, including compliance with privacy and confidentiality requirements and completion of the SCAN information privacy deed **prior** to participation in the meeting.

3.15 Completing SCAN information privacy deeds

A SCAN information privacy deed is a contract between an agency or individual and Child Safety that ensures the privacy of personal information released to that agency or individual.

A SCAN information privacy deed **must** be completed when an invited stakeholder or meeting participant:

- is from an agency that does **not** have a current service agreement compliant with the information privacy principles applicable to government agencies for collecting and managing personal information **or**
- is **not** affiliated with an agency.

The SCAN team coordinator will provide that individual or agency with a SCAN information privacy deed to be completed and returned via facsimile or in person to the SCAN team coordinator **prior** to the commencement of the SCAN team case discussion. An invited stakeholder who does **not** comply with this requirement will be unable to participate in the meeting.

The SCAN team coordinator will ensure SCAN information privacy deeds are filed in the SCAN team business file for SCAN team core member agreements and information privacy deeds.

3.16 Formulating and documenting SCAN team recommendations

SCAN team recommendations relate to the coordination of multi-agency actions to assess and respond to the protection needs of the child.

A recommendation comprises actions by more than one core member agency. For example, a recommendation may include an undertaking by QH to conduct a medical assessment, and a joint investigation by QPS and Child Safety. A SCAN team cannot make a recommendation where the SCAN team determines that only a single agency response is required.

Once a recommendation has been determined, the information will be recorded in the SCAN team minutes. There is one set of SCAN team minutes per case discussion, documented and agreed to during the SCAN team meeting, which will be a **summary** of discussion by SCAN team core member representatives **not** a verbatim record of discussion. The SCAN team coordinator

will ensure dissemination of the SCAN team minutes to all SCAN team core member representatives within **five** business days.

SCAN team minutes are stored on the SCAN team case file by Child Safety in accordance with recordkeeping requirements.

SCAN team recommendations **must** be communicated as soon as practicable by the relevant SCAN team core member representative to the appropriate officers within their own agency for action. The timing of this communication will be dependent upon the immediacy of response required to the protection needs of the child.

Departing from SCAN team recommendations and initiating an escalation process are addressed in sections 3.19 and 3.20 respectively.

Closing a case to the SCAN team is addressed in section 3.21.

Refer to Appendix 3 for examples of appropriate SCAN team recommendations.

3.17 Conducting SCAN team case reviews

Within **six weeks** of the SCAN team recommendations being made, the SCAN team will review each case to:

- discuss progress on SCAN team recommendations
- monitor the implementation and review the effectiveness of SCAN team recommendations
- determine if a case should be closed to the SCAN team. (Refer to 3.21 Closing a case to the SCAN team)

SCAN team case reviews should include:

- a review of the original protection needs of the child and the impact of any changes on the original SCAN team recommendations
- identification and analysis of all outstanding SCAN team recommendations
- any current, updated information
- a review of the effectiveness of the SCAN team recommendations in responding to the protection needs of the child.

The case review date should balance the need to provide sufficient time for SCAN team recommendations to be actioned with the importance of reviewing progress for the child at the earliest possible opportunity.

When a case is reviewed and a SCAN team recommendation has not been actioned, the SCAN team **must** review current information to ensure the protection needs of the child continue to be addressed.

It may be necessary for officers from SCAN team core member agencies to share information outside the formal SCAN team meeting, particularly if available information and issues are changing frequently. This information should also form part of the case review discussion at the next SCAN team meeting.

When a case is scheduled for review, the SCAN team core member representative of the agency responsible for actioning SCAN team recommendations or providing information to the SCAN team **must** complete the SCAN team review form.

Information regarding agreed SCAN team recommendations unable to be actioned due to service availability and/or capacity issues **must** also be included on the SCAN team review form and relevant details recorded in the SCAN team minutes. The SCAN team coordinator will collate and maintain this data for inclusion in the SCAN team quarterly report and subsequent provision to the CSDN SCAN subcommittee.

The completed SCAN team review form will be forwarded by the relevant SCAN team core member representative to the SCAN team coordinator no later than **three** business days prior to the scheduled SCAN team meeting or as otherwise negotiated. The SCAN team coordinator will ensure SCAN team core member representatives receive copies of all SCAN team review forms no later than **two** business days **prior** to the SCAN team meeting, or as otherwise negotiated.

The SCAN team core member representative should be comprehensively briefed by their relevant agency officer in relation to the current status of the case to ensure full participation in discussion and planning.

Any discussion, decisions or recommendations made during a SCAN team case review will be recorded in the SCAN team minutes.

Responding to new concerns or additional information regarding an open SCAN team case

Any SCAN team core member representative who becomes aware of new concerns or additional information about harm or risk of harm to a child whose case is already open to the SCAN team, **must** report the concerns to Child Safety intake for determination of the appropriate response. The relevant SCAN team core member representative will be informed by Child Safety of the intended response to the child protection concerns received.

Additional information identified by any SCAN team core member agency in relation to a case already open to the SCAN team, may trigger the need for a review of the case by the SCAN team sooner than the scheduled review date. The relevant SCAN team core member representative **must** complete and submit the SCAN team review form, incorporating any additional information, to the SCAN team coordinator.

The SCAN team coordinator will ensure the case is listed for review at the next scheduled SCAN team meeting and the SCAN team review form distributed to SCAN team core member representatives prior to the meeting.

SCAN team outcomes resulting from case reviews

Following a review of information relating to the protection needs of the child as documented in the SCAN team review form, a SCAN team may:

- maintain the original recommendations
- modify the original recommendations
- formulate new recommendations
- transfer the case to another SCAN team

- close the case. (Refer to 3.21 Closing a case to the SCAN team.)

3.18 Negotiating and completing a case transfer to another SCAN team

SCAN team case transfers will:

- occur in a manner that prioritises the safety of the child
- demonstrate timely information sharing between SCAN teams and within SCAN team core member agencies
- ensure continuation of planned and coordinated service delivery to the child.

Prior to transferring a case, the SCAN team **must** first assess whether the case meets the criteria for closure. If closure criteria are met, the SCAN team will close the case rather than transfer it to another team. Refer to 3.21 Closing a case to the SCAN team.

Effecting SCAN team case transfer

To ensure the prompt transfer of a SCAN team case, relevant SCAN team core member representatives from the transferring SCAN team will make every effort to verify the child has moved and confirm the new address of the child's primary residence.

The transferring and receiving SCAN team coordinators **must** discuss the details of the case and outstanding SCAN team recommendations to ensure smooth transfer of information and timely case review by the receiving SCAN team. The receiving SCAN team coordinator, and where possible, relevant SCAN team core member representatives from the receiving SCAN team, will participate in the transferring SCAN team meeting to ensure awareness of critical issues and recommendations.

During any transfer process the case is **not** closed to the SCAN team system and will remain on the transferring SCAN team caseload until the transfer has been confirmed by the receiving SCAN team coordinator. In all cases, transfer of case information via the SCAN system electronic database will **not** occur until CSSC case transfer has been confirmed by the SCAN team coordinator. Upon confirmation of the CSSC transfer, the transferring SCAN team coordinator will complete and forward the approved SCAN team transfer form immediately to the receiving SCAN team coordinator.

Ensuring access to SCAN team documentation following case transfer

The transferring SCAN team coordinator will ensure access for the receiving SCAN team coordinator, to all SCAN team case documentation either via email, the SCAN database or hard copy files, within **three** business days of confirmation of the CSSC case transfer. The SCAN team transfer will be completed upon receipt of all SCAN team documents by the receiving SCAN team coordinator. The receiving SCAN team coordinator will ensure the case is listed on a SCAN team meeting agenda for review within **ten** business days of receiving the transfer, unless the need for an earlier response is indicated by the transferring SCAN team.

SCAN team case transfer when the case is subject to an open investigation and assessment by Child Safety

If the SCAN team case is subject to an open investigation and assessment by Child Safety and the child moves residence to another CSSC area, transfer to another SCAN team should **only**

occur if agreement has been reached between the CSSCs to transfer the investigation and assessment.

When CSSCs decide the CSSC that received the initial notified concerns is within a reasonable distance to complete the investigation and assessment, the case will **not** be transferred to another SCAN team and will continue to be discussed by the SCAN team that received the original referral.

SCAN team case transfer when the case is subject to ongoing intervention by Child Safety

Following completion of the investigation and assessment where a decision is made by Child Safety to provide ongoing intervention, coordination of multi-agency actions is required and the SCAN case closure criteria are not met, the SCAN team case is to be transferred to the relevant SCAN team. This transfer **must** occur in conjunction with relevant SCAN team core member agency case transfer processes.

If the SCAN team case is already subject to ongoing intervention by Child Safety and the child moves residence to another CSSC area, transfer to another SCAN team should **only** occur if agreement has been reached between the CSSCs to transfer case management responsibility.

Case transfer occurring without prior SCAN team knowledge

If a case is open to the SCAN team, but the Child Safety case transfer occurs without prior knowledge of the SCAN team, the SCAN team will determine how the case is to be managed, including whether the case can be closed. If closure cannot occur, the SCAN team will determine the most effective way to engage all relevant stakeholders in the case discussion, which may be via telephone or video conference or transfer of the case to the appropriate SCAN team.

Managing issues impacting SCAN team case transfer

Where a case cannot be transferred within **ten** business days of SCAN team agreement, the transferring SCAN team coordinator will list the case for review on the next available agenda and ensure:

- where possible, participation of appropriate stakeholders from the receiving SCAN team in the case review discussion
- formulation of actions to be undertaken by SCAN team core member agencies located within the area where the child is now residing to enable completion of outstanding recommendations and the protection needs of the child to be addressed.

Any disagreement in relation to the transfer of a SCAN team case, which cannot be resolved by the SCAN team coordinators, will be referred by the relevant SCAN team coordinator to the CSSC manager.

Managing SCAN team case transfer where a child is highly mobile

Where a child is highly mobile, the SCAN team case will be managed by the SCAN team that received the original referral. The Child Safety SCAN team core member representative will discuss the case with the CSSC team leader in the area where the child is currently residing to ensure casework continues. The SCAN team will ensure representatives from the relevant CSSCs, core member representatives from both SCAN teams and other agencies undertaking casework are invited to participate in the SCAN team discussion. Participants may attend in person or via telephone or video conference.

Managing SCAN team case transfer when a child is hospitalised

Where several siblings within one family are referred to a SCAN team, but one child is transferred to a hospital in another city, the case will continue to be managed by the SCAN team that received the original referral. This SCAN team will then facilitate the participation of representatives from the relevant hospital at the SCAN team discussion via telephone or video conference.

If a child is transferred to a hospital and there are no other siblings, ownership of the child's case will remain with the SCAN team closest to the child's primary residence. The Queensland Health SCAN team core member representative will liaise with the hospital staff treating the child and include them in the SCAN team discussion.

3.19 Departing from SCAN team recommendations

When departing from an agreed SCAN team recommendation following the SCAN team meeting:

- the officer taking the departure action will consult with an appropriate senior officer within their agency to seek approval for the departure and provide a clear rationale as to why it is in the best interests of the child
- when the departure action is **not** approved by the senior officer, the recommendation **must** be implemented as agreed upon by the SCAN team
- when the departure action is approved, the officer will inform their SCAN team core member representative and complete a SCAN team review form, detailing the rationale for departure
- the SCAN team core member representative will ensure the completed SCAN team review form is provided to the SCAN team coordinator for distribution to all SCAN team core member representatives and scheduled for the next SCAN team meeting
- when the protection needs for the child warrant more immediate discussion, the SCAN team core member representative will request an emergency SCAN team meeting be convened to discuss the departure
- the SCAN team **must** consider the information provided in relation to the departure and either, all SCAN team core member representatives agree to modify the original recommendation, or reaffirm their commitment to actioning the original recommendation
- if **one** SCAN team core member representative does **not** agree to modify or reaffirm their commitment to the original recommendation, issues of disagreement **must** be recorded in the minutes and an escalation process initiated. Refer to 3.20 Initiating an escalation process and Appendix 4 Departure and escalation process flowchart.

3.20 Initiating an escalation process

When, after full and open discussion by a SCAN team, the SCAN team core member representatives are unable to reach consensus on a recommendation, issues of disagreement **must** be recorded in the SCAN team minutes. Where necessary, an escalation process is initiated to ensure timely outcomes for the child and the accountability and transparency of the SCAN team.

The escalation process can **only** proceed when there is clear disagreement by SCAN team core member representatives in relation to recommendations regarding the coordination of multi-

agency actions to assess and respond to the protection needs of the child. Refer to Appendix 4 Departure and escalation process flowchart.

This does not include disagreement in relation to an action that is the core business of another SCAN team core member agency. Refer to 3.16 Formulating and documenting SCAN team recommendations. Issues in relation to these areas will be addressed outside the SCAN team forum in accordance with relevant agency complaints mechanisms.

Process for escalating a matter

- If the SCAN team **cannot** reach agreement:
  - each SCAN team core member representative articulates their assessment of the protection needs for the child and actions required to respond to these which are also recorded in the SCAN team minutes
  - issues where consensus cannot be reached are recorded in the SCAN team minutes
  - a SCAN team escalation report **must** be completed by the SCAN team coordinator.

Progressing a SCAN team escalation report

- A SCAN team escalation report **must** include:
  - a summary of each agency's assessment of the protection needs for the child and actions required to respond to these
  - the potential impact on the child of not providing a service
  - possible alternative actions
  - a summary of any known future interventions to occur with the family
  - a summary of discussions held at the most recent SCAN team meeting
- SCAN team core member representatives will be available to clarify information during the preparation of the SCAN team escalation report
- the SCAN team coordinator will provide the draft SCAN team escalation report to all SCAN team core member representatives who will have **five** business days to provide feedback and consent for the report to be escalated to senior officers
- the SCAN team escalation report will then be provided to appropriate senior officers, as determined by the respective SCAN team core member agencies, for discussion and decision making
- senior officers, as identified by the respective SCAN team core member agencies, will:
  - determine the multi-agency actions required based on the information provided in the SCAN team escalation report where SCAN team consensus regarding recommendations cannot be reached
  - uphold, amend or withdraw the original recommendation made by the SCAN team which is subject to departure action
- the decision will be provided to the SCAN team coordinator by the relevant SCAN team core member representative to be tabled at the next SCAN team meeting for appropriate action by the SCAN team.

While the matter is being discussed, individual officers will, in consultation with the appropriate senior officer, continue to carry out their statutory responsibilities to ensure the ongoing protection of the child.

Each SCAN team core member representative will be responsible for ensuring the appropriate senior officers within their agency are briefed about each SCAN team escalation report.

The number and outcome of all SCAN team escalation reports will be reported by the SCAN team coordinator in the SCAN team quarterly report and each SCAN team escalation report included as an attachment to the quarterly report.

3.21 Closing a case to the SCAN team

If coordination of multi-agency actions to assess and respond to the protection needs of the child continues to be necessary, the case will remain open to the SCAN team.

If, during the first SCAN team discussion of a SCAN team referral, the SCAN team does not propose any recommendations, the case **will** be closed.

Where the SCAN team has formulated recommendations and at least one review has occurred to assess the progress of implementation, **and** the SCAN team agrees there has been no additional information provided to change the protection needs of the child and coordination of multi-agency actions is no longer required, the case **will** be closed.

If there remains only one relevant SCAN team core member agency to complete an action that forms part of a broader recommendation for multi-agency action/s or forms part of their core business, the following **closure process** applies:

- the case **may** be listed for two consecutive SCAN team reviews following the SCAN team meeting where it is identified that only one agency has an outstanding action (for example, a Child Safety investigation and assessment or QPS advises there is an ongoing criminal investigation in relation to the matter).
- if at the **second** SCAN team review, the relevant SCAN team core member agency action has not been completed, the case **will** be closed to the SCAN team, with a commitment by the relevant agency to advise the SCAN team of the outcome of the outstanding action following its completion.
- the minutes from the SCAN team review will be sent to the core member agency responsible for the completion of the outstanding action by the SCAN team coordinator to ensure awareness of the matter and the need for appropriate prioritisation
- the SCAN team coordinator will ensure any closed cases with an outstanding action continue to be listed on the SCAN team agenda, or attached to the agenda as may be appropriate, under the heading "*Matters with an outstanding action closed to SCAN*" as a prompt for receipt of the outcome of the outstanding action. In such cases the matters will **not** be discussed by the SCAN team until the relevant agency provides the outcome of the outstanding action to a future SCAN team meeting

These matters **are closed to SCAN** despite being listed on the SCAN agenda. The purpose of the listing is to ensure other core member agencies are aware of the conclusion of the action and any relevant outcomes or determinations. Should the outcome of the outstanding action indicate that the matter requires a multi-agency response and meets the referral criteria, the core member

agencies must consider referral as a new SCAN team case. In relation to any closed cases to the SCAN team, where new information is received or identified by any core member agency, such information must be referred to the regional intake service.

If, following a referral to the SCAN team, a family moves residence and cannot be located, SCAN team core member representatives should attempt to locate the family in accordance with respective agency policies and procedures. If the family is still unable to be located, the case **will** be closed. Where a family has relocated interstate, the case **will** be closed to the SCAN team. The reason for case closure in either of these circumstances, including an overview of the actions taken to locate a family and a summary of any outstanding actions where relevant, will be noted in the SCAN team minutes.

Although a case may be closed to the SCAN team, each agency can continue to share information outside the SCAN team as required in accordance with their respective roles, responsibilities and information sharing guidelines.

CHAPTER FOUR

SCAN team governance and reporting

4.1 Managing occasional attendance by individuals at SCAN team meetings

In addition to invited stakeholders, other individuals may be required to attend or request attendance at SCAN team meetings who do not form part of the membership of the SCAN team including:

- a person participating in a support role to a SCAN team core member representative
- a tertiary student or new employee observing a SCAN team meeting for training purposes
- a person observing a SCAN team meeting for research, monitoring or auditing purposes.

Requests for one-off attendance at a SCAN team meeting by a support person, student, new employee, other individual or multiple one-off attendances by a group of individuals (e.g. medical students across a six month period) will be requested by the relevant SCAN team core member representative at a SCAN team meeting or business meeting prior to participation in the meeting. Refer to 3.25 Convening business meetings. If all SCAN team core member representatives agree to the request, the decision is recorded in the SCAN team minutes or SCAN team business meeting minutes.

SCAN team approval is not required for attendance by Child Safety Directors and CSDN SCAN subcommittee members at a SCAN team meeting, providing the relevant SCAN team core member representative has advised the SCAN team of the attendance.

The SCAN team may approve attendance by other individuals where this has not been requested at a prior meeting, providing the relevant SCAN team core member representative has sought and received agreement from each SCAN team core member representative prior to the SCAN team meeting.

If considered appropriate by the SCAN team, an individual requesting attendance at a SCAN team meeting as an observer for research, monitoring or auditing purposes, will submit a written application through the relevant SCAN team core member representative to the SCAN team. This submission will include information in relation to:

- their name, position and organisation
- the SCAN team to be observed
- the proposed date/s for attendance
- the reason for attendance
- how the information gathered will be used
- where the information will be stored
- their agreement with all relevant privacy and confidentiality requirements
- the status of ethical clearance where relevant.

The SCAN team coordinator will advise their line manager and Regional Service Delivery Operations of the outcome of the SCAN team's decision for provision to the CSDN SCAN subcommittee. Any individual approved by the relevant SCAN team to observe a SCAN team meeting **must** where required, complete and return the SCAN information privacy deed to the

SCAN team coordinator **prior** to participation in the SCAN team meeting. Any individual who does not comply with this requirement will be unable to participate in the meeting.

4.2 Managing a potential conflict of interest

A potential conflict of interest may include situations when a SCAN team core member representative has a family, personal, professional or private business relationship with a person or child referred to the SCAN team.

When a SCAN team core member representative identifies a potential conflict of interest in relation to their participation as a member of a SCAN team, they **must** immediately advise the relevant SCAN team coordinator and determine if an appropriate agency proxy is necessary.

If a SCAN team core member representative identifies or suspects a potential conflict of interest exists in relation to the participation of another member of their SCAN team, they **must** immediately advise the SCAN team coordinator who will discuss the concerns with the SCAN team core member representative in question. If necessary, the SCAN team coordinator will contact a senior officer from the relevant agency and advise of the identified or potential conflict of interest for appropriate action by the senior officer.

4.3 Managing complaints or issues in relation to SCAN teams

SCAN teams will attempt to resolve complaints or issues **locally** with relevant officers and agencies.

Concerns in relation to SCAN team processes and functioning **must** be referred in the first instance to a SCAN team business meeting. If resolution cannot be reached, the concerns **must** then be referred by the relevant SCAN team core member representative to their SCAN team core member agency senior officers.

Concerns or complaints by a client or SCAN team core member representative in relation to the operations of SCAN team core member agencies, or the conduct or performance of individual agency officers, **must** be directed to the particular agency in accordance with their complaints management process.

In addition to established SCAN team core member agency complaints processes, agency officers with concerns about the actions or decisions of other agency officers, are entitled to use the Commission for Children and Young People and Child Guardian's complaints process. The Commission is empowered to receive and resolve concerns about the services provided, or that should be provided, to children and young people in the child safety and youth justice systems.

In cases where resolution cannot be reached locally, the Commission's complaints process may be appropriate. Officers may contact the Commission's complaints team to discuss specific concerns if appropriate.

4.4 Convening business meetings

A SCAN team business meeting **must** be held quarterly and is a forum to discuss the functioning of a SCAN team and review issues and trends emerging from the draft quarterly report and to finalise the quarterly report. An emergency business meeting may be convened when a SCAN team core member representative believes it is necessary to discuss a serious, ongoing issue directly impacting upon SCAN team functioning.

The SCAN team coordinator is responsible for scheduling the business meeting, preparation of the SCAN team business meeting agenda and distribution to SCAN team core member representatives prior to the meeting.

Wherever possible all SCAN team core member representatives will attend. Child Safety Directors and CSDN SCAN subcommittee members may also attend, providing the relevant SCAN team core member representative has advised the SCAN team of the attendance. Other additional officers from SCAN team core member agencies may be invited to attend the business meeting **only** if their participation will contribute significantly to the discussion and is agreed to by all SCAN team core member representatives. Names and positions of additional officers attending will be provided to the SCAN team coordinator prior to the business meeting.

Business meetings are chaired by the SCAN team coordinator and minutes of the meeting recorded in the SCAN team business meeting minutes and filed in the SCAN team business file. Copies of the minutes will be forwarded by the SCAN team coordinator to SCAN team core member representatives for distribution to senior officers as appropriate and Regional Service Delivery Operations for provision to the CSDN SCAN subcommittee.

Each SCAN team will have two business files as follows:

- Business file number **one** will contain all SCAN team core member agreements and information privacy deeds (A new file does not need to be created for each calendar year. This file can be used for the life of the SCAN team, with new file parts created as required.)
- Business file number **two** will contain all SCAN team meeting agendas, business meeting agendas and minutes, quarterly reports and teleconference/support information (A new file will be created at the beginning of each calendar year, with new file parts created as required throughout the year.)

4.5 Preparing and submitting quarterly reports

The purpose of the SCAN team quarterly report is to review and analyse the SCAN team's workload during the previous three months utilising data from the SCAN System database. It is expected that SCAN team core member representatives will assist the SCAN team coordinator to analyse and provide comment in relation to any emerging trends or themes.

The SCAN team coordinator is required to prepare a SCAN team quarterly report in consultation with SCAN team core member representatives which will be tabled and discussed at a quarterly business meeting in accordance with the following schedule:

Quarter	Reporting period	Month due
1st	January – March	April
2nd	April – June	July
3rd	July – September	October
4th	October – December	January

Following the quarterly business meeting, the SCAN team coordinator will distribute the finalised report to SCAN team core member representatives, the regional director, CSSC manager and

other relevant regional staff. SCAN team core member representatives will be responsible for briefing appropriate senior officers within their respective agencies about each quarterly report.

A copy of the quarterly report will also be forwarded by the SCAN team coordinator to Regional Service Delivery Operations to inform service delivery review processes and for reporting to the CSDN SCAN subcommittee.

4.6 Conducting SCAN team annual planning days

SCAN teams **may** initiate annual planning days if SCAN team core member representatives agree it would be useful to enhance team functioning and SCAN team core member agency partnerships.

The planning day will, where possible, be facilitated by a person with appropriate facilitation skills and knowledge in relation to SCAN team operations and be independent of the SCAN team.

Issues discussed and outcomes from the planning day will be recorded and provided to SCAN team core member representatives by the SCAN team coordinator.

4.7 Reviewing the configuration of SCAN teams

A review of the number and configuration of SCAN teams across Queensland may be initiated by the CSDN SCAN subcommittee, or requested of the CSDN SCAN subcommittee by SCAN teams, to ensure the most effective use of resources in response to operational need.

The CSDN SCAN subcommittee will seek approval from the relevant Child Safety Directors and/or the CSDN as appropriate in relation to proposed changes to the configuration of SCAN teams.

4.8 Requesting establishment of a new SCAN team

The CSDN SCAN subcommittee is responsible for decisions about the establishment of any new SCAN teams. Refer to Appendix 7 for the current configuration of SCAN teams across Queensland.

A request for the establishment of a **new** SCAN team **must** be submitted to the CSDN SCAN subcommittee as follows:

- the relevant CSSC manager **must** prepare a written submission including:
  - details of the SCAN teams currently dealing with referrals
  - the targeted community, location and client population
  - projected volume of work to be managed by the proposed new SCAN team, including information about how this projection was calculated
  - SCAN team core member agency support for the application and availability of SCAN team core member representatives
  - relevant operational details, including the transfer of existing cases, frequency and proposed location of meetings
  - possible resource and training requirements
  - planning and consultation undertaken to produce the submission

- the CSSC manager will forward the submission to the Child Safety regional director and to the local SCAN team core member representatives who will ensure provision to their respective agency senior officers
- the Child Safety regional director will then forward the submission to Regional Service Delivery Operations
- Regional Service Delivery Operations will forward copies of the submission to all members of the CSDN SCAN subcommittee and table the request for discussion at their next meeting
- the CSDN SCAN subcommittee will review the submission and either endorse the submission, seek further information or reject the request
- if the submission is endorsed, the CSDN SCAN subcommittee will seek approval from the relevant Child Safety Directors for the establishment of the new SCAN team
- following advice of approval by Child Safety Directors, Regional Service Delivery Operations will then inform the relevant regional director and CSSC manager of the outcome of their submission and any future action.

4.9 Changing the frequency, duration or location of SCAN team meetings

Where an **existing** SCAN team, SCAN team core member representative or SCAN team coordinator determines the frequency, duration or location of meetings **cannot** effectively address the outstanding workload of the team, the SCAN team coordinator will refer the matter to the next SCAN team business meeting for discussion.

Information to be gathered and discussed by the SCAN team will include:

- current workload managed by the SCAN team, including the number of cases referred, reviewed and closed during the past six months and the number of cases currently open to the SCAN team
- current frequency, duration or location of meetings and volume of work
- impact of the SCAN team workload on service delivery to children referred to the SCAN team
- the proposed change in frequency, duration or location and implications for service delivery, including additional resources, if required, i.e. travel for SCAN team core member representatives.

Following consideration of all relevant information, the SCAN team will make the appropriate determination in response to operational need and document their discussion and decision in the SCAN team business meeting minutes. The SCAN team coordinator **must** subsequently advise Regional Service Delivery Operations of any decision to change the frequency, duration or location of the SCAN team meeting, for reporting to the CSDN SCAN subcommittee.

4.10 Managing requests for SCAN team documentation

All requests for SCAN team documentation, including requests from inquiries, reviews or child death investigations, **must** be directed to the relevant CSSC records officer. The SCAN team does **not** have decision making authority in relation to the release of SCAN team documentation.

Subpoenas requesting agency documentation, including any SCAN system documentation held on agency files, **must** be managed in accordance with agency specific policies and procedures.

Refer to Appendix 2 Legislative provisions – Right to Information for further information regarding the release of SCAN system documentation under the *Right to Information Act 2009*.

4.11 SCAN team information in court application affidavits

SCAN teams should only be referred to within the applicant's affidavit material when there is relevant information to put before the court resulting from SCAN team involvement, which is unable to be obtained from any other direct source.

Supporting affidavits should only be sought from SCAN team core member representatives when they hold additional direct knowledge of the matter and/or information relevant to proceedings.

Appendices

Appendix 1 Definitions

- A **child concern report (CCR)** is recorded when child protection concerns received about a child or an unborn child do not meet the threshold for a notification, that is, the child or unborn child is not reasonably suspected to be in need of protection, or in need of protection after birth. The three possible responses to a CCR are information and advice, referral to another agency and information provision to the police or another state authority. These are short-term responses that do not require ongoing action by Child Safety.

- A **child in need of protection** as defined under the *Child Protection Act 1999*, section 10, is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm **and** does not have a parent able and willing to protect the child from the harm.

- **Harm** is defined in the *Child Protection Act 1999*, section 9(1), as any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.

- **Intake** is the mechanism by which Child Safety receives and gathers information about child protection concerns and determines the appropriate response to the information received.

- The threshold for recording a **notification** requires that there is an allegation of harm or risk of harm to a child, and a reasonable suspicion that the child is in need of protection (*Child Protection Act 1999*, section 14). A notification records the key child protection concerns received from the notifier, including any direct information about the alleged harm or risk of harm to the child or unborn child. The response to a notification is an investigation and assessment.

- The **Structured Decision Making (SDM) screening criteria** assists the Child Safety decision about whether the child protection concerns will be recorded as a child concern report (CCR) or meet the threshold for recording a notification. The screening criteria includes an over arching definition for neglect, physical harm, sexual abuse and emotional harm. It also includes screening criteria within these abuse and harm types and a separate screening criteria for unborn children. If no screening criteria are selected, the matter is 'screened out' and the concerns are recorded as a CCR. If one or more screening criteria are selected, the matter is 'screened in' as a notification.

Appendix 2 Legislative provisions

Information sharing

The *Child Protection Act 1999*, chapter 5A, provides for service delivery coordination and information exchange amongst government agencies and non-government service providers, to meet the protection and care needs of children. The provisions detailed in chapter 5A enable the sharing of relevant information between government agencies, and government agencies and non-government service providers, including the core members of the SCAN team system.

While discussion of a case at a SCAN team meeting facilitates information sharing between core member agencies, SCAN team core member representatives may also share information outside the SCAN team system in accordance with relevant legislative provisions.

Confidentiality

The *Child Protection Act 1999*, chapter 6, part 6, details relevant confidentiality provisions. Specifically, sections 187 and 188 detail legislative provisions in relation to confidentiality of information obtained or given by persons involved in the administration of the Act. SCAN team core member representatives **must** comply with these provisions.

Information discussed at SCAN team meetings is often extremely sensitive in nature and the child and family have a right to expect such information, wherever possible, remains confidential. However, as the welfare and best interests of a child are paramount, a balance **must** be maintained between the need to share information to address the child's protection needs, with the right to confidentiality.

Information Privacy

The *Information Privacy Act 2009* (IP Act) contains two sets of privacy principles, which regulate how personal information is collected, secured, used and disclosed by Queensland public sector agencies. There are 11 Information Privacy Principles (IPPs) for Queensland public sector agencies and 9 National Privacy Principles (NPPs) for Queensland Health, which are detailed in the IP Act, schedules 3 and 4 respectively.

Right to Information

The *Right to Information Act 2009* (RTI Act) provides a right of access to government information unless, on balance, it is contrary to the public interest to release the information.

All SCAN team system documents held by government agencies are subject to the RTI Act. This includes any documents presented to a SCAN team, such as reports prepared by non-government agencies.

Individual SCAN team members and participants hold no responsibility for decision making in relation to the release of information under the RTI Act. Officers from RTI units within each government agency will make decisions for the agency regarding the release of information under the RTI Act.

A SCAN team core member agency, other than Child Safety, that receives an RTI application regarding SCAN system documents, will make decisions for their agency regarding the release of information under the RTI Act. Where it is known by the receiving agency that Child Safety holds

further information, the receiving agency should contact Right to Information, Information Privacy and Screening, Department of Communities, to discuss the possibility of a part transfer of the RTI application.

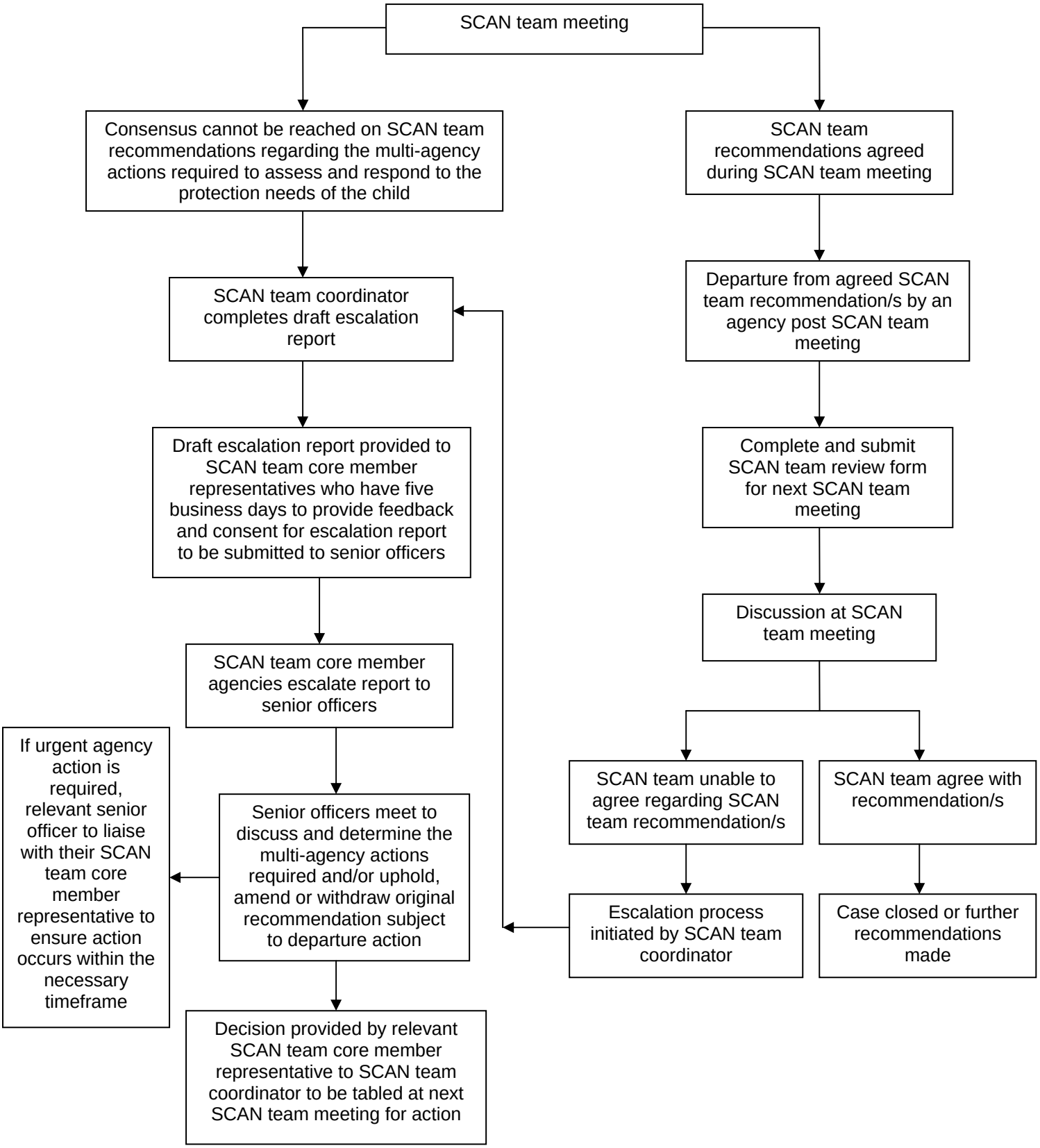
As original copies of all SCAN system documents are retained by the relevant Child Safety SCAN team coordinator, any individual seeking the release of SCAN system information under the RTI Act should be referred to Right to Information, Information Privacy and Screening, Department of Communities. All documents relevant to the request will be retrieved and forwarded by the relevant SCAN team coordinator for decision making by officers within the Right to Information, Information Privacy and Screening, Department of Communities.

Appendix 3 Examples of appropriate SCAN team recommendations

Alleged risk/harm	Recommended actions and timeframes for review
Domestic violence 1. Angela is at risk of serious physical trauma or injury, due to her attempts to intervene during domestic violence incidents between parents and the severity and unpredictable nature of the incidents. 2. Angela is at risk of high levels of guilt, anxiety and fear related to experiencing ongoing violence in the household.	It is recommended that the following multi-agency actions occur to assist Angela and her family in reducing the likelihood of future violence in the home: 1. Child Safety to link parents with available local domestic violence service and monitor and assess demonstrated change. 2. QPS to provide relevant interstate dealings with police for mother and father to inform assessment. 3. DET and QH to provide information about available services and programs to work with Angela to raise her self esteem and confidence. 4. DET to engage guidance officer to provide support to Angela and feedback on identified needs. **Review: 1 week**
Unborn child Susan's unborn child is at risk of severe neglect after birth due to Susan's homelessness and substance misuse. Risk to the unborn child after birth is heightened due to Susan's whereabouts being unknown.	It is recommended that the following multi-agency actions occur to locate and offer intervention options to Susan prior to the birth of her baby: 1. QPS to provide any updates regarding contact with Susan and her partner. 2. Child Safety to invite a representative from Homelessness Services to provide input into options for locating Susan across the state. 3. QH to consult with ATODS regarding possible services for Susan once she is located. **Review: 4 weeks** - as Susan is 20 weeks pregnant.
Substance misuse Fred, aged 15, is at risk of septicaemia, from injecting speed. Chronic history of neglect due to his mother's intellectual disability.	To assist and support Fred and his family to engage with appropriate services: 1. Child Safety to liaise with QH to consult with ATODS regarding eligible services for Fred. 2. DET to provide options for alternative schooling given Fred is unable to continue with daily routine of mainstream schooling.

	3. SCAN team coordinator to invite the local youth service, with whom Fred is engaged, to provide an update at next meeting. 4. Child Safety to provide support to Fred's parents and attempt to link them with local community support. **Review: 2 weeks**
Mental health Toby, aged 6, has experienced neglect due to his grandmother's unmedicated, diagnosed bipolar disorder. He is particularly at risk due to periods where he is left to care for himself. He is currently in placement under an assessment care agreement.	It is recommended that the following multi-agency actions occur to support the planning to meet Toby's care and protection needs: 1. RE to assist in the facilitation of a referral to an Aboriginal and Torres Strait Islander family support service to support the grandmother and Toby's foster carers and provide further information about extended family members who may be able to care for Toby in the future. 2. Child Safety to explore placement options closer to the grandmother's home. 3. DET to liaise between Toby's previous school and current school during placement to assist in smooth transition and feedback about his behaviour. 4. QH to liaise with adult mental health unit to identify support services available. **Review: 1 week**
Coordinated, multi-agency response Chloe, aged 7, is at risk of neglect, as her father has refused to send her to school. QPS has interviewed and charged the father with failing to ensure a child in his care was participating in full time education. Chloe has developmental delays. Chloe's family is well known to the QPS, DET and QH in differing capacities. Father has previously threatened Child Safety staff.	The following multi-agency actions are recommended to assist in the assessment of harm/risk of harm to Chloe. 1. QPS to assist Child Safety with the investigation. 2. QH to arrange for a paediatric assessment to be conducted following the assessment by QPS and Child Safety. 3. DET case manager to liaise with Chloe's father to facilitate Chloe's return to school. **Review: 2 weeks**

Appendix 4 Departure and escalation process flowchart



Appendix 5 Responsibilities of the SCAN team coordinator and SCAN team administration officer

SCAN team coordinator

The SCAN team coordinator reports to the CSSC manager or as determined by the relevant regional director. Duties include:

- coordinate functioning of the SCAN team in a manner that enables effective, professional discussion of referrals, reviews and recommendations responsive to the child's protection needs
- consult and liaise about SCAN team processes with core members of the SCAN team and other invited government and non-government agencies
- provide advice, consultancy and support to SCAN team members, including in the preparation of written material for SCAN team meetings
- ensure effective communication between teams within the SCAN team system
- develop and maintain record and review systems consistent with statutory requirements and the administrative requirements of the SCAN team system
- ensure the effective involvement of all participants in SCAN team meeting
- contribute to the development and delivery of training programs in relation to SCAN team system operations
- assist the development of practice standards, operational guidelines and review mechanisms to promote effective and efficient SCAN team system functioning.

SCAN team administration officer

The SCAN team administration officer reports to the SCAN team coordinator or as determined by the relevant CSSC manager. Duties include:

- organise scheduled and emergency SCAN team meetings as required
- record accurate minutes to reflect SCAN team discussions and recommendations, including the identification of appropriate actions
- quality preparation and dissemination of documents such as minutes, agenda, reports, statistics, memoranda and correspondence
- contribute to the development, maintenance and validation of data on computerised information systems and databases consistent with SCAN team system legislation, policies and procedures whilst ensuring accuracy, completeness, quality and timeliness of output
- develop, manage and maintain appropriate filing and record keeping systems to ensure the security of all SCAN team records in accordance with policies, procedures and standards, including the management of highly sensitive, confidential matters in a professional manner
- provide high level and efficient administrative support services to the SCAN team coordinator and SCAN team to facilitate the effective functioning and operation of the SCAN team process and ensure a quality service is provided to clients
- plan and prioritise workload in accordance with operational requirements

- develop and maintain constructive and consultative working relationships with stakeholders.

Regional Service Delivery Operations may be contacted for more detailed information in relation to tasks undertaken by the SCAN team coordinator and SCAN team administration officer.

Appendix 6 SCAN team system core member agencies

Department of Communities – Child Safety

The Department of Communities – Child Safety is the lead agency for the whole of government response to child protection in Queensland and is also recognised as the lead agency for the SCAN team system.

The Department of Communities – Child Safety has a legislative mandate to investigate allegations of harm or risk of harm to a child and intervene to ensure the child's ongoing protection where the child does not have a parent able and willing to protect the child from the harm. The provision of support for children and their families who are subject to ongoing statutory intervention, and safe care environments that meet the diverse needs of children, are also key priorities.

Queensland Police Service

The Queensland Police Service (QPS) operates predominantly in the tertiary section of the child protection system in Queensland. The primary functions of the QPS in the child protection system include the investigation of suspected serious neglect, physical harm and sexual abuse of children and young people, organised paedophilia, institutionalised abuse, child exploitation, and the sudden or suspicious deaths of children. A corresponding function of the QPS is to initiate criminal proceedings against alleged offenders of abuse against children.

The QPS is a key partner in the coordinated response to child protection matters in Queensland and is committed to working with other SCAN team system core member agencies to meet child protection needs through information sharing, planning and coordination of resources. The QPS participates in the SCAN team system to collaboratively address the needs of children who have been harmed or are at risk of harm. A QPS representative will actively participate in SCAN team meetings to discuss complex child protection matters, contribute to the sharing of information, provide relevant advice and assistance regarding investigations and legal issues, and participate in the formulation of recommendations to address the protective needs of children.

Queensland Health

Queensland Health is committed to providing children and young people who are at risk of abuse or neglect with health services of the highest quality. Queensland Health provides a range of services to clients and other agencies in relation to child protection. As a SCAN team core member these services include:

- undertaking medical examinations where there are allegations of harm
- providing expert health opinion and forensic medical knowledge in the assessment of harm
- completing psychosocial, psychiatric or developmental assessments of children and young people who have been harmed or are at risk of harm
- working collaboratively with other government, non-government and community agencies to provide a coordinated and holistic service response, including the sharing of confidential health information where the information directly relates to the welfare and protection of a child or young person

- presenting key health information at SCAN team meetings in relation to a child or young person
- making and/or extending a Care and Treatment Order for a Child where there are significant concerns a child has been harmed or is at risk of harm, and where the child is likely to be taken from the health service facility and suffer harm unless immediate action is taken.

Queensland Health meets these obligations through the provision of information, education and training to staff in key service delivery areas. Within each Health Service District, Queensland Health has Child Protection Liaison Officers, Child Protection Advisors and SCAN team core member representatives who act as consultants to assist local staff in responding to child protection concerns.

Department of Education and Training

In keeping with the principles set out in the *Child Protection Act 1999*, the Department of Education and Training asserts that the welfare and best interests of children are paramount and every child has a right to protection from harm.

The department is committed to providing safe, supportive and disciplined learning environments, preventing incidents of harm, and responding when an employee of a state school reasonably suspects harm or risk of harm to students.

School employees, based on their day to day observations and interactions with children and their families in the school setting, play a vital role in monitoring the safety and wellbeing of children.

Senior guidance officers fulfil the role of core member agency representative on SCAN teams across Queensland. Senior guidance officers assist state and non-state school principals with the referral of cases to an ICM or SCAN team meeting subject to the respective referral criteria.

Senior guidance officers collect relevant information from school personnel to contribute to case discussions at an ICM or SCAN team meeting, provide updated information for SCAN team case reviews and provide feedback, if necessary, to school principals and guidance officers following a case discussion at an ICM or SCAN team meeting.

Personal information collected by employees of the department for provision to SCAN team meetings is managed in accordance with the *Child Protection Act 1999*, and where relevant the *Education (General Provisions) Act 2006*, and the IP Act.

The Recognised Entity

The role of the recognised entity within the child protection system is to provide culturally appropriate advice in relation to an Aboriginal or Torres Strait Islander child and explain cultural protocol regarding the wellbeing of a child who has been harmed or is at risk of harm.

The *Child Protection Act 1999*, section 6, requires Child Safety to provide the recognised entity with the opportunity to participate in the decision making process for all significant decisions for an Aboriginal or Torres Strait Islander child, and consult with them on all other decisions.

The recognised entity representative is a core member of the SCAN team when an Aboriginal or Torres Strait Islander child is being discussed, provides advice regarding cultural and family issues and ongoing interventions for the child, and contributes to the formulation of SCAN team recommendations regarding the child.

Appendix 7 SCAN team coordination points and operational SCAN teams

There are **21 SCAN team coordination points** across the state, which are aligned with the designated SCAN team coordinators and administration officers.

There are **30 operational SCAN teams** across the state. An operational SCAN team is defined as a meeting where the SCAN team core member representative from Child Safety and one or more other SCAN team core member representative, changes.

SCAN team coordination point	Operational SCAN team	Meeting venue
Browns Plains	**Browns Plains SCAN team** CSSC cases discussed: Browns Plains and Beaudesert	Browns Plains CSSC
Inala	**Inala SCAN team** CSSC cases discussed: Inala and Forest Lake	Inala CSSC and Forest Lake CSSC
Logan	**Logan SCAN team** CSSC cases discussed: Woodridge, Loganlea and Logan Central	Woodridge CSSC
Mackay	**Mackay SCAN team** CSSC cases discussed: Bowen and Mackay	Mackay CSSC
Rockhampton	**Gladstone/Emerald SCAN team** CSSC cases discussed: Gladstone and Emerald	Video conference from Rockhampton and Gladstone
	Rockhampton SCAN team CSSC cases discussed: Rockhampton North and South	Rockhampton North CSSC
Bundaberg	**Bundaberg SCAN team** CSSC cases discussed: Bundaberg and Maryborough	Bundaberg CSSC and Maryborough CSSC
Cairns	**Cairns SCAN team** CSSC cases discussed: Cairns and Edmonton	Cairns CSSC
	Innisfail SCAN team CSSC cases discussed: Innisfail	Innisfail CSSC
Cape Torres	**Cape SCAN team** CSSC cases discussed: Cape Torres	Cape Torres CSSC
	Atherton SCAN team CSSC cases discussed: Atherton	Atherton CSSC

SCAN team coordination point	Operational SCAN team	Meeting venue
Chermside	**Chermside SCAN team** CSSC cases discussed: Chermside	Chermside CSSC
	Pine Rivers SCAN team CSSC cases discussed: Pine Rivers	Pine Rivers CSSC
Fortitude Valley	**Fortitude Valley SCAN team** CSSC cases discussed: Fortitude Valley and Alderley	Fortitude Valley CSSC
Sunshine Coast	**Sunshine Coast North SCAN team** CSSC cases discussed: Sunshine Coast North	Sunshine Coast North CSSC
	Caloundra SCAN team CSSC cases discussed: Caloundra	Caloundra CSSC
Gympie	**Gympie SCAN team** CSSC cases discussed: Gympie	Gympie CSSC
	South Burnett SCAN team CSSC cases discussed: South Burnett	Murgon Hospital
Redcliffe	**Redcliffe SCAN team** CSSC cases discussed: Redcliffe and Caboolture	Redcliffe CSSC and Caboolture CSSC
Ipswich	**Ipswich SCAN team** CSSC cases discussed: Ipswich North, Ipswich South and Goodna	Ipswich North CSSC and Ipswich South CSSC
Toowoomba	**Toowoomba SCAN team** CSSC cases discussed: Toowoomba North, Toowoomba South, Roma and Charleville	Toowoomba North CSSC
Mt Isa	**Mt Isa SCAN team** CSSC cases discussed: Mt Isa and Gulf	Mt Isa CSSC
Townsville	**Townsville SCAN Team** CSSC cases discussed: Thuringowa, Aitkenvale and Townsville	Townsville Regional Office, Thuringowa CSSC and Aitkenvale CSSC
Stones Corner Bayside	**Redlands SCAN Team** CSSC cases discussed: Redlands	Redlands CSSC
	Wynnum SCAN Team CSSC cases discussed: Wynnum	Wynnum CSSC

SCAN team coordination point	Operational SCAN team	Meeting venue
Stones Corner City	**Stones Corner SCAN team** CSSC cases discussed: Stones Corner	Stones Corner CSSC and Mater Hospital
	Mt Gravatt SCAN team CSSC cases discussed: Mt Gravatt	Mt Gravatt CSSC
Gold Coast Northern	**Beenleigh SCAN team** CSSC cases discussed: Beenleigh	Beenleigh CSSC
	Nerang SCAN team CSSC cases discussed: Nerang	Nerang CSSC
Gold Coast Southern	**Gold Coast Southern SCAN team** CSSC cases discussed: Labrador and Mermaid Beach	Labrador CSSC and Mermaid Beach CSSC

Appendix 8 Acronyms

- **ATODS** – Alcohol, Tobacco and Other Drugs Service
- **CCR** – Child concern report
- **CSDN** – Child Safety Directors' Network
- **CSSC** – Child Safety Service Centre
- **DET** – Department of Education and Training
- **FIS** – Family Intervention Service
- **ICM** – Information coordination meeting
- **ICMS** – Integrated Client Management System
- **IP Act** – *Information Privacy Act 2009*
- **IPP** – Information Privacy Principles
- **NPP** – National Privacy Principles
- **QH** – Queensland Health
- **QPS** – Queensland Police Service
- **RTI Act** – *Right to Information Act 2009*
- **SCAN** – Suspected Child Abuse and Neglect
- **SDM** – Structured Decision Making

Queensland Government

Report of a Reasonable Suspicion of Child Abuse and Neglect

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

I have consulted with ..... **regarding my concerns of a reasonable suspicion of harm:** ☐ **Yes** ☐ **No**

1. DETAILS OF CHILD SUBJECT TO REPORT *Please fill in completely - One form per child*

Family name: ..... Given name(s): .....

Aliases (if known): ..... Date of birth: .....

Current location of child: .....

.....

Telephone number: .....

If the child is **unborn**: Gestation : ...../40 weeks Expected delivery date: .....

Indigenous status: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin
☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal or Torres Strait Islander origin
☐ Not stated / unknown

☐ **Other cultural or language background** (specify): .....

Is an interpreter required? ☐ Yes ☐ No If *yes*, preferred language: .....

Does the child have a disability? ☐ Yes ☐ No If *yes*, specify: .....

2. CHILD'S USUAL CARE ARRANGEMENTS

Does the child live in more than one household? ☐ Yes ☐ No ☐ Unknown

Primarily lives with:

Name: .....

Relationship to child: .....

Date of birth / age: .....

Address: ☐ Same as current address above *(or detail below)*

.....

.....

Telephone number: .....

Other parent / carer:

Name: .....

Relationship to child: .....

Date of birth / age: .....

Address: ☐ Same as current address above *(or detail below)*

.....

.....

Telephone number: .....

Name of **school / child care** facility attended by child: .....

Are there any relevant orders in place (eg. Child Protection, Domestic Violence)? ☐ Yes ☐ No ☐ Unknown

If *yes*, please specify: .....

3. PERSONS OTHER THAN PARENTS/CARERS LIVING WITH CHILD (include siblings)

Name (including aliases)	**Date of birth / Age**	**Relationship to subject child**

4. ABUSE TYPE BEING REPORTED (more than one may be ticked) - refer to guide for assistance

Suspected:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect
At risk of:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect

Original: Faxed to Child Safety Services then filed in the child's record, correspondence section. **Yellow carbon copy:** Forwarded to local Queensland Health Child Protection Liaison

DO NOT WRITE IN THIS BINDING MARGIN

v5.00 - 03/2011
Mat. No.: 10191892
SW010

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT (1 of 3)

Queensland Government

Report of a Reasonable Suspicion of Child Abuse and Neglect

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

5. DETAIL OF REPORT (if further space is required please attach additional pages)

No abbreviations / medical terminology / legible handwriting

In responding to the following questions provide information that has led to your reasonable suspicion of harm or risk of harm.

Are you aware of any *harm* to the child? ☐ **Yes** *(detail below)* ☐ **No**

(eg. signs / symptoms / indicators of child abuse and/or neglect; physical appearance of any injury; recency of injury; severity; frequency; any ongoing concerns; delays in presentation; explanation of harm; emotional/behavioural impacts of harm; any disclosures made by the child)

Are you aware of any *risk of harm* to the child? ☐ **Yes** *(detail below)* ☐ **No**

(eg. vulnerability; history of harm; emotional/behavioural presentation; presence of medical needs or developmental delays; relationships with parents and significant others [if the information relates to an unborn child, the alleged risk to the unborn child after he or she is born should be provided])

Can you provide details of the *parents' / carer's circumstances*? ☐ **Yes** *(detail below)* ☐ **No** ☐ **Unknown**

(eg. their parenting capacity; their protective capacity; the presence of complicating factors such as domestic violence; drug / alcohol misuse; mental health history; physical or intellectual abilities; relationship stability)

Are you aware of any relevant *environmental factors*? ☐ **Yes** *(detail below)* ☐ **No** ☐ **Unknown**

(eg. condition of the child's home; socioeconomic factors that impact on the family; family and individual stressors; mobility and transience)

Are you aware of any *protective factors* and / or *family / child strengths*? ☐ **Yes** *(detail below)* ☐ **No** ☐ **Unknown**

(eg. the presence in the home of a protective caregiver; a child's ability to seek external help when they feel they are at risk)

Are you aware of any relevant previous health presentations? ☐ **Yes** *(detail below)* ☐ **No** ☐ **Unknown**

(eg. identify any previous presentations that may hold child protection concerns / reports in relation to the child)

Source of information:

(eg. clinical presentation / assessment / observation / contact / advice)

DO NOT WRITE IN THIS BINDING MARGIN

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT (2 of 3)

Original: Faxed to Child Safety Services then filed in the child's record, correspondence section. **Yellow carbon copy:** Forwarded to local Queensland Health Child Protection Liaison

Queensland Government

Report of a Reasonable Suspicion of Child Abuse and Neglect

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Has the parent / carer / child been advised of the report to the Child Safety Services? ☐ Yes ☐ No ☐ Unknown

Comments:

Note: If you make a decision to inform the parent / child / carer that a report has been made any reasonable expectation of confidentiality is lost.

6. DETAILS OF PERSON(S) ALLEGEDLY RESPONSIBLE FOR HARM OR RISK OF HARM

Name(s) including aliases:

Relationship to child:

Address:

Telephone number: Age / date of birth:

☐ **Not known**

7. QUEENSLAND HEALTH'S RESPONSE

Is the child a current client of a **health service provider**? (eg. Child Health, social worker) ☐ Yes ☐ No ☐ Unknown

If *yes*, name service and any contact details:

Have you made a referral? ☐ Yes ☐ No ☐ Unknown

If *yes*, specify contact details (eg. Life Line, ATODS):

8. DETAILS OF CONTACT WITH CHILD SAFETY REGIONAL INTAKE SERVICE

Name of authorised Child Safety Officer (include family name):

Comments / information from Child Safety Officer:

Child Safety Regional Intake Service:

Date reported by phone: Time:

Date reported by fax: Time: Fax number:

9. DETAILS OF QUEENSLAND HEALTH OFFICER MAKING REPORT

Reporting officer's name (print):

Reporting officer's position:

Clinical / professional stream: ☐ Nursing ☐ Allied health (specify):

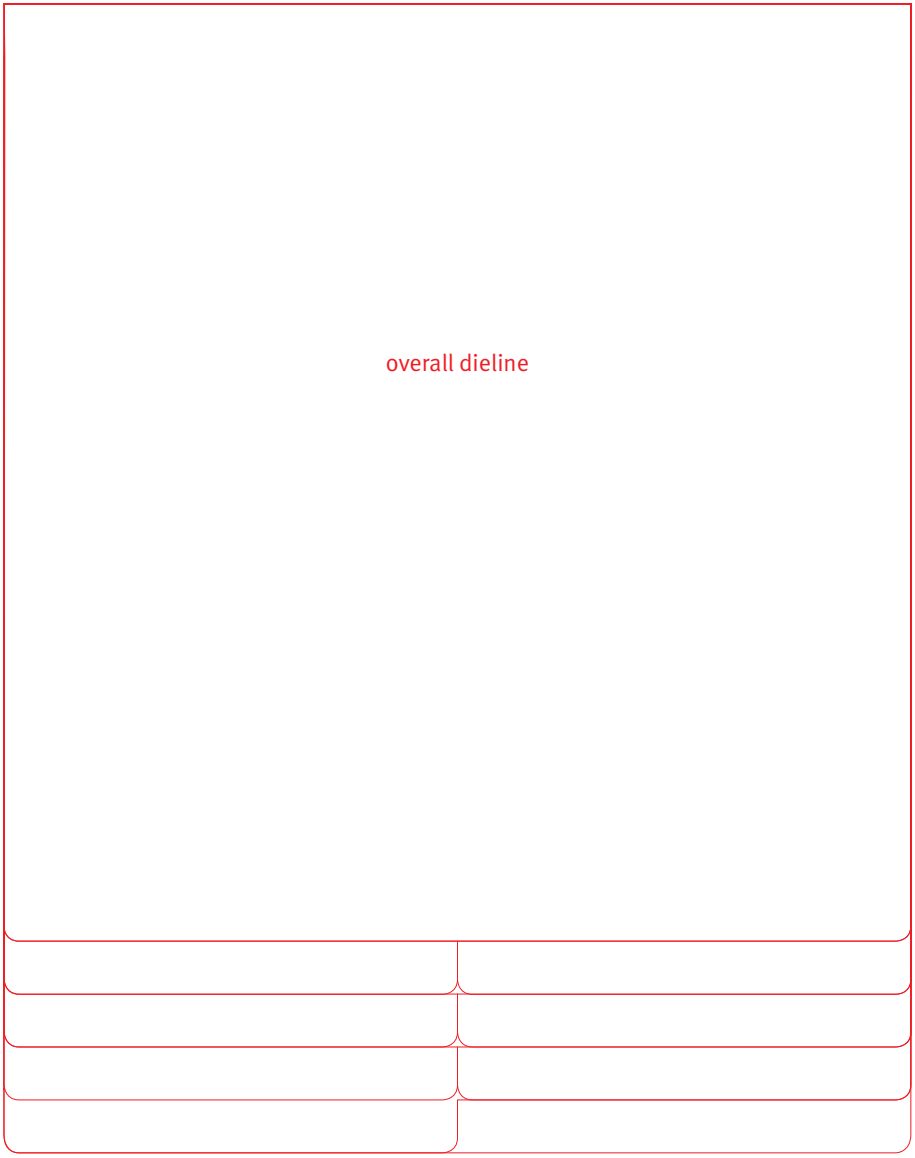
☐ Medical ☐ Health worker ☐ Other (specify):

Queensland Health facility / unit: Telephone number:

Signature of reporting officer: Date:

Original: Faxed to Child Safety Services then filed in the child's record, correspondence section. **Yellow carbon copy:** Forwarded to local Queensland Health Child Protection Liaison

DO NOT WRITE IN THIS BINDING MARGIN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Protecting Queensland Children

How to complete the Queensland Health 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010)

Snapshot

Queensland Government

Key child protection contacts:

District Child Protection Liaison Officer	Name:	
	Phone:	
	Pager no:	
	Fax:	
District Child Protection Advisor	Name:	
	Phone:	
	Pager no:	
	Fax:	
Child Safety Regional Intake Service	Phone:	
	Fax:	
Child Safety After Hours Service Centre	Phone:	1300 681 513
	Fax:	3235 9898

Introduction

This ***How to complete the Queensland Health 'Report of Reasonable Suspicion of Child Abuse and Neglect' form (SW010)*** guide reflects Queensland Health's commitment to our staff and to children and young people who have been harmed, or who are at risk of harm, and their families. We recognise that our staff play a vital role in recognising, responding to and reporting child abuse and neglect.

This guide provides a framework and reference for all Queensland Health staff when they are completing a 'Report of Reasonable Suspicion of Child Abuse and Neglect' form (SW010).

In addition, there are key positions within each Health District that have been appointed to support staff in recognising, responding to and reporting child protection concerns – Child Protection Liaison Officers and Child Protection Advisors.

Doctor Michael Cleary

DEPUTY DIRECTOR-GENERAL, POLICY, STRATEGY AND RESOURCING DIVISION

Please read this guide carefully to assist you in completing the report form.

How to make a report to Child Safety Services

1. **During office hours**
   Telephone your local Child Safety Regional Intake Service (RIS) to make a verbal report. The telephone number is located on the Department of Communities, Child Safety Services internet site: http://www.childsafety.qld.gov.au/

   After hours
   Telephone Child Safety After Hours Service Centre on 1300 681 513. Fax: 3235 9898.

2. **Complete** the 'Report of Reasonable Suspicion of Child Abuse and Neglect' form (SW010).

3. **Fax** a copy of the SW010 form to the RIS that received your verbal report within 7 days.

4. **File** the original copy of the SW010 form in the correspondence section of the child's hospital record.

5. **Forward** the yellow copy of the SW010 form to your District Child Protection Liaison Officer. Contact details are available on the QHEPS site: http://qheps.health.qld.gov.au/csu/districtcpacplo.htm

Flow chart

Health professional suspects child abuse and neglect

To assist in formulation of a reasonable suspicion of child abuse and neglect, health professionals are **encouraged to consult** with a senior staff member, Child Protection Liason Officer or Child Protection Advisor.

(PLEASE NOTE: if you have a suspicion that an unborn child may be at risk of harm after birth you are required to consult with a Child Protection Advisor before reporting.)

YES

If you have formed a reasonable suspicion of child abuse and neglect you are **required** to immediately report to Child Safety Services

NO

Document your decision making process in the child's record

When reporting you are **required** to immediately complete the QH form 'Report of a Reasonable Suspicion of Child Abuse and Neglect' (SW010 v4.00)

- You are **required** to telephone your Child Safety Regional Intake Service* (details available on the QH Child Safety Unit QHEPS site)
- You are **required** to fax the original form to your Child Safety Regional Intake Service*
- You are **required** to file the original form in the correspondence section of the child's record
- You are **required** to forward the self-carbonated copy to the nominated Child Protection Liaison Officer in your District

*** Please note:** After hours you are **required** to contact the Child Safety After Hours Services.

Disagreement about the need to report should not prevent the staff member reporting their reasonable suspicion to Child Safety Services

It is your responsibility to document all actions and conversations in relation to this report in the child's record.

How to complete the 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010)

Attach a patient identification label, or complete all details in the box in the upper right area of page 1.

Section 1

Details of child subject to report

Please fill in this section completely using one report form per child.

- Include any known aliases of the child or family
- 'Current location of the child' if the child is a hospital inpatient this should be identified in this section
- 'Indigenous status' indicate if the child is Aboriginal and or Torres Strait Islander, both, neither, not stated or unknown
- Identify any other cultural or language background, and if an interpreter is required
- Identify any known disabilities.

Section 2
Child's usual care arrangements

This section is intended to capture the usual residence of the child, and to identify alternate addresses where the child may live.

- 'Primarily lives with' refers to the usual residence of the child
- 'Other parent/carer' should be completed if the child regularly stays with another parent/carer, for example if parents are separated and the child spends alternate weekends with one of the parents.

In this section you are requested to identify the name of the child care facility or school that the child attends.

- 'Name of school or child care facility attended by the child' refers to any family day care, child care, kindergarten, preparatory school or school attended by the child.

Any relevant orders that are in place related to the child or family should be listed.

- 'Are there any relevant orders in place' refers to any type of order, for example child protection, domestic and family violence, or family court orders.

Section 3

Persons other than parents/carers living with the child

This section should include all other persons who reside at the same address as the child. NOTE: If these other persons are children and are also deemed to be at significant risk of, or suffering harm, separate reports of reasonable suspicion should be completed. The following information should be included:

- The name of the other person/s, including as much detail as is known about the other person/s, for example date of birth or age, and relationship to the child subject to the report

- If the child resides between two residences with separate groups of other persons, including children, then this section should include details of all persons residing at each of the residences, indicating in which residence the person/s reside.

Section 4

Abuse type being reported

This section requires the identification of the abuse type that is being reported. A child may be subject to more than one abuse type. If so, you will need to tick more than one box.

Section 5
Detail of the report

This section provides a free text area to identify/describe your concerns of the harm or risk of harm to the child. There are a series of questions to assist you with this section. Please consider the following points when providing information:

- The use of jargon, medical terminology or abbreviations is **not** recommended. Child Safety Service's authorised officers are not familiar with health service abbreviations
- Ensure all of your notes are legible
- Information you provided in your verbal report to child safety regional intake service should also be included.

In this section it is important to:

- Be child focused–identify the risk, and/or your child abuse and neglect concerns
- Identify any known protective factors
- Be specific regarding your concerns for the child–dot points are recommended.

If further space is required you are encouraged to attach 'additional information' pages available at: http://qheps.health.qld.gov.au/csu/reportingforms.htm

Section 5 continued

Are you aware of any *harm* to the child?

Information about signs/symptoms/indicators of abuse and/or neglect—such as physical injuries and the appearance of these injuries; severity of injuries; delays in presentation; inconsistent history of injury; emotional and/or behavioural impacts; and/or disclosures made by the child or another person (identify in your report the person responsible for the disclosure) should be included here.

Further examples of indicators of *harm* or *risk of harm* can be found in the Child Safety Fact sheets (section 4) available at: http://qheps.health.qld.gov.au/csu/Factsheets.htm

Are you aware of any *risk of harm* to the child?

Information on emotional/behavioural presentation; a history of harm; a child who is dependent and unable to protect themselves; a child with special needs which increases their vulnerability; a parent's admission that they fear they may injure their child; and/or parental reluctance or inconsistency in explaining the injury should be included here.

Further examples of indicators of *harm* or *risk of harm* can be found in the Child Safety Unit Fact sheets (section 4) available at: http://qheps.health.qld.gov.au/csu/Factsheets.htm

Can you provide details of the *parents'/carer's circumstances*?

Information about whether the capacity of the parent/carer to meet their child's protective needs is impaired; domestic or family violence; a mental health illness; financial stress; and/or a history, including the present time, of substance misuse that impairs a parent/carer to act protectively for their child should be included here.

Further examples of indicators of parental risk factors can be found in the Child Safety Unit Fact sheets (section 4) available at: http://qheps.health.qld.gov.au/csu/Factsheets.htm

Are you aware of any *environmental* factors?

Information on risk factors in the child's home (if you are providing a home visiting health service); homelessness or transience of the family; and financial stressors that impact on the capacity of the parent/carer to provide a safe and protective environment for the child should be included here.

Further examples of environmental factors can be found in the Child Safety Unit Fact sheets (section 4) available at: http://qheps.health.qld.gov.au/csu/Factsheets.htm

Section 5 continued

Are you aware of any *protective factors and/or family/child strengths?*

Information about the presence of a known protective caregiver; an extended protective and supportive network of family or friends; and/or the ability of a child to seek external help, if required, should be included here.

Further examples of protective factors can be found in the Child Safety Fact sheets (section 4) available at:
http://qheps.health.qld.gov.au/csu/Factsheets.htm

Are you aware of any relevant previous health presentations?

Information about any previous presentations to health services by the child subject to the report, or any other siblings, that may indicate child protection concerns should be included here, **if known.**

Source of information

Information about the presentation to the health service that led to this report, for example: presentation of child to Emergency Department with an injury; home visiting of child and family as per a community home visiting program; and/or the presentation of an adult to mental health service where the health professional has concerns about the safety of the child or the capacity of the parent to provide for the safety, welfare and wellbeing needs of the child should be included here.

Has the parent/carer/child been advised of the report to Child Safety Services?

Identify if the parent/carer/child has been informed of the report to Child Safety Services.

Please note: if you make a decision to inform the parent/carer/child that a report of reasonable suspicion of child abuse and neglect has been made, any reasonable expectation of confidentiality is lost.

Section 6

Details of person(s) allegedly responsible for harm or risk of harm

Include details of the person who allegedly may be responsible for the harm or risk of harm, if known/disclosed to you.

- If the child or any other person discloses details of the person allegedly responsible, record the name of the person who has made the disclosure and the person who is alleged to be responsible for the harm
- If you are unaware of who is allegedly responsible for the harm, tick the box marked 'not known'.

Section 7

Queensland Health's response

Include details of any Queensland Health services that the child may be a client of, if known to you e.g. Child Health, social worker.

- If, as a response to this report, you have referred the child/family to a support service, identify the referred service, facility and contact details for the service e.g. Lifeline, ATODS.

Section 8

Details of contact with the Child Safety Regional Intake Service

When you phone the Child Safety Regional Intake Service with your immediate verbal report—you **should** complete this section with all of the following details:

- The full name, including surname of the **authorised** person who you spoke to at the Child Safety Regional Intake Service;
- The name of the Child Safety Regional Intake Service contacted;
- The date and time of your phone call;
- The fax number, the date and time that you faxed the written report to the Child Safety Regional Intake Service.

Section 9

Details of Queensland Health officer making the report

This section is **required** to be fully completed by the Queensland Health staff member who is making the report.

Legislation

- Under the ***Public Health Act 2005*** **it is mandatory for registered nurses and doctors to report reasonable suspicions of child abuse and neglect directly to the Department of Communities Child Safety Services** (please note mandatory reporting does not apply to unborn children).
- The ***Child Protection Act 1999*** **enables any person, acting honestly, to report that they suspect a child has been, is being or is likely to be harmed; or an unborn child may be at risk of harm after he or she is born.**

Protections for persons who report child abuse and neglect

Section 22 of the ***Child Protection Act 1999*** provides protection from liability for notification of, or information given about, alleged harm or risk of harm for a person, who acts honestly, in notifying or giving information to the Chief Executive of the Department of Communities Child Safety Services, another officer of the Department of Communities Child Safety Services or a police officer. The person is not liable, civilly, criminally or under an administrative process, for giving the report. In doing so, the person cannot be held to have breached professional etiquette or ethics, or departed from accepted standards of professional conduct.

Section 186 of the ***Child Protection Act 1999*** protects the identity of a person who reports a reasonable suspicion of harm to the Department of Communities Child Safety Services.

Information sharing

Under the ***Child Protection Act 1999*** a service provider (meaning a person providing a service to children or families–section 159E) may give relevant information about a child in need of protection, the child's family or someone else to a prescribed entity. The relevant information may be comprised of facts or opinions but does not include information about a person's criminal history to the extent that it relates to a conviction for which the rehabilitation period under the ***Criminal Law (Rehabilitation of Offenders) Act 1986*** has expired.

Section 195 of the ***Public Health Act 2005*** provides protection to a person from liability for giving information to a doctor or registered nurse, if that person is acting honestly. This section provides protection to: fellow professionals seeking help about whether or not reasonable grounds for suspicion are justified; a health professional or administrative worker in a health practice; emergency services officer; teacher or other person who in the course of the person's employment observed something that raised a suspicion a child has been harmed; or a relative or friend of the child.

Common definitions that will guide you in completing the report form

- **Immediately**

  If an action is to be done immediately, it must be done as soon as possible in the circumstances, having regard to the nature of the act to be done, and all the circumstances of the particular case.

Abuse types

- **Physical abuse** is any physical injury to a child that is not accidental. It includes any injury caused by excessive discipline, severe beatings, punching, slapping, shaking, burning, biting, throwing, kicking, cutting, suffocation, drowning, strangulation or poisoning. Physical abuse can result in death. (http://www.yesican.org/definitions/WHO.html)
- **Emotional abuse** occurs when children are not provided with the necessary and developmentally appropriate supportive environment to develop mentally and/or emotionally. Emotional abuse includes constant criticism, restriction of movement, patterns of belittling, denigrating, scape-goating, threatening, scaring, discriminating, and exposure to domestic violence, ridiculing or other non-physical forms of hostile or rejecting treatment. (http://www.yesican.org/definitions/WHO.html and Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organisation.)

- **Neglect** is depriving a child of their basic needs. These include food, clothing, warmth and shelter, emotional and physical security and protection, medical and dental care, cleanliness, education and supervision. (http://www.yesican.org/definitions/WHO.html)
- **Sexual abuse** occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. It can be physical, verbal or emotional and includes any form of sexual touching, penetration, sexual suggestion, sexual exposure, exhibitionism and child prostitution.
- **Intra-familial abuse** is where children and young people are harmed by parents, caregivers, family members or someone from within the household in which they live.
- **Extra-familial abuse** occurs when the child or young person is harmed by a person or persons outside the child's family.

Risk factors that are associated with child abuse and neglect

Child

- Child unborn
- Child under 5 years
- Emotional/behavioural concerns
- Exposure to domestic and family violence
- Physical/intellectual disability
- Previous reports of concerns to Child Safety Services
- Previous Child Safety Services involvement

Family

- Domestic or family violence
- Physical/intellectual disability
- Substance abuse
- Compromised parenting ability
- Mental health concerns
- Social isolation/limited support networks
- Previous injury/concern to a sibling

Environment

- Relevant socio-economic factors
- Unsafe living circumstances
- Family/individual stressors
- Family moves frequently
- Homelessness

These risk factors are not considered to be a comprehensive list of all harms, behaviours or presentations that may give rise to a reasonable suspicion of abuse and neglect. Similarly one risk factor in isolation does not indicate abuse and neglect. Each risk factor needs to be considered in the context of the child's and family's presenting circumstances.

Informing the parent/carer/child of a report made to Child Safety Services

It is not a requirement of the reporting process to inform the parent/carer/ child that a report of suspected child abuse and neglect has been made to Child Safety Services. It is the health professional's decision as to whether the parent/carer/child is informed. When making your decision on whether or not to advise the parent/carer/child of the report, you need to take the following into consideration:

- Safety of the child
- Potential impact on the family
- Safety of staff within the health service.

Please note: If you make a decision to inform the parent/carer/ child that a report has been made, any reasonable expectation of confidentiality is lost.

Support for parents/carers/child

A report of a reasonable suspicion of child abuse and neglect is considered to be stressful for both the child and the parent/carer. Health professionals need to be aware of the potential emotional impact that this situation may have on the family as a whole. If the parent/carer/child are/is advised that a report has been made, they may require additional support. Therefore, it is the health professional's duty of care to ensure that a referral to a support agency is offered to the parent/carer/child.

Support agencies which may assist families include:

- Lifeline 24 hr Counselling Service 13 11 14
- Salvo Care Line (Salvation Army) 1300 363 622
- Centacare Catholic Family & Community Counselling Service (Counselling and Relationship and Parenting Education) 3252 4371
- Local services–Mental Health Service, ATODS, Child Health.

Queensland Government

Queensland Government

Maternity, Child Health and Safety Branch

Child abuse and neglect

Capability self-assessment tool

responsibility
recognising
reporting

a resource for the interdisciplinary team

Queensland Government
Queensland Health

A guide to the Queensland Health child safety education process

All health professionals who, in the course of their professional duties, provide care, or have a care responsibility to children, young people and adults, are required to complete an annual self-assessment of capability. This tool will assess their capability to identify actual or potential child abuse or neglect.

The outcome of the annual self assessment of capability will indicate to the health professional if they should undertake further education and training to fulfil their reporting responsibilities. Further education is available to staff in the form of the Queensland Health Child Abuse and Neglect Education Module.

Steps for staff to undertake:

1. complete annual self-assessment of capability tool
2. meet with line manager to sign the completion of the annual self-assessment of capability on: LATTICE form HR 039 — Child Abuse and Neglect Self-Assessment of Capability
3. if line manager agrees the health professional meets the criteria of self-assessment, they sign the Lattice form and forward this form to the relevant District Service (for example Shared Services)

OR

4. if line manager does not agree the health professional meets the criteria of self-assessment, the health professional is requested to complete the Child Abuse and Neglect Education Module and undertake the self-assessment of capability tool again.

Additional information on child abuse and neglect educational resources, including the education module and Lattice form are available on the Maternity Child Health and Safety Branch QHEPS site:
http://qheps.health.qld.gov.au/csu/edumodule.htm and go to

- Child Abuse and Neglect Education Module
- Lattice Form (HR 039) – Child Abuse and Neglect Self Assessment of Capability

The Human Resources Policy E7: Child Safety – Health Professionals Capability Requirements and Reporting Responsibilities is available at:

http://www.health.qld.gov.au/hrpolicies/ethics_conduct/e_7.pdf

Capability statement one
responsibility

The expectation is that you are able to:

1. demonstrate that you have acquired and retained in your practice, the necessary knowledge concerning your legal responsibilities in child protection
2. interpret and apply your specific discipline's professional competency standards, code of conduct and/or ethical behaviours to child protection.

Criterion	yes	no
I am aware of and know how to put into operation the legal and/or duty of care responsibilities that apply to me when I form a reasonable suspicion that a child or young person has been or is at risk of being abused or neglected.		
I am aware of and know how to put into operation the legal responsibilities that apply to me when I make a report to the Department of Child Safety about a child or young person that may have been or is at risk of being abused or neglected.		
I am aware of the legislative elements that provide me with confidentiality when I make a report to the Department of Child Safety about a child or young person who may have or is at risk of being abused.		
I am aware of the difference between, and the processes involved in the reporting of an "at risk" unborn child and the management of a Department of Child Safety Unborn Child High Risk Alert.		
I am aware of the relevant professional competency standards, codes of ethical behaviour and standards of practice that guide the way in which I provide health care to children and young people who have been or are at risk of being abused.		

Comments

Capability statement two
recognition

The expectation is that you:

1. use a child protection perspective in the assessment of the health needs and the provision of health care to an unborn child, child or young person
2. make use of the common child protection indicator set in the identification of, and when formulating a differential diagnosis, that may include abuse and neglect.

Criterion	yes	no
I am able to demonstrate that my health assessment of children and young persons always considers the possibility of abuse or neglect.		
I am able to demonstrate that my health assessment of children and young persons is comprehensive and includes relevant information about other children in household and family members.		
I am aware of and use the common child protection indicator set to categorise the suspected abuse and neglect type.		
The safety needs of the child or young person are always considered in my planning and delivery of care.		
When documenting suspected child abuse and neglect in the client record I aim to always comply with all relevant Queensland Health policies and standards.		
My documentation accurately represents all elements of the assessment and care I have provided including all communication with other Queensland Health employees, the Department of Child Safety and any other agencies.		

Comments

Capability statement three
reporting

The expectation is that you:

1. are aware of, and know how to access the child protection supports and resources within your district to determine if your suspicion is reasonable
2. are able to make a report to the Department of Child Safety using the Queensland Health *Report of a Reasonable Suspicion of Child Abuse and Neglect* form (SW010).

Criterion	yes	no
When I encounter a potential child abuse and neglect situation I consult with other health team members, team leaders / line managers, child protection advisor and/or child protection liaison officer.		
The child protection liaison officer for the district is: ..... The child protection advisor for the district is:		
I know where to access the Queensland Health *Report of a Reasonable Suspicion of Child Abuse and Neglect* form (SW010) to report suspected abuse and neglect.		
Location:		
I know where to access the Child Safety Unit QHEPS page that contains the Protecting Queensland Children: How to complete the Queensland Health 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010) snapshot.		
http://		
I know which Department of Child Safety Service Centre to contact when making a report of suspected child abuse and neglect.		
Location:..... Tel: ..... Department of Child Safety after hours service Tel:		

Using the following clinical scenario, complete the Queensland Health *Report of a Reasonable Suspicion of Child Abuse and Neglect* form (SW010) and discuss with your line manager / team leader.

Clinical scenario

James Brown, eight weeks of age, is brought to hospital by mother and her partner with very recent history of difficulty in feeding, vomiting, constant crying and irritability.

Upon examination, child has red marks around neck and shoulders (they have an outline of a handprint). The child is difficult to arouse and starts to fit during the triage process. Child is subsequently admitted to hospital and a CT scan reveals multiple cerebral haemorrhages.

Mother, Mary Brown is 17 years old and has previously been in the care of the Department of Families as a result of being sexually abused by her mother's partner. She lives with her boyfriend, Bill Burr who is 19 years old and a friend of the partner, Matt Blinco, aged 18 years.

Mary tells you that she and her partner had a fight last night and she left the unit at around 11pm and stayed with a friend for a few hours as she was scared that she would be hurt by Bill as he was drunk and had beaten her in the past. She is not breastfeeding and the baby is not yet sleeping through the night. Despite this she was so scared she just left the unit and left the child asleep in the unit. Bill is not the father of the baby but Mary tells you that he has cared for the baby by himself on previous occasions.

The basis of the argument was that Bill had accused her of having sex with Matt while he was at the hotel. Matt and Bill also were violent with each other during the argument.

Mary receives Supporting Parent's benefits. Bill lost his job yesterday, came home and started drinking with a mate. Bill drinks regularly and heavily according to Mary.

Bill tells you that the baby started crying after Mary left. He went to change him and give him a bottle. He and the baby then went off to sleep and didn't awake until Mary returned at around 7am.

Mary states that when she returned home, the baby was crying and had vomited on his clothes and bedding. She tried to comfort the baby but was unsuccessful and that the baby periodically shook. She became worried as the baby looked very unwell and decided to take him to the hospital.

Mary also tells you that she has been visited at home by the Child Health nurse over the last few weeks since the birth of the baby and that she has had contact with her local GP. The baby is on the 10th percentile for weight.

Address: 12 Harris Lane, Highwood. There is no landline telephone in the house and the mobile phone has no credit and has been disconnected.

Comments

Queensland Government
Queensland Health

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT

Facility:.....

AFFIX PATIENT IDENTIFICATION LABEL HERE

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

Assemble as much information as possible when writing this report – refer to the reporting guideline booklet for assistance. Allow sufficient time to discuss your concerns with your District Child Protection Liaison Officer or Child Protection Advisor

1. DETAILS OF CHILD SUBJECT TO REPORT *Please fill in completely - One form per child*

Family name:..... Given names:.....

Aliases (if known):..... Date of birth:.....

Current location of the child:.....

.....

Telephone number:.....

If the child is **unborn**: Gestation :...../40 weeks Expected delivery date:.....

Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Not stated / inadequately described

☐ **Other cultural or language background** (specify):.....

Is an interpreter required? ☐ Yes ☐ No If *yes*, preferred language:.....

Does the child have a disability? ☐ Yes ☐ No If *yes*, specify:.....

2. CHILD'S USUAL CARE ARRANGEMENTS

Does the child live in more than one household? ☐ Yes ☐ No ☐ Unknown

Primarily lives with:

Name:.....

Relationship to child:.....

Date of birth / age:.....

Address:.....

.....

Telephone number:.....

Other parent / carer:

Name:.....

Relationship to child:.....

Date of birth / age:.....

Address:.....

.....

Telephone number:.....

Name of **school / child care** facility attended by child:.....

Are there any relevant orders in place (eg. Child Protection, Domestic Violence)? ☐ Yes ☐ No ☐ Unknown

If *yes*, please specify:.....

3. PERSONS OTHER THAN PARENTS/CARERS LIVING WITH CHILD (include siblings)

Name (including aliases)	**Date of birth / Age**	**Relationship to subject child**

4. ABUSE TYPE BEING REPORTED (more than one may be ticked) - refer to guide for assistance

Suspected:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect
At risk of:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect

Original: Faxed to local DChS Service Centre then filed in the child's record, correspondence section. Yellow carbon copy: Forwarded to local Queensland Health Child Protection Liaison Officer.

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Queensland Government
Queensland Health

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT

Facility:.....

AFFIX PATIENT IDENTIFICATION LABEL HERE

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

5. DETAIL OF REPORT (if further space is required please attach additional pages) **No abbreviations / medical terminology**

In responding to the following questions provide information that has led to your reasonable suspicion of harm or risk of harm.

Are you aware of any *harm* to the child? ☐ **Yes** *(detail below)* ☐ **No**

(eg. signs / symptoms / indicators of child abuse and/or neglect; physical appearance of any injury; recency of injury; severity; frequency; any ongoing concerns; delays in presentation; explanation of harm; emotional/behavioural impacts of harm; any disclosures made by the child)

Are you aware of any *risk of harm* to the child? ☐ **Yes** *(detail below)* ☐ **No**

(eg. vulnerability; history of harm; emotional/behavioural presentation; presence of medical needs or developmental delays; relationships with parents and significant others [if the information relates to an unborn child, the alleged risk to the unborn child after he or she is born should be provided])

Can you provide details of the *parents'/carer's circumstances*? ☐ **Yes** *(detail below)* ☐ **No**

(eg. their parenting capacity; their protective capacity; the presence of complicating factors such as domestic violence; drug/alcohol misuse; mental health history; physical or intellectual abilities; relationship stability)

Are you aware of any relevant *environmental factors*? ☐ **Yes** *(detail below)* ☐ **No**

(eg. condition of the child's home; socioeconomic factors that impact on the family; family and individual stressors; mobility and transience)

Are you aware of any *protective factors* and/or *family/child strengths*? ☐ **Yes** *(detail below)* ☐ **No**

(eg. the presence in the home of a protective caregiver; a child's ability to seek external help when they feel they are at risk)

Are you aware of any relevant previous health presentations? ☐ **Yes** *(detail below)* ☐ **No**

(eg. identify any previous presentations that may hold child protection concerns / reports in relation to the child)

Source of information:

(eg. clinical presentation / assessment / observation / contact / advice)

DO NOT WRITE IN THIS BINDING MARGIN

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT (2 of 3)

Original: Faxed to local DChS Service Centre then filed in the child's record, correspondence section. Yellow carbon copy: Forwarded to local Queensland Health Child Protection Liaison Officer.

Queensland Government
Queensland Health

REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT

Facility:.....

AFFIX PATIENT IDENTIFICATION LABEL HERE

URN:

Family name:

Given names:

Date of birth: Sex: ☐ M ☐ F

Has the parent / carer / child been advised of the report to the Department of Child Safety? ☐ Yes ☐ No ☐ Unknown

Comments:.....

Note: If you make a decision to inform the parent / child / carer that a report has been made any reasonable expectation of confidentiality is lost.

6. DETAILS OF PERSON(S) ALLEGEDLY RESPONSIBLE FOR HARM OR RISK OF HARM

Name(s) including aliases:.....

Relationship to child:.....

Address:.....

Telephone number:..... Age / date of birth:.....

☐ **Not known**

7. QUEENSLAND HEALTH'S RESPONSE

Is the child a current client of a **Queensland Health Service**? ☐ Yes ☐ No ☐ Unknown

If *yes*, specify service and facility:.....

Contact person:..... Telephone:.....

Has a Queensland Health response / referral been initiated as a result of the current concerns? ☐ Yes ☐ No ☐ Unknown

If *yes*, specify service and facility:.....

Contact person:..... Telephone:.....

8. DETAILS OF CONTACT WITH THE DEPARTMENT OF CHILD SAFETY

Name of authorised Department of Child Safety Officer (include family name):.....

Department of Child Safety Service Centre:.....

Date reported by phone:..... Time:.....

Date reported by fax:..... Time:..... Fax number:.....

9. OUTCOME OF REPORT

In keeping with the provisions of Section 159M of the *Child Protection Act 1999*, advice about the outcome of this report is requested:

- by the reporting Queensland Health officer? ☐ Yes ☐ No

or

- to be provided to the following person on my behalf:

Name:..... Telephone number:.....

10. DETAILS OF QUEENSLAND HEALTH OFFICER MAKING REPORT

Reporting officer's name (print):.....

Reporting officer's position:.....

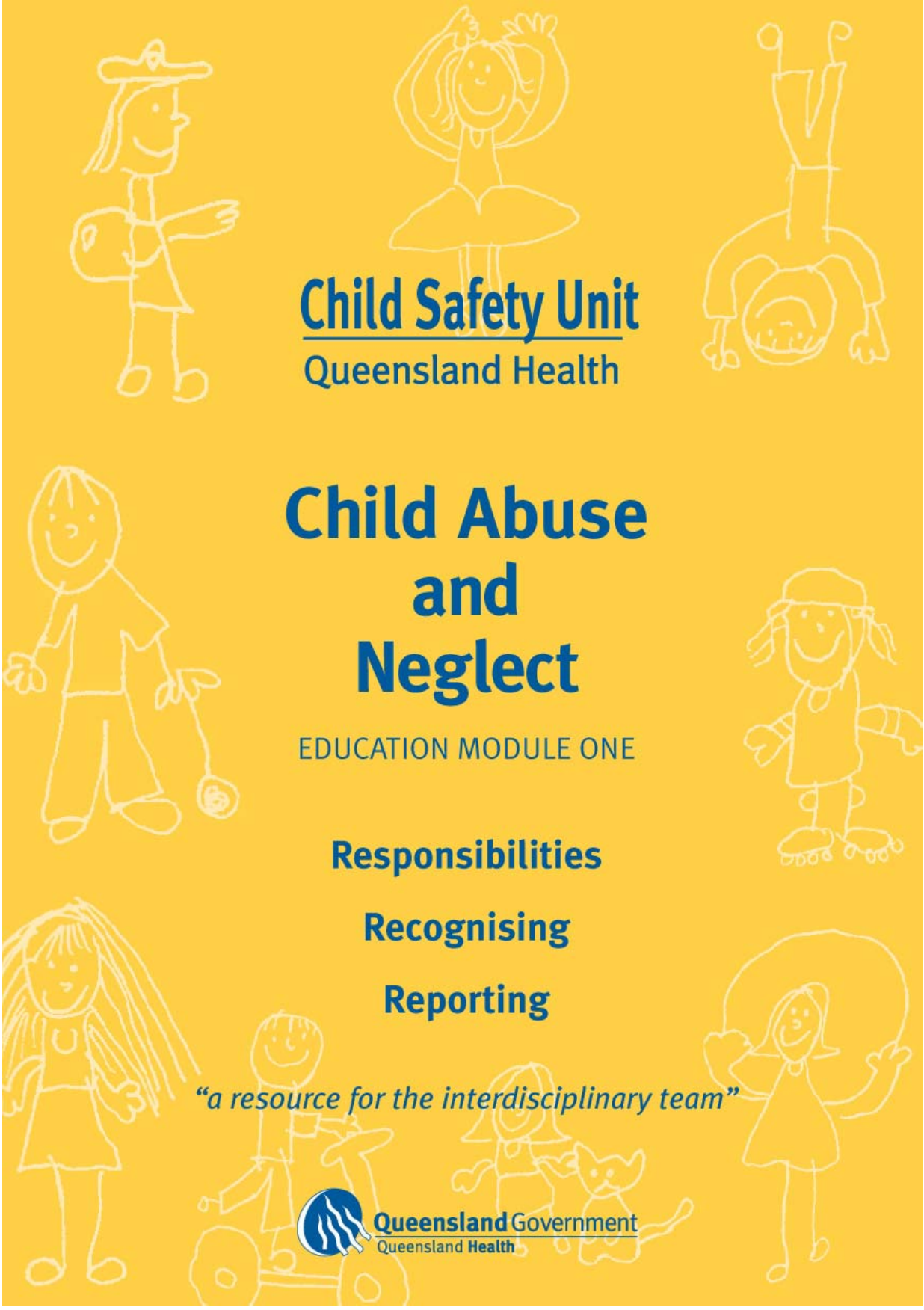
Clinical / professional stream: ☐ Nursing ☐ Allied health (specify):.....

☐ Medical ☐ Health worker ☐ Other (specify):.....

Queensland Health facility/unit:..... Telephone number:.....

Signature of reporting officer:..... Date:.....

Original: Faxed to local DChS Service Centre then filed in the child's record, correspondence section. Yellow carbon copy: Forwarded to local Queensland Health Child Protection Liaison Officer.



Child Safety Unit
Queensland Health

Child Abuse and Neglect

EDUCATION MODULE ONE

Responsibilities

Recognising

Reporting

"a resource for the interdisciplinary team"

Queensland Government
Queensland Health

The module has been developed within a multi-disciplinary framework by the Queensland Health Child Safety Unit.

Table of Contents

Section 1 – Introduction

Target Group

This is the first in a series of education modules in child safety. The target group for this module is:

> *"All Health Professionals who in the course of their duties are required to provide care to children and young people."*

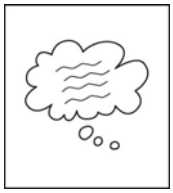
It is intended to support the learner in developing their capability in relation to their responsibilities, ability to recognise and confidence to report their suspicion of child abuse and neglect. This module is not intended to support the development of advanced practice. Those health professionals where more advanced abilities are required should complete either an additional module of study or enrol in an approved tertiary award program.

Module Assessment

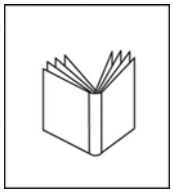
The Participant Guide for Education Module One contains detailed information on the assessment framework for this module. You should access this guide and discuss the assessment requirements with your line manager / team leader or educator prior to commencing the module.

Legend for Icons

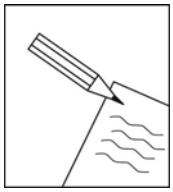
Throughout the module you will encounter symbols that generally require you to undertake a specific action. Explanatory descriptions are provided for your information and to assist with your progress through the module.



Reflect/review: Requires the participant to think about or revisit experiences (professional and/or personal), previous readings or activities.

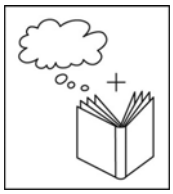


Reading: Directs the participant to a required reading.



Activity: Requires the participant to consolidate learning through an action such as seeking information, analysing a scenario or performing clinical practice.

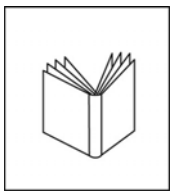
A Key Point to Think About: This is an important point for your practice.



Recollection of Previous Content: This is a summary of previous content that is important for the current section.

Why Learn About Child Abuse and Neglect?

"When Kempe and his colleagues first drew attention to the battered child syndrome, little was known or understood about their causes and correlates of abusive behaviour. Today a great deal is known: we know that poverty and disadvantage provide the milieu for this violence, that isolation and ignorance exacerbate the stresses of parenting and that the experience of being a victim of child abuse has important consequences for later adult behaviour. It is vital that adequate resources be committed to the provision of assistance beneficial to all parents and essential to identifiable high risk parents, in order to reduce the levels of abuse, both fatal and non-fatal, which exist in our society"[1].



Kempe HC. and Helfer RE., et al editors: *The Battered Child.* 5th edition, Chicago: Chicago University Press, 1997

This resource can be accessed through the Queensland Health Central Library. It will provide additional reading for those health professionals seeking more information on the topic.
http://qheps.health.qld.gov.au/library/centlib/home.htm

"A century that began with children having virtually no rights is ending with children having the powerful legal instrument that not only recognises but protects their human rights"[2].

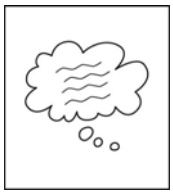
[1] Child Abuse Homicides in Australia: Incidence, Circumstances, Prevention and Control by Health Strang
[2] Carol Bellambi, UNICEF Executive Director referring to the Convention outcome
http://www.unicef.org/crc/crc.htm

Personal Considerations

Responding to children and young people who have been harmed or who are at risk of harm can be demanding, upsetting and even shocking. No one is immune to the impact of its occurrence or exposure.

In undertaking this education module you may be exposed to content, scenarios and reactions that you can clearly identify with due to your own experiences as a child. You may be confronted with painful reminders and feelings associated with those times. You may identify that you have some unresolved issues associated with those experiences that continue to impact on your life and subsequently on your career as a professional within the health system. If this is the case, it is important that you seek assistance and support from your colleagues and managers. In some cases, referral to the Employment Assistance Scheme (EAS) for counselling may be very beneficial. Please refer to your District's EAS policy that will identify how to access this service should you need support as a result of the content of this program.

Key Reflective Exercise



Before commencing this module you need to recall a clinical scenario where there was suspicion that a child or young person had been abused or neglected. As you progress through the module you will be asked to reflect on varying aspects of this scenario and consider if there would be changes to the way in which you responded after completing the different learning elements in this module.

If you have never had this level of involvement – Appendix One provides two scenarios to use as you progress through the module.

Section 2 – Responsibility

Capability Statement One – "Responsibility"

The expectation is that you are able to;

1. Demonstrate that you have acquired and retained in practice, the necessary knowledge concerning your legal responsibilities in child protection.

2. Interpret and apply your specific disciplines' professional and/or competency standards, code of conduct and/or ethical behaviours to child protection.

Crime and Misconduct Review – a catalyst for change

The 2003/4 inquiry into the abuse of children in foster care conducted by the Crime and Misconduct Commission (CMC) identified that the child protection system was failing in its duty to protect children and young people. The CMC report into "*The Abuse of Children in Foster Care*" (2004) included 110 recommendations to transform the child protection system, and the subsequent *Blueprint* report (2004) documented the reform agenda and timetable for implementation.

These recommendations have resulted in

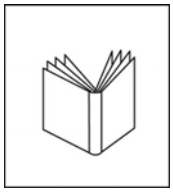
- The disbandment of Department of Families and the creation of the **Department of Child Safety** (DChS) to focus exclusively upon core child protection functions and be the lead agency in a whole-of-government response to child protection matters.
- **Directors-General Coordinating Committee** to coordinate the delivery of multi-agency child protection services and comprising the Directors-General of all relevant departments including the Department of the Premier and Cabinet.
- **Child Safety Director** positions within those departments identified as having a role in the promotion of child protection.
- **Child Guardian** position within the office of the Commissioner for Children and Young People with responsibility to oversee the provision of services provided to, and decisions made in respect of children within the jurisdiction of the DChS.

These and other proposed recommendations from the CMC's Public Inquiry reflect the Queensland Government's commitment to create an effective, holistic and whole of government response to child protection issues. It is driven by the shared vision that "*A society…. maximises opportunities for the safety, well-being and development of Queensland children and young people*".[3]

Practically this means;

[3] Child Protection Queensland:2004 Child Protection System 'Baseline' Performance Report, page16

- Legislation changes and
- Policy review and development
- Additional service provision capacity in some practice areas, in the creation of a truly responsive system.



WEB: http://www.cmc.qld.gov.au/library/cmcWEBSITE/ProtectingChildren.pdf

The Department of Child Safety

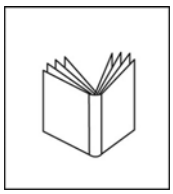
The Department of Child Safety (DChS) was established (November 2004) to meet the needs of children at risk and to focus upon the wellbeing of Queensland children.

The Child Protection Act 1999 is administered by the DChS and is the overarching legislation relating to the protection, welfare and best interests of children and young people.

The specific role of the DChS is to:

- Investigate reports that allege that a child has been harmed or is at risk of harm; and
- Ensure an ongoing provision of services to children who have been assessed as experiencing, or being at risk of experiencing, significant harm in the future.

It also acts as the lead agency in facilitating a whole-of-government response to child protection issues including the Suspected Child Abuse and Neglect (SCAN) system. SCAN will be discussed later in the module.



WEB: http://www.childsafety.qld.gov.au

Queensland Health

Implications for Health Professionals

These reforms have resulted in several critical practice implications for all *health professionals*. They are:

- Mandatory reporting for registered nurses
- Amended mandatory reporting responsibilities for doctors
- SCAN System - a new model

- Therapeutic care for children with severe psychological and behavioural problems
- Disclosure of confidential health information between government agencies where the information directly relates to the welfare or protection of a child or young person
- Legislative changes that enable statutory intervention where it is suspected that an unborn child may be at risk of harm after birth

Queensland Health Child Safety Unit (CSU)

In July 2004, Queensland Health (QH) established the Child Safety Unit to support the Child Safety Director[4].

The Unit's role is to:

- Contribute to whole-of-government and whole-of-system promotion of child safety
- Promote an understanding of child safety issues within Queensland Health.
- Promote an understanding of the whole of government reforms for child safety from the CMC Inquiry and their implications for Queensland Health.
- Work with other government departments to implement the CMC recommendations and child safety reforms
- Ensure that QH employees are aware of legislative and policy changes in the area of child safety through the provision of information and education about child safety.
- Encourage participation in the promotion of child safety.
- Report on QH's progress in relation to meeting child protection obligations
- Encourage a collaborative approach across Queensland Health services
- Work in partnership with other government departments involved in child safety

The CSU contact details are:
Tel: 3235 9461
Email: CSU@health.qld.gov.au
QHEPS: http://qheps.health.qld.gov.au/csu

Legislation and Child Safety

The implementation of the CMC's recommendations has resulted in four key changes to legislation that impact specifically on the responsibilities of registered nurses and medical officers. They are:

- **Mandatory Reporting by registered nurses** of suspected child abuse and neglect[5].
- **Mandatory Reporting directly to Department of Child Safety** by registered nurses and medical officers of suspected child abuse and neglect[6].
- **Authorised Involvement by the Department of Child Safety** in circumstances relating to unborn children who may be at risk of harm after birth and notification to hospitals of **Unborn Child High Risk Alerts[7].**

[4] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf
[5] *Section 191 of the Public Health Act 2005*
[6] *Section 191 of the Public Health Act 2005*
[7] Section 21A of the *Child Protection Act 1999*

- **Disclosure of confidential information** between the DChS and other government departments[8].

Reporting Responsibilities

All health professionals have an obligation to report their concern if they suspect that a child or young person has been abused or is at risk of abuse and neglect. This responsibility rests in the common law principle of duty of care. This legal principle requires all health professionals to exercise proper professional care in the way they perform their duties and responsibilities and to take all reasonable and practical steps to prevent harm[9].

Mandatory reporting is an additional **legislative** requirement.

Mandatory Reporters

Mandatory reporting aims to overcome the reluctance of some professionals to become involved in suspected cases of abuse by imposing a public duty to do so[10].

The CMC considered whether the extension of mandatory reporting in Queensland would result in a demonstrated benefit upon children subject to abuse[11]. It recognised that nurses tend to have more contact with children and families particularly in rural and remote communities and believed that they are well placed to make objective and reliable assessments of possible abuse.

The CMC was persuaded that "requiring registered nurses to report suspected child abuse will empower them to make complaints in appropriate circumstances, and provide statutory protection to them in this function, allowing them to meet the requirements within their code of conduct"[12]. Consequently, under *Section 191 of the Public Health Act 2005*, registered nurses are mandated to report all suspicions of child abuse and neglect to the DChS. This mandatory reporting responsibility relates only to concerns or suspicions that they ***recognise in the course of their professional practice.***

Medical officers and registered nurses who fail to report their suspicions may be deemed as having committed an offence and may receive a prescribed penalty under the Act.

The CMC report also recommended that mandated medical officers amend their reporting directions so that their concerns are made directly to the DChS rather than to delegated *authorised officers* nominated in the *Health Regulations 1996.*

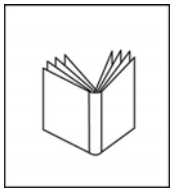
Non-Mandatory Reporting

Whist medical officers and nurses must report, ***all other health*** professionals are able to report instances of child abuse and harm under Section 1590 of the *Child Protection Act 1999*. In doing so, under Section 22 of the *Child Protection Act 1999,* they do not breach

[8] Section 159M and 159N of the *Child Protection Act 1999*
[9] http;//csu.edu.au/favulty/arts/humss/bioethic/duty1.htm
[10] Child Abuse Prevention Resource Sheet No.# June 2004 National Child Protection Clearinghouse
[11] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf
[12] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf

professional ethics and do not become liable to civil or criminal process if the report is made in good faith and on reasonable grounds.

This focus on mandatory reporting should not be interpreted as diminished acknowledgment of the key role in child protection provided by Allied Health Professionals, especially Social Workers, and Indigenous Health Workers. Clearly the reporting requirement for this group as for all health professionals has existed within the common law principle of *Duty of Care*.



These links will allow you to access the legislation referred to in this section. You may wish to do some additional reading.

Public Health Act (2005)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf

Health Services Act (1991)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthServA91.pdf

Child Protection Act (1992)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

Professional Standards and Child Safety

All health professionals within their own disciplines have their own professional competency standards and code of ethical behaviour and conduct. You should access these resources and consider the ways in which they influence and guide your professional behaviour in child protection.

Confidentiality and Disclosure

Under Section 1590 of the *Child Protection Act 1999*, all employees of QH are able to provide information directly to the DChS or a Queensland Police Officer if the information is relevant to the welfare or protection of a child or young person, or is given before a child is born and is relevant to the protection of the child after he or she is born.

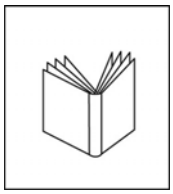
In providing this information, health professionals are afforded a number of protections under the *Public Health Act 2005* and the *Child Protection Act 1999.* They include:

- Professionals who make a mandatory report are deemed not to have breached any duties of confidentiality or privacy and are not liable to criminal, civil or disciplinary action for making the report (Section 186 *Public Health Act 2005).*
- Anyone who gives information to a professional about child harm is also protected (Sections 195 and 196 of the Public *Health Act 2005*). These protections enable, for example, a grandparent to give information to a doctor about harm to a child without fear of the doctor or the DChS revealing to the parents of the child that the information came from the grandparent.

- The provisions also enable a professional to discuss their suspicions with another professional. For example, a junior registered nurse may be uncertain about whether a particular presentation indicates child harm, so they would be able to discuss the presentation with a more senior registered nurse, social worker, or a medical officer.

- Section 22 of the *Child Protection Act 1999* provides protection from civil and criminal liability for making a notification or giving information about child harm to the DChS. For instance, a person who notifies the DChS of harm to a child or young person cannot be sued for defamation, charged with a breach of confidentiality or held to have breached any code of professional ethics.
- Section 186 of the *Child Protection Act 1999* prohibits an authorised officer from disclosing a notifier's identity except in the specified circumstances outlined in the Act (Section 186(2)). This includes when it is required to enable others to perform duties under the *Child Protection Act 1999* or under direction from a court or the Children's Services Tribunal.

These provisions also apply to a person who provides information about an unborn child who may be in need of protection after he or she is born.



WEB: http://www.legislation.qld.gov.au/OQPChome.html

Reporting Child Abuse and Neglect

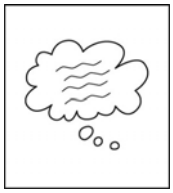
To fulfil the responsibilities as mandatory reporters, *Section 191 of the Public Health Act 2005* requires doctors and nurses to immediately notify the chief executive of the DChS of a ***reasonable suspicion*** that a child has been, is being, or is likely to be harmed. This threshold is also relevant to non-mandated health professionals whose duty of care obligation to report is equally compelling.

Whilst there is no legal definition of ***reasonable suspicion,*** a reasonable suspicion requires more than just an isolated fact that may or may not indicate harm. To reach this threshold for reporting means **forming a concern or well-founded suspicion that is based on the presence of signs, disclosures, injuries, symptoms and behaviours** that heighten concerns about the safety, health and well being of a child or young person.

Determining if Abuse and Neglect Has Occurred

Reasonable grounds are reached when:

- a child or young person tells you they have been abused or neglected
- your own observations of a particular child or young person's behaviour or injuries and your knowledge of children and young people generally leads you to suspect abuse or neglect is occurring
- a child or young person tells you that he/she knows someone who has been abused or neglected (the child or young person may be referring to themselves)
- someone who is in a position to provide information about a child or young person (parent, relative, friend, neighbour, sibling) expresses concern that the child/young person may be abused or neglected
- there is evidence such as injury or behaviour which is consistent with abuse or neglect and unlikely to be caused in any other way
- there is an injury or behaviour where there are corroborative indicators supporting the concern that it may be a case of abuse or neglect e.g. a pattern of injuries, an implausible explanation for the injuries, other indicators of abuse or neglect
- there is consistent indication, over a period of time, that a child is suffering from physical, sexual, emotional abuse or neglect



Reflecting on your previous experience … (i) Did your suspicions reach the threshold to report? (ii) What was the evidence that you observed that allowed you to establish that your suspicions were reasonable?

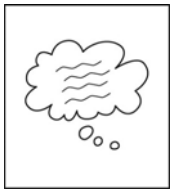
Reflect on the scenario of your choice … (i) Would your suspicions reach the threshold to report? (ii) What is the evidence that would suggest that your suspicions are reasonable?

Is your Suspicion Reasonable?

Additional actions to undertake when forming a reasonable suspicion include:

1. a review of the child's record to ascertain previous presentations / concerns
2. discussion with health colleagues who have had contact with the child and family
3. discussion and consultation with colleagues, social workers where available, line managers, team leaders, and the District's Child Protection Advisor or Child Protection Liaison Officer.

These processes of information collection, clinical assessment, analysis and documentation are the basis of sound clinical practice and form a substantive basis of a reasonable suspicion to report child abuse and neglect.



Reflecting on your previous experience … (i) Did you utilise secondary data sources such as the child record? (ii) Did you consult with colleagues to assist in the formulation of reasonable suspicion?

Reflect on the scenario of your choice … (i) What secondary data sources are available? (ii) With whom would you consult to assist in the formulation of reasonable suspicion?

The Unborn Child

The CMC Inquiry identified that the existing child protection system had significant legislative limitations in its capacity to respond to unborn children who may be at risk of harm after birth. This meant that an unborn child who was suspected of being at harm or at risk of harm was not able to be the subject of a child protection notification and investigation by the DChS prior to birth. Subsequent amendments to existing legislation, namely Section 21A of the ***Child Protection Act 1999***, have now enabled the DChS to take appropriate action where it suspects than an unborn child may be at risk of harm after birth.

The intent behind this change is not to interfere with the rights of the pregnant woman but to provide assistance and support that would reduce the likelihood that her child will be subject to abuse or neglect after birth.

The mandatory reporting by health professionals of child protection concerns related to an unborn child is not specifically prescribed in child protection legislation. However, this does not prevent health professionals from reporting their concerns about the potential risk of harm to a child following their birth to their local DChS service centre. Sections 22, 1590 and 186 of the *Child Protection Act 1999* provide protection for health professionals who report their concerns in these instances.

It is essential that all unborn child reports are discussed with the Districts' child protection advisor prior to the report being made to DChS.

Responding to an Unborn Child High Risk Alert

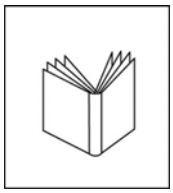
An ***Unborn Child High Risk Alert*** is an action that is ***initiated*** by the ***Department of Child Safety only***. It means that there are significant protective concerns about the unborn child and that the parent/s of the unborn child may have refused to participate or be engaged in an assessment of their circumstances.

Queensland Health policy indicates that it is the ***responsibility*** of the admitting midwife to undertake the relevant inquiries associated with these alerts and to facilitate advice to the DChS when the woman presents at hospital for delivery. (Please refer to your relevant

District policy and local facility procedures). This action then not only allows Child Safety Officers to fully assess the safety concerns regarding the child once born, but enables them, where appropriate, to initiate legal action to secure the protection and well-being of the child.

Unborn Child High Risk Alerts are only initiated after significant assessment and consideration by the DChS. The alert **must not** be disclosed to the woman who is the subject of the alert. They are made only in situations when the Child Safety Officer has assessed that the child will be in need of protection after he or she is born.

The existence of an ***Unborn Child High Risk Alert*** does not preclude health professionals from making further reports to the DChS if they suspect an unborn child will be in need of protection after birth.



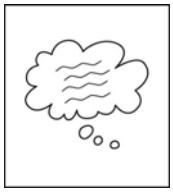
WEB: http://qheps.health.qld.gov.au/csu/UCHRA_policy.htm

Assessment Principles

Working with children and families where child abuse and neglect may be present raises issues of values, rights and potentially conflicting interests[13]. It is therefore important to work within a set of principles that influence clinical practice when assessing the presence of a reasonable suspicion.

The core principles are:

- always consider child protection when assessing the health needs of ***every*** unborn, child and young person
- utilise a child centred approach where the safety and well being of the child is paramount
- consider the wider needs of the child, other children and family members



Reflecting on your previous experience … Did your assessment of this child reflect these core principles of assessment?

Reflect on the scenario of your choice … Is there evidence of these core principles in the assessment of this scenario?

[13] http://www.lincolnshire.gov.uk/section.asp?pageType=1&docId=28232

Responding to Children and Parents/Caregivers

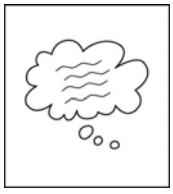
Communicating clearly and openly with children and their families facilitates the collection of information to support assessment. The following provides some guidelines for best practice.

The Child or Young Person

- stay calm
- communicate in a way that is appropriate to their age and understanding
- provide a private and child-friendly environment if possible
- respond in a caring and sensitive manner
- provide support without being judgemental
- listen to what the child wants to tell you.
- use open ended questions only
- do not probe for details by asking leading/direct questions of the child as this may prejudice any subsequent investigation by relevant officers
- do not promise **confidentiality**
- minimise the number of medical and nursing personnel examining and interviewing the child or young person
- avoid any emotional expression or response (anger, pity, outrage, taking sides)

Parents/caregivers

- communicate in a non-judgemental and helpful manner
- do not ask leading/direct questions as this may prejudice any subsequent investigation by relevant officers
- avoid any emotional expression or response (anger, pity, outrage, taking sides)
- empathise with any expressed coping problems the parents/caregivers may verbalise but do not support the abusive behaviour
- keep parents/caregivers informed about their child's medical condition and treatment needs



Reflecting on your previous experience … (i) How did you respond to the parents or carers in this situation? (ii) How would you do it differently?

Reflect on the scenario of your choice … (i) If you were in this situation how would you respond to the parents or carers?

Report Don't Investigate

In forming a reasonable suspicion of abuse and neglect, it is **not** the responsibility of health professionals to prove abuse or neglect has occurred nor who might have caused it. Investigation of these matters remains the responsibilities of officers from the DChS and/or the QPS. Their combined roles are to :

- investigate allegations of harm or risk of harm;
- determine the immediate safety of a child

- continually reassess a child's safety throughout the investigation and assessment process;
- determine if a child has been harmed;
- determine if a criminal offence has occurred
- assess the risk to a child ie. estimate the likelihood that a child will suffer harm in the future; and
- assess if a child is in need of protection

It is important that the report to the DChS contains information that is relevant, accurate and reflective of a holistic clinical assessment.

An assessment of reasonable suspicion becomes an investigation when you exceed the boundaries, expectations and scope of your designated professional role and discipline.

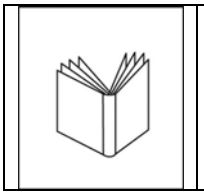
Client Record Documentation

Guidelines for documentation in the client record are available in all QH facilities. Specific child protection content needs to:

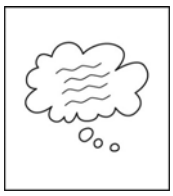
- include the date and time and reason for the presentation and who accompanied the child
- record the findings and outcomes of all interviews (child / parent / carer / person accompanying the child) and treatments and interventions (medical and psychosocial)
- record disclosures made by the child or caregiver. These should be recorded as verbatim quotations. For example; Mother said "I left him with his stepfather" or "mother states that she left him with his stepfather"
- be objective. For example, 'child presents with mother…….minimal interaction observed…….child withdrawn'. Do not include any documentation of feelings, judgemental reactions and intuitive responses . They play a role in care delivery however they do ***not*** belong in medical record documentation
- use precise anatomical descriptions. Describe each discreet injury separately and use a body map to document injuries
- be clear on the basis for your suspicion. Include specific indicators (refer to the recognition section)
- document discussions in determining if your suspicion is reasonable. Remember that there are experts in the District (medical, nursing and allied health) and they are there to assist you with determining if your suspicion is reasonable. Consultation is essential.
- consider clinical photography in relevant cases. You will need to refer to your local consent for medical photography policy to assist you through this process. QPS may initiate this if there is an investigation.
- Write legibly, sign the entry and print name for clarification

Accurate documentation is an important facet of child protection intervention. Your entries may form part of the assessment, treatment and ongoing care of this child or young person and in the determination if abuse and neglect has been perpetrated on this child. Mandatory

reporting requires the completion of the QH form ***Report of a Reasonable Suspicion of Child Abuse and Neglect.*** (Please refer to the Child Safety Unit website for this form)



WEB: http://qheps.health.qld.gov.au/csu



Reflecting on your previous experience … (i) Did you document everything you needed to? (ii) Would you do it differently now?

Reflect on the scenario of your choice … From this scenario – what exactly would you document?

Freedom of Information

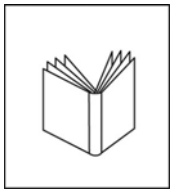
The Queensland *Freedom of Information Act 1992* provides the public with a legally enforceable right to obtain information about the operations of Queensland government, to gain access to documents held by government and to seek amendment to information held by government concerning their personal affairs if that information is inaccurate, incomplete, out-of-date or misleading.

The rights of access under the FOI Act are subject to certain exclusions and exemptions specified in the FOI Act which may, in certain circumstances, provide grounds for refusing to grant access to information held by government (eg. information contained in a patient's medical record).

It is not possible to give absolute assurances that information could not be released under FOI in any circumstances. However, in relation to child protection issues, there are very strong arguments in favour of exemption for:

- documents relating to suspected or actual child abuse, and
- documents revealing the involvement and deliberations of a SCAN Team in relation to a specific patient.

Further information on the FOI processes can be accessed though the District designated FOI officer or on the Legal and Administrative Law Unit QHEPS site.



WEB: http://qheps.health.qld.gov.au/ibm/css/lalu/contact.htm

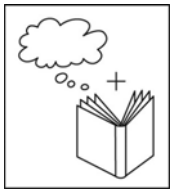
Section 3 – Recognition

Capability Statement Two – "Recognition"

The expectation is that you;

1. Utilise a child protection perspective in the assessment of the health needs and the provision of health care to the unborn, child and young person.

2. Make use of the common child protection indicator set in the identification when formulating a differential diagnosis that may include abuse and neglect.



The key points from the Responsibility Section are:

- You have a legislative and/or duty of care responsibility to report your suspicion of child abuse and neglect
- You are afforded a number of protections in the reporting of your suspicion
- You are bounded by the responsibilities and requirements of your own professional discipline to report child abuse and neglect

Defining Harm Abuse and Neglect

Within the area of child protection there are a number of definitions that are important to consider. These definitions can be categorised as legal or operational.

Legal Definitions

In Queensland, a *'child'* is defined in the *Acts Interpretation Act 1954* as an individual under 18 years. The *Child Protection Act 1999* supports this interpretation.

'Harm' is defined in the *Child Protection Act 1999:*

- As any detrimental effect of a ***significant*** nature on the child's physical, psychological or emotional wellbeing
- It can be caused by physical, psychological or emotional abuse or neglect, sexual abuse or exploitation
- It is immaterial how the '***harm***' is caused.

In the *Public Heath Act 2005, 'harm to a child'* is defined as meaning any detrimental effect on the child's physical, psychological or emotional wellbeing -

(a) that is of a significant nature: and
(b) that has been caused by -
    1. physical, psychological or emotional abuse or neglect; or
    2. sexual abuse or exploitation.

It is important to recognise the difference between these definitions of *'harm'*. Given the nature of health services, health professionals are confronted daily with children and young people who have suffered harm of some sort. It would therefore be unreasonable to report every sick or injured child that presents for care and treatment. The distinction for the health professional is that there has to be a reasonable suspicion that the harm may or has been caused by ***abuse or neglect***.

Significant harm means that the effect of the abuse or neglect "must have more than a minor impact upon a child's physical, psychological or emotional wellbeing. It must be substantial, serious and demonstrable - that is, measurable and observable on the child's body, in the child's functioning or behaviour"[14].

For officers from the Department of Child Safety to ***respond*** to a report of child abuse and neglect, they have to satisfy the legislative requirements of Section 10 of the *Child Protection Act 1999* which states that a child in need of protection is a child who:

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

The term ***'parent'*** of a child is defined in Section 11 of the *Child Protection Act 1999* as:

- the child's mother, father or someone else (other than the chief executive) having parental responsibility for the child.
- a person standing in the place of a parent of a child on a temporary basis is not the parent of the child.
- a parent of an Aboriginal or Torres Strait Islander child includes a person who, under Aboriginal tradition or Island custom, is regarded as parent of the child[15].

Operational Definitions

Harm

There are many definitions of child abuse and neglect found within contemporary literature. The common concept within these definitions is that child abuse includes ***harm*** arising from physical abuse and physical neglect, emotional abuse and neglect, and sexual abuse and exploitation.

The use of this term “harm” rather than “abuse” helps to focus on the *effects* on the child, rather than the *actions* of the adults. This distinction becomes important when assessing the child’s ongoing safety and wellbeing and the parents’ capacity to protect the child.

Physical abuse is any physical injury to a child that is not accidental[16]. It includes any injury caused by excessive discipline, severe beatings, punching, slapping, shaking, burning,

[14] Child Safety Practice Manual v1.0, page 43
[15] http://legislation.govnet.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf
[16] http://www.yesican.org/definitions/WHO.html)

biting, throwing, kicking, cutting, suffocation, drowning, strangulation or poisoning. Physical abuse can result in death.

Sexual abuse occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. It can be physical, verbal or emotional and includes any form of sexual touching, penetration, sexual suggestion, sexual exposure, exhibitionism, and child prostitution.[17]

Emotional abuse occurs when children are not provided with the necessary and developmentally appropriate supportive environment to develop mentally and/or emotionally. Emotional abuse includes constant criticism, restriction of movement, patterns of belittling, denigrating, scape-goating, threatening, scaring, discriminating, exposure to domestic violence, ridiculing or other non-physical forms of hostile or rejecting treatment[18] [19].

Neglect is depriving a child of their basic needs. These include food, clothing, warmth and shelter, emotional and physical security and protection, medical and dental care, cleanliness, education and supervision[20].

Presenting Characteristics of Physical, Sexual and Emotional Abuse and Neglect

Child abuse and neglect is *identified* within any community by the presence of signs, injuries, symptoms and behaviours that heighten concerns about the safety, health and well being of children and young people.

Some general characteristics of child abuse and neglect relevant to the everyday practice for health professionals are:

- The child or young person discloses abuse
- The child or young person gives some indication that the injury did not occur as stated
- The explanation provided by the parents/caregivers does not account for the injury/symptoms/behaviour
- There is an unreasonable delay in the child's presentation for the child's injury or condition.
- Parents' or caregivers' capacity to meet the child's care and protective needs is impaired.
- Parent or caregiver has unrealistic expectations/poor understanding of the child's developmental needs.
- Child related behaviours/triggers present at time of abuse.
- Abuse precipitated by family crisis.
- Parental history of abuse/violence.
- Child is dependent and unable to protect him/herself.
- Child is fearful of parent/caregiver or of going home.

[17] Department of Child Safety, Child Safety Practice Manual, Intake and Investigation and Assessment, V1.0, page 29
[18] http://www.yesican.org/definitions/WHO.html
[19] *World Health Organisation, Report of the Consultation on Child Abuse Prevention*, Geneva, 29-31 March 1999
[20] http://www.yesican.org/definitions/WHO.html

- Child has special needs which increase his/her vulnerability.

Indicators of Abuse

Indicators are clues or warning signs that suggest possible harm. They ***do not prove*** abuse or neglect as harm ***can occur in the absence of these indicators*** but they do require ***further assessment, interpretation and consultation***.

The following guidelines provide a framework for understanding and identifying the occurrence of child abuse and neglect. Relevant indicators/risk factors are specific to each abuse type and are described in terms of the way a child or young person presents and the behaviours of those who abuse and neglect children and young people[21]. The following lists are a guide for clinical practice only and ***are not considered to be comprehensive*** of all actions, harm, behaviours and presentations that may give rise to a concern or suspicion of abuse or neglect.

[21] New South Wales Interagency Guidelines fro Child Protection Intervention 2002

Indicators of Physical Abuse [22]

Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Facial, head and neck bruising • Ruptured internal organs without a history of trauma • Fractures of bones, especially in children under 3 years • Lacerations and welts from excessive discipline or physical restraint • Burns / scalds • Ingestion of poisonous substances, alcohol or other harmful drugs • Other bruising and marks which may show the shape of the object that caused it (eg. a hand print, buckle) • Bite marks and scratches where the bruise may show teeth patterns • Multiple injuries or bruises • Head injuries where the child may have indicators of drowsiness, vomiting, fitting, retinal haemorrhages, suggesting the possibility of the child having been shaken • Dislocations, sprains, twisting injuries / symptoms • Explanation offered by the child or young person that is not consistent with the injury or other minor complaints	• Direct admissions by parents or carers that they fear they may injure or have injured the child or young person • Family history of violence, including previous harm to the children • History of their own maltreatment as a child • Repeated presentation of the child to health or other services with injuries • Marked delay between injury and seeking appropriate medical assistance • Parental history of injury inconsistent with child's developmental stage and physical findings • Parental history of injury is vague, bizarre or variable • Parental reluctance or inability to adequately explain injury • History of domestic / family violence.
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

[22] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework

Indicators of Emotional Abuse [23]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Feelings of worthlessness about life and themselves • Inability to value others • Lack of trust in people • Lack of interpersonal skills necessary for adequate functioning • Extreme attention seeking behaviours • Other behavioural disorders (eg. disruptiveness, aggressiveness, bullying).	• Constant criticism, belittling, teasing of a child, or ignoring or withholding praise and affection • Excessive or unreasonable demands • Persistent hostility and severe verbal abuse, rejection and scape-goating • Belief that a particular child is bad or 'evil' • Using inappropriate physical or social isolation as punishment • Situations where an adult's behaviour harms a child's wellbeing • Exposure to domestic violence
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances. *	

[23] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework

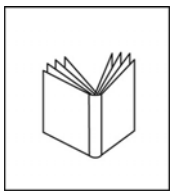
Indicators of Sexual Abuse [24]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Describes sexual acts • Direct or indirect disclosures • Age-inappropriate behaviour and/or persistent sexualised behaviour • Self-destructive behaviours: drug dependence, suicide attempts, self-harming • Unexplained changes in behaviour • Persistent running away from home • Poor concentration at school • Not wanting to go home from school • Anorexia or over-eating • Going to bed fully clothed • Regression in developmental achievements in younger children • Child being in contact with a known or suspected perpetrator of sexual assault • Unexplained accumulation of money or gifts • injuries such as tears or bruising to the genitalia, anus or perineal region • Bleeding from the vagina, external genitalia or anus • Sexually transmissible infections • Adolescent pregnancy • Traumas to buttocks, breasts, genitals, lower abdomen or thighs.	• Intentional exposure of child or young person to sexual behaviour of others • Committed / suspected of child sexual assault • Coercing child to engage in sexual behaviour with other children • Verbal threats of sexual abuse • Exposing child or young person to prostitution or child pornography or using a child for pornographic purposes • Inappropriate curtailing or jealousy regarding age-appropriate development of independence from the family • Denial of adolescent pregnancy by family • Perpetration of spouse abuse or physical abuse
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

[24] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework

Indicators of Neglect [25]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers
• Non-organic failure to thrive • Delay in developmental milestones • Loss of skin bloom • Poor hair texture • Untreated physical problems • Poor standards of hygiene leading to social isolation • Scavenging for or stealing food • Extended stays at school, public places, other homes • Self-comforting behaviour, eg. rocking, sucking • Being focused on basic survival • Extreme seeking of adult affection • A flat and superficial way of relating, lacking a sense of genuine interaction • Anxiety about being abandoned	• Failure to provide adequate food, shelter, clothing, medical attention, hygienic home conditions • Leaving the child inappropriately without supervision • Inability to respond emotionally to a child • Abandoning child or young person • Depriving or withholding physical contact or stimulation for prolonged periods
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

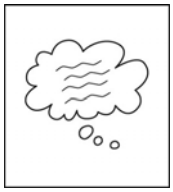
These indicators provide a guide for clinical practice and, as previously stated, are not considered to be comprehensive of all harm, behaviours or presentations. One indicator in isolation may not indicate abuse or neglect. Each indicator needs to be considered in the context of a child's personal circumstances. Furthermore, child abuse and neglect can occur in the absence of any of these demonstrable risk indicators. Their presence are merely clues or warning signs that require further assessment, interpretation and consultation.

Additional risk indicators or characteristics of child and family and examples of possible clinical findings of child abuse and neglect can be found in the fact sheets developed by the Child Safety Unit. These indicators are presented in a child developmental framework and have been compiled by a cross section of experienced clinicians. Please refer to the Child Safety Unit QHEPS site for this resource.



WEB: http://qheps.health.qld.gov.au/csu/

[25] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework



Reflecting on your previous experience … Utilising the "Indicators for Abuse and Neglect" – which specific indicator(s) were evident?

Reflect on the scenario of your choice … Which specific indicators are you able to identify from the scenario?

Child Abuse and Neglect and Antenatal Care

The first indication of potential risk for an unborn child may be uncovered during antenatal care. All health professionals providing care to a mother during her pregnancy should be alert to the signs of abuse and neglect remembering also that the mother may not necessarily be the perpetrator of the abuse but a victim if she resides in an abusive relationship.

"Research and experience indicates that very young babies are extremely vulnerable to abuse and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm"[26].

Antenatal assessment offers health professionals clues or indicators that point to the need for parental support and/or intervention to facilitate the adequate parenting, protection and well being of the unborn child. An awareness of those indicators [27]relevant to antenatal assessment is therefore critical.

[26] http://www.acpc.norfolk.gov.uk/right_frame(protocols23).html
[27] ibid.

Factors to be considered when undertaking an Antenatal Assessment of Risk:		
Unborn Baby	**Parenting Capacity**	**Family / Household / Environmental**
• Unwanted/concealed pregnancy • Lack of awareness of baby's needs • Unattached to unborn baby • Unrealistic expectations • Inappropriate parenting plans • Premature birth • Different/abnormal perceptions about the baby • Inability to prioritise baby's needs • Poor/nil antenatal care • Special/extra needs • Stressful gender issue	• Negative childhood experience • Childhood abuse • Denial of past abuse • Multiple carers • Substance abuse • Family violence • Abuse/neglect of previous children • Age of parent - very young parent • Mental illness • Learning difficulties • Physical disabilities • Ill health • Inability/unwilling to work with professionals • Postnatal depression • Past antenatal/postnatal neglect	• Domestic violence • Violent network • Poor impulse control • Unsupportive partner • Isolation • High mobility/transience • No or little commitment to parenting • Relationship difficulties • Multiple relationships • Lack of community support • Poor engagement with professional services

Again, it must be remembered that these indicators are clues that suggest possible harm. They do not prove abuse or neglect as harm can occur in the absence of these indicators but they do require further assessment, interpretation and consultation.

"Antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk. The aim is to provide support for families, to identify and protect vulnerable children and to plan effective care programmes, recognising long-term benefits of early intervention on the welfare of the child"[28].

[28] http://www.acpc.norfolk.gov.uk/right_frame(protocols23).html

Domestic Violence an Indicator for Potential Abuse and Neglect

Domestic and Family Violence (D&FV) occurs when one person in a relationship uses their power to control the other person, in any way, including physical, emotional, verbal, sexual, financial, social, cultural, and spiritual abuse.

Intimate Partner Violence (IPV) occurs when abuse and/or violence is used within an intimate partner relationship.

There is increasing evidence that there is a substantive correlation between domestic or intimate partner violence and the incidence of child abuse within the community, with one being an indicator of the other[29].

The Australia Women's Safety Survey reported that 61 per cent of women who experienced violence by a current partner had children in their care during the course of the violent relationship. The survey also revealed that 46 percent of women who experienced violence by a previous partner said that their children had witnessed the violence (ABS 1996). In the Victorian study, an estimated one in four Victorian children had witnessed intimate partner violence, increasing their risk of mental health problems, behavioural and learning difficulties[30]..

Children can be severely traumatised by witnessing domestic and family violence or intimate partner violence with possible persistent behavioural and psychological sequelae. They can also become victims of the abusive and/or violent behaviour. The type of violence is not always the primary factor determining the long term outcome but the more important predictors are the duration of the violence, its severity and frequency. However, physical violence is an overriding concern and as such should be carefully assessed with an appropriately prioritised response.

This evidence of possible co-existence of D&FV and child abuse necessitates the need for all health professionals to have a child protection perspective when confronted with D&FV or intimate partner violent situations. The recognition of indicators associated with domestic violence is a critical component of a supportive and protective response to ***all*** its victims.

[29] Astbury J., (2000) 'The impact of domestic violence on individuals' Medical Journal of Australia, Vol 173.
[30] NSW Health: Policy and Procedures for Identifying and Responding to Domestic Violence, page 51.

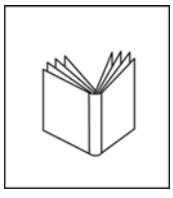
Indicators associated with domestic or intimate partner violence [31]	
Indicators in adult victims • Unexplained bruising and other injuries • Social isolation • Never making a decision without referring to partner • Low self esteem • Anxiety/depression/post-natal depression • No access to transport • Being submissive/withdrawn • Frequent absences from work or studies • 'Accidents' during pregnancy • Repeated presentations at emergency departments • Psychosomatic and emotional complaints • Sometimes there are no obvious indicators	**Indicators in young children** • Difficulties with eating • Difficulties in sleeping • Slow weight gain (in infants) • Regressive behaviour in toddlers • Delays or problems with language or other development **Indicators in school age children** • Behaviour which is clingy, dependent, sad and secretive • Academic achievement problems • Poor concentration • Poor school attendance • Withdrawal at school • Aggressive or violent behaviour • Defiance at school, particularly with female teachers • Over-protectiveness of or fear of leaving mother • Anxiety • Physical complaints • Sleeping difficulties

[31] Domestic Violence Interagency Guidelines, http://lawlink.nsw.gov.au/lawlink/vaw/dvguidelines

Indicators associated with domestic or intimate partner violence [32]	
Indicators of perpetrator behaviour in adults • Values/attitudes about 'ownership' of partner and/or children • Controlling behaviour • Always speaking for the partner (or child) • Describing the partner as 'incompetent' 'stupid' or other derogatory terms • Being overly concerned towards the suspected victim • Admitting to some violence, but minimising the frequency and severity • Holding rigidly to stereotyped sex roles • Not allowing partner or child to access service providers alone • Threatening and/or intimidating • Behaviour directed towards workers • Sometimes there are no obvious indicators	**Indicators in adolescents** • Physical/verbal abusiveness/violence • Social isolation • Abuse of siblings or parents • Eating disorders • Depression or suicide attempts • Over- or under-achievement • Alcohol or other drug abuse • Frequent absences from work or studies • Psychosomatic and emotional complaints • Exhibiting sexually abusive behaviour • Homelessness or prolonged staying away from home • Extreme risk taking behaviour
*** Please note: the indicators listed may also be indicators of other abuse or neglect issues and should be used as a guide only.**	

The QH Domestic Violence Initiative (DVI) is a screening tool that is used to identify women who are experiencing Domestic and Family Violence, particularly Intimate Partner Violence (IPV), and to provide referral options for further information, support, assistance and/or counselling.

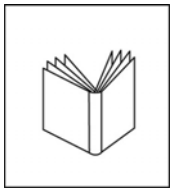
Queensland, and other Australian and international studies confirm that IPV often commences or escalates in pregnancy. Therefore, it is appropriate that women are asked about this possibility at the earliest opportunity during the pregnancy.



The DVI tool can be accessed at:
http://www.health.qld.gov.au/violence/domestic/dvpubs/DVIForm.PDF

[32] Domestic Violence Interagency Guidelines, http://lawlink.nsw.gov.au/lawlink/vaw/dvguidelines

The DVI tool offers the health professional an opportunity to recognise adult victims and children and young people who have been harmed or who are at risk of harm. It does not specifically ask about children and young people. However, if IPV is disclosed, midwives are encouraged to ask about the impact on children and young people. Identification or recognition of such harm facilitates the undertaking of health professionals' mandatory and duty of care responsibilities to report to the Department of Child Safety.



http://www.communities.qld.gov.au/violenceprevention/dv_legislation.html

http://www.health.qld.gov.au/violence/domestic/dvi/

Other useful starting points for relevant internet links are

- the Australian Domestic Violence Clearing House Links Page at: http://www.austdvclearinghouse.unsw.edu.au/Links.htm
- The Australian Government Partnership against Domestic Violence page at http://ofw.facs.gov.au/padv/index.htm

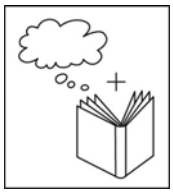
Section 4 – Reporting

Capability Statement – "Reporting"

The expectation is that you;

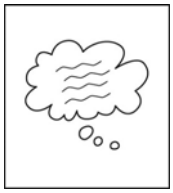
1. Are aware of, and know how to access the child protection support systems (District / State-wide) to determine if your suspicion is reasonable.

2. Are able to make a report to the Department of Child Safety utilising the standard QH child safety report form.



The key point from the Recognition Section is:

- That there are presenting characteristics and indicators that can alert health professionals to the presence of child abuse and neglect.



Reflecting on your previous experience … did you report and did you know how to report?

Reflect on the scenario of your choice … prior to completing this module, would you have reported this and to whom?

Support Systems

District

When reporting your suspicion of child abuse and neglect it is essential to determine if your suspicion is reasonable. To do this it is recommended that you ***consult*** with other health professionals. Remember that the provision of child protection involves many different professional groups and that your consultation does not have to be limited to your own specific professional group.

In a **metropolitan** or **larger regional centre** consultation may only need to occur locally. In this instance there are Paediatricians who fulfil the role of a Child Protection Advisor and Child Protection Liaison Officers (these positions may be either a nurse or a social worker).

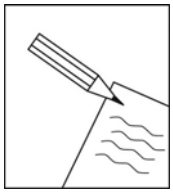
It may be that you choose to discuss your suspicion with your colleagues or line manager / team leader prior to a more formal consultation with the District's Child Protection Advisor and Child Protection Liaison Officer.

In **regional, rural** and **isolated** facilities the consultation may need to occur with colleagues and advisors in other facilities. For example, if you are a health professional in Cloncurry or Mornington Island then the flow of consultation may include colleagues locally and then with advisors in Mt Isa.

In isolated facilities where you may be a solo practitioner or a member of a very small team, then it is also acceptable to consult with the child's teachers and local police officer to determine if your suspicion is reasonable.

Remember as a health professional you are afforded legal protection in this consultation under Sections 159M,N,O,andQ the *Child Protection Act 1999*.

Information on supports that you are able to access should be available in your local facility. There is also a comprehensive list of child protection advisor positions available on the CSU QHEPS site.



It is important for you to know who the Child Protection Advisor or Child Protection Liaison Officers in your District are and how to contact them. Locate the contact details for these positions now.

Locate the contact details for those Child Protection Advisors in other Districts that you may need to contact.

Other

Other resources that could be of assistance to you in the formation of reasonable suspicion include;

1. Child Advocacy Service – Royal Children's Hospital
2. Mater Health Services, Child Protection Unit
3. Child Protection Unit – The Townsville Hospital
4. Your local DChS service centre staff (refer to the DChS internet site for contact information - http://www.childsafety.qld.gov.au
5. QH Child Safety Unit (QHEPS or telephone)

Department of Child Safety Officer (authorised officer)

The Chief Executive is the Director General and ***all Child Safety Officers*** from the DChS are *authorised officers* under Section 149 of the *Child Protection Act 1999.* They have the power to investigate allegations of alleged harm or alleged risk of harm to a child, and assess the child's need of protection or take appropriate action under Section 14 of the *Child Protection Act 1999.*

It is important to remember that you are not in breach of Section 62A of the *Health Services Act 1991* when you communicate confidential information to an *authorised officer,* **a Child Safety Officer,** *of the Chief Executive* of the DChS as long as the disclosure is relevant to the protection and welfare of a child.

Queensland Police Officers *are not authorised officers* but have legal provisions for involvement in child protection investigations and responses given the possibility of the commission of a criminal offence related to the alleged harm to a child[33].

However, under Section 159O of the *Child Protection Act 1999,* health professionals are also able to provide information directly to **Queensland Police Officers** if it is relevant to the protection or welfare of a child.

Written and Verbal Reporting

Making a Report

Given the sensitive nature of child abuse and neglect, and the serious potential outcomes for those involved, the need for objectivity and impartiality is important.
The types of report you are required to make to the DChS are;

- Written, and
- Verbal.

Verbal contact with an authorised officer of the DChS may be the first step you take when reporting. The DChS call this process an "*intake".* During this process the Child Safety Officer will ask a specific set of questions to assist them in determining the response level for the report.

The **QH "Report of a Reasonable Suspicion of Child Abuse and Neglect"** has been developed to mirror the "*intake*" questions you will be asked. It is anticipated that this will facilitate effective and efficient communication between QH and the DChS. You may find it prudent to work through the form prior to your telephone conversation with the Child Safety "*intake officer*".

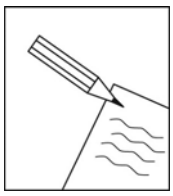
It is a legislative requirement that all verbal reports must be followed up with a written report. A written report must be forwarded to the DChS within seven days, even if you consider that your suspicion is no longer reasonable. This is mandated in Section 192 of the *Public Health Act 2005*.

Just remember - the ***contact*** with the Child Safety Officer is ***your responsibility*** if you have formed the reasonable suspicion, and cannot be undertaken by or delegated to another colleague, clinical team member or manager.

Other issues to consider when making a report are;

- Objectivity,
- Credibility, and
- Professional boundaries.

[33] Section 14(2) of the *Child Protection Act 1999*



Using your own scenario …

Using the scenarios provided …

Categorise the abuse type and complete the following extract from the QH "Report of a Reasonable Suspicion of Child Abuse and Neglect" form.

3. ABUSE TYPE BEING REPORTED (more than one may be ticked) - refer to Guide for assistance, if needed

Suspected:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect
At risk of:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect

Objectivity means having an awareness of any potential biases that may relate to a child, young person, parent or caregiver's age, gender, race, ethnicity, religion, sexual orientation, disability, cultural/community child rearing practices, or socio-economic status.

Credibility is reliant on the report being impartial and free of any possible interpretation/judgement of an individual's values, morals or religious or cultural beliefs.

Achieving credibility in reporting suspicions of child abuse and neglect is also important to maximising opportunities for the safety, well-being and development of children or young people who have been harmed or are at risk of harm. Credibility relates to the quality of the information you have collected and which forms the basis of your reasonable suspicion. Relevant, professionally sound, and accurate data are critical elements of a credible report.

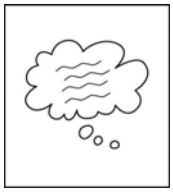
Professional boundaries are grounded within a clearly articulated ethical framework that is comprised of four central principles. These being;

- Beneficence (of always doing good for the patient)
- Non-maleficence (of avoiding doing harm)
- Respect for patient autonomy as a decision making individual
- Justice (treating everyone equally)[34].

These boundaries must be central to your practice when you are working with children and young people who have experienced or who are experiencing abuse and neglect. The involvement with and consideration of the family and/or their carers may present you with professional dilemmas and challenges in maintaining appropriate professional boundaries. It is important to know your District support systems and access them as required.

Despite your possible distress to a child or young person's abusive experience, it is important that your care, response, treatment and support remains within the parameters of your professional boundaries and responsibilities. Expressions of anger, pity, and outrage have no place in the provision of professional health care to the victims and possible perpetrators of child abuse and neglect.

[34] Bridges J., Hanson R., Little M., et.al. 'Ethical relationships in paediatric emergency medicine: Moving beyond the dyad' Paediatric Emergency Medicine (2001)13,pp344-350



Reflect on your professional boundaries and consider strategies you may utilise in your practice to ensure that these boundaries are not exceeded.

Department of Child Safety Intake Process

When ***reporting*** to the DChS, the minimal information requirements are contained in the prescribed QH reporting form. However in your discussion with the Child Safety officer/Intake Officer at the relevant service centre, additional information will be sought to assist them in their assessment and determination of the appropriate level of response.

You may be asked very specific questions related to:

- the harm which is the basis for the report eg. body location of an injury, severity, cause of reported/suspected injury
- child or young person's presentation, appearance, developmental and emotional capacity, attachment to parents/caregivers, behaviour.
- parents/caregivers presentation, their protective capacity of the child, attachment to child, relationship history, parenting capacity, behaviour during presentation.
- family characteristics such as their family/household type, (eg. step, single, blended), mobility, social isolation, cultural factors.
- child's environment such as type of housing, living conditions
- presence of any immediate safety concerns
- presence of any factors that may affect worker safety should a notification result.
- source of the information being provided eg. child/parental disclosure, hearsay from others, direct observation, deduction, other possible corroborative sources.

Your response to these queries needs to be objective and honest. If you are unable to answer the questions, state this and the reason you are unable to do so (that is you did not ask about that, you did not observe anything in relation to that etc). It is important to cooperate with the Child Safety Officer to provide as much information as possible as your report may be critical to the safety and wellbeing of the child. Remember though – you are a reporter not an investigator.

Your capacity and willingness to be recontacted by the Child Safety Officer may also be discussed.

Documenting the Report

Given that the information you may provide orally to the DChS may be more extensive than what you may have prepared for your written report, it is important that you document in the child's medical record, a summary of your discussion along with the name and details of the Child Safety Officer that you spoke with.

Maintaining an accurate, considered, objective and up to date account of your concerns, consultations, contacts, actions and plans will facilitate you and your colleagues' involvement in any subsequent response/intervention involving the child or young person. Good documentation not only clearly demonstrates your responsibility to reporting but reflects

professionalism and clinical skill and your commitment to the protection and wellbeing of the child or young person you have identified as being at risk.

Possible Report Outcomes by the DChS

After a report is made to the DChS, the Child Safety Officer must decide what action or response is required to the information you have provided. There are three possible outcomes:

1. An enquiry

This is a report that does not relate to child welfare issues of child protection concerns or there is insufficient information about a child's need for protection. This was previously known as an intake response.

2. A child concern report

A child concern report is a child protection concern that does not meet the threshold for recording for a child protection notification and so does not result in an investigation and assessment by the Department. This level was previously known as a protective advice.

Whilst there may be some concern for the child or young person's safety and wellbeing, it is not of a significant nature to warrant any statutory departmental intervention. Other services of assistance or support may be offered to the family.

3. Child protection notification

A matter is determined to be a child protection notification when the department receives information that a child is reasonably suspected to be in need of protection. That is, a child who:

- Has suffered harm or is at unacceptable risk of suffering harm, and does not have a parent able and willing to protect him/her from harm (*Child Protection Act 1999*, section 10); or
- Is unborn but is reasonably suspected to be in need of protection after he or she is born (*Child Protection Act 1999*, section 21A).

A notification response will result in an initial assessment by Child Safety Officers of the allegations of abuse and/or neglect and the family circumstances of the child or young person.

If the information received in the report indicates the commission of a criminal offence, the Queensland Police Service is immediately contacted for their response.

Involvement after Making a Report

In addition to the possible responses to the report by the DChS and the QPS, there are other child protection processes that may be initiated after a report which may include the involvement of health professionals. They include:

- a referral to the relevant Suspected Child Abuse and Neglect (SCAN) system
- a 'Care and Treatment Order for a Child'
- involvement in judicial proceedings
- provision of ongoing health and therapeutic care responsibilities

Referral to the SCAN System

As a result of the CMC Inquiry, Suspected Abuse and Neglect (SCAN) teams have been redeveloped with a legislative basis and a rejuvenated holistic 'whole of government' commitment to address and enhance their functioning.

The SCAN system now consists of a two-tiered model which provides a forum for inter-agency discussion and planning ensuring that the safety of the child is paramount.[35]

The **SCAN Assessment and Management Team (AM)** team is the first tier of the SCAN model and is the conduit for all matters to be referred to the SCAN System for deliberation. It is comprised of an authorised representative from these core departments:

- Department of Child Safety
- Queensland Police Service
- Queensland Health
- Department of Education and the Arts
- Recognised Aboriginal and Torres Strait Islander agencies

Referrals to the SCAN AM teams are made by the core member agency representatives based on specific criteria. Meetings are very regular and health professionals, in addition to the QH core member, may be required to attend to provide specific knowledge or expertise which will add value to the case discussion and resulting recommendations for action[36].

Their purpose is to ensure:

- the ongoing protection of the child or young person
- the provision of support to the child, young person and their family
- the intervention is effective and coordinated; through
- coordinated assessment of protective and support needs
- collaborative planning
- the implementation of recommendations for action[37].

The SCAN Community Implementation (CI) Team is the second tier of the SCAN model and is responsible for planning and implementation of the AM Team recommendations in association with the DChS case management plan. QH professionals may also be involved in service delivery at this level.

The DChS, as the lead child protection agency, has responsibility for the coordination of the 20 regionally based AM teams and the locally based CI teams.

[35] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005, p9
[36] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005, page 18
[37] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005

Care and Treatment Order for a Child

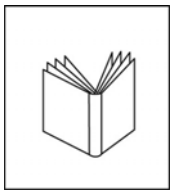
Under the *Public Health Act 2005*, Designated Medical Officers, have the power to order that a child be held at a health service facility for an initial period not exceeding 48 hours, if the Designated Medical Officer reasonably suspects that the child

- has been harmed, or is at risk of harm, AND
- the child is likely to be taken from the facility and suffer harm if immediate action is not taken.

The order may be extended for an additional 48 hours only with the agreement of a second Designated Medical Officer.

A Care and Treatment Order for a Child needs to be administered with the welfare and best interests of the child as paramount as it is a very powerful intrusion on the normal decision making rights of parents or guardians and can be invoked without judicial review. It is Queensland Health's policy position that a Care and Treatment Order only be invoked in circumstances where a child is likely suffer harm if immediate action is not taken and it is not possible to use the custody provisions of the *Child Protection Act 1999*, which in general is the preferred course of action.

This order makes it an offence to remove the child from the health service facility or to obstruct a Designated Medical Officer or another person involved in holding a child under the Order.



LINK TO 'Care and Treatment Order for a Child' Information Booklet
WEB
http://www.qheps.health.qld.gov.au/csu

LINK TO *Public Health Act 2005*
WEB:
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf

- Has been harmed or is at risk of harm:

And

- Is likely to leave or be taken from the facility and suffer harm if the designated medical officer does not take immediate action.

Judicial Proceedings

Involvement in a child protection case does not necessarily mean just completing a report of your concerns to the DChS. There may be occasions when you will be requested to provide an affidavit or statement to officers from the DChS and/or the Queensland Police Service about the delivery of your professional services to a child and/or family member who is subject to a subsequent court action. You may also be subpoenaed to give evidence in a court proceeding.

This will only occur in instances when a child or young person's safety can only be secured through the provision of a protection order and/or an alleged perpetrator of abuse or neglect to a child or young person has been charged with a criminal offence.

It is important to remember that on these occasions, this will not be about your role as the reporter of the alleged abuse. Your involvement in these instances will have most likely resulted from the performance of your clinical responsibilities involving a child or young person who has been harmed or who has been at risk of harm.

When confronted with these requests, seek support, direction and advice from your service supervisor/manager and remember that this is part of your professional responsibilities to the children and young people of Queensland who have been harmed or who are at risk of harm. You will be supported in your performance of these responsibilities. You should refer to your District policy for further information.

Other Possibilities

Other ongoing roles for health professionals can include:

- Provision of clinical services as an inpatient or outpatient
- Provision of clinical services to parent/s
- Participation in case planning
- Attendance at relevant case discussions/meetings
- Monitoring child's health and behaviour needs during the delivery of clinical services
- Advocating access to appropriate services to ensure good health outcomes
- Providing progress reports to the SCAN system, DChS, or other relevant agencies

As can be seen, your responsibilities do not cease with the completion of a report of a reasonable suspicion of abuse or neglect. Whilst the majority of these subsequent duties are not mandated, they fall within the charter of your health role. All children and young people have the right to access and receive adequate health care. The care they receive should reflect the holistic approach which underpins the Queensland's government commitment to children and young people who have been harmed.

Remember Yourself and Access Support

Recent evidence now reveals that practitioners who work with or help traumatised persons are indirectly or secondarily at risk of developing the same symptoms as persons directly affected by the trauma.

"The pain and helplessness of these children can be passed on to those around them. Listening to children talk about the trauma, trying to work in a complicated, frustrating and often "insensitive" system, feeling helpless when trying to heal these children - all can make the adults working with these children vulnerable to develop their own emotional or behavioural problems"[38].

There are many aspects of involvement in a child protection situation that can be very stressful for health professionals. Being confronted with a child with serious injuries or even their death is distressing and painful. Similarly, having regular contact with a child who is being constantly neglected by his parents can also result in feelings of frustration, powerlessness and anger.

Being mandated to report may not sit comfortably with you on a philosophical basis.

The very act of making a mandatory report about a child can also be demanding. You may worry about the implications of your action. Have I done the right thing? What will happen to the child now? Will the child be removed from his/her parents? Do I advise the parents that I am making a report? This decision depends on the relationship you have with the parent. Remember, you are obliged by law to report and this can be explained to the parents if appropriate. You are not obliged to advise parents of your report.

In addition, you may be exposed to situations that you can clearly identify with due to your own experiences as a child.

You can also expect to encounter high levels of distress, anger, and possible aggressive behaviour from parents whose child may have been harmed or is at risk of harm. Be aware of your own safety needs especially if you home visit, work alone or work in a rural or isolated centre. Seek appropriate advice and assistance if you are concerned.

It is important to ***recognise*** when you feel fearful, distraught or emotionally overwhelmed because of your involvement in a particularly difficult or series of difficult cases.

There are "individual indicators of distress" which can tell us all that we are at increased risk for developing secondary trauma[39].

Emotional Indicators		Physical Indicators	
Anger	Prolonged grief	Headaches	Lethargy
Sadness	Anxiety	Stomach aches	Depression
	Depression		

[38] Perry B D. "The Cost of Caring" Secondary traumatic Stress and the Impact of Working with High-Risk Children and Families, 2003 http://www.childtrauma.org/ctamaterials/Sec.Trma2_03_v2.pdf

[39] Perry B D. "The Cost of Caring" Secondary traumatic Stress and the Impact of Working with High-Risk Children and Families, 2003 http://www.childtrauma.org/ctamaterials/Sec.Trma2_03_v2.pdf

Personal Indicators		Workplace Indicators	
Self Isolation	Mood swings	Avoidance of certain clients	Missed appointments
Cynicism	Irritability with family / spouse	Tardiness	Lack of motivation

It is important to ***acknowledge*** that you have been impacted by an incident or your participation in a situation of abuse and neglect.

It is important to ***seek*** appropriate assistance due to an incident or your participation in a situation of abuse and neglect.

As colleagues, supervisors, managers, you need to assist by:

- recognising that your colleague has been affected by their involvement
- providing encouragement and emotional support
- providing an opportunity to "talk" about how they have been impacted by the trauma
- assisting and encouraging your colleague to seek professional assistance and/or counseling

Checklist for Responding to Abuse and Neglect

Response	*Action*
Responsibility	• Recognise mandatory obligations • Fulfil mandatory responsibility
	• Recognise duty of care obligations • Undertake duty of care responsibility
Recognition	• Suspect abuse or neglect
	• Gather information
	• Assess information
	• Identify abuse type
	• Specify indicators/basis for concern
	• Consider if concern reaches 'reasonable suspicion' threshold.
	• Consult with colleagues/child protection advisor
	• Confirm concern as being a 'reasonable suspicion'
	• If no, still document your concerns with reasons for nil report.
	• Attempt case management of your concerns eg. refer to social work or community agency
	• If yes to reasonable suspicion, continue to **Reporting.**
Reporting	• Document concerns/suspicion in medical record
	• Obtain relevant information
	• Complete written documentation on prescribed QH Reporting form.
	• Contact your local DChS service centre during business hours or Crisis Care after hours.
	• Discuss your reasonable suspicion based on your observations and clinical assessment with an authorised officer from the DChS.
	• Document the officer's name, Service Centre, contact details and date and time of your contact on QH form and in the medical record.
	• Document any additional information discussed during reporting process to DChS in medical record.
	• Forward forms to DChS Service Centre and District Child Protection Advisor/Contact as per directions on the form
You have now done your part in protecting this child.	

Module Content Objectives

Section One

1. Discuss the concept of social justice and the role of Government in the provision of child safety policy and services.
2. Outline the basic principles of the "Ecological Model" and discuss its benefits as a conceptual model in the identification and reporting of suspected child abuse and neglect.

Section Two

3. Briefly outline findings and recommendations of the recent CMC report on "Children in Foster Care" and the impact of this report on current Government policy.
4. Briefly discuss the role of the DChS as the lead government agency for child safety.
5. Outline the recommendations that specifically relate to Queensland Health.
6. Discuss the role of the Queensland Health Child Safety Unit and differentiate its purpose from that of the DChS.
7. List the legislative changes that impact directly on clinical practice in the area of child safety.
8. Discuss the concept of mandatory versus discretionary reporting of suspected child abuse and neglect.
9. Outline the protections for health service employees with specific reference to section 62(a) of the Health Services Act.
10. Discuss the concept of reasonable suspicion
11. List the legislation that relates to the unborn child.
12. Briefly overview and describe the difference between;
    - reporting of an at risk unborn child
    - DChS unborn child high risk alert
13. Outline the guiding principles that should be considered when undertaking a health assessment of a child or young person that may have experienced abuse or neglect
14. Differentiate between the concept of assessment and investigation.
15. List the essential elements that need to included when documenting (in the clients medical record) an assessment of a child or young person that may have experienced child abuse and neglect.
16. Outline the "FOI" protections and limitations specifically relating to staff confidentiality when documenting in the medical record.

Section Three

17. Define the concepts of harm, neglect and abuse.
18. Outline the common presenting characteristics of physical, sexual and emotional abuse and neglect.
19. List the common risk indicators to be considered when assessing a child or

young person that may have experienced abuse and neglect.

20. Relate the concepts of harm, neglect and abuse to different scenarios and the role of the QH Health Professional
21. Provide information on where more detailed information on child protection indicators can be accessed.
22. Outline the role of the health professional in the antenatal assessment of child abuse and neglect
23. Briefly overview the relevance of Domestic and Family Violence (D&FV), including intimate partner violence (IPV), as an indicator when considering the possibility of child abuse and neglect in a family unit
24. Discuss the use of Queensland Health Domestic Violence Initiative (DVI) assessment tool and its benefit in determining the presence of D&FV or intimate partner violence.

Section Four

25. Outline the support systems (Corporate and District) that can be accessed by individuals to assist them in determining if their suspicion is reasonable.
26. Discuss the concept of an *authorised person*.
27. Overview the two mechanisms (written and verbal) of reporting suspected child abuse and neglect.
28. Discuss the importance of credibility and objectivity when reporting any suspicion of abuse and neglect.
29. List the common questions that may be asked when making a verbal report to the DChS.
30. Discuss the importance of recording the DChS Officer's name together with the content of the information disclosed during the verbal reporting process in the client medical record.
31. Overview the possible responses by the DChS following a report of suspected child abuse or neglect to the DChS
32. Overview the common outcomes likely to occur following a report of suspected child abuse or neglect to the DChS eg. Referral to the SCAN system, care and treatment order, DChS specific actions, affidavit
33. Define SCAN
34. List the core members agencies of the SCAN System.
35. Describe the two-tiered models of SCAN System and their basic activities.
36. Overview possible subsequent involvement in judicial proceedings
37. Overview the circumstances of a Care and Treatment Order for a Child.
38. Discuss the importance of obtaining support in the event that the reporting process causes personal distress.

Appendix One

Scenario 1:

James Brown, DOB 24.3.05, is brought to hospital by mother and her partner with very recent history of difficulty in feeding, vomiting, constant crying and irritability.

Upon examination, child has red marks around neck and shoulders (they have an outline of a handprint). The child is difficult to arouse and starts to fit during the triage process. Child is subsequently admitted to hospital and a CT scan reveals multiple cerebral haemorrhages.

Mother, Mary Brown is 17 years old and has previously been in the care of the Department of Families as a result of her mother's failure to protect her from being sexually abused by her stepfather. She lives with her boyfriend, Bill Burr who is 19 years old and a friend of the partner, Matt Blinco, aged 18 years. Mary tells you that she and her partner had a fight last night and she left the unit at around 11PM and stayed with a friend for a few hours as she was scared that she would be hurt by Bill as he was drunk and had beaten her in the past. She is not breastfeeding and the baby is not yet sleeping through the night. Despite this she was so scared she just left the unit and left the child asleep in the unit. Bill is not the father of the baby but Mary tells you that he has cared for the baby by himself on previous occasions. The basis of the argument was that Bill had accused her of having sex with Matt while he was at the hotel. Matt and Bill also were violent with each other during the argument.

Mary receives Supporting Parent's benefits, and Bill lost his job yesterday, came home and started drinking with a mate. Bill drinks regularly and heavily according to Mary.

Bill tells you that the baby started crying after Mary left. He went to change him and give him a bottle. He and the baby then went off to sleep and didn't awake until Mary returned at around 7am. Mary states that when she returned home, the baby was crying and had vomited on his clothes and bedding. She tried to comfort the baby but was unsuccessful and that the baby periodically shook. She became worried as the baby looked very unwell and decided to take him to the hospital.

Mary also tells you that she has been visited at home by the Child Health nurse over the last few weeks since the birth of the baby and that she has had contact with her local GP. The baby is on the 10th percentile for weight.

Address: 12 Harris Lane, Highwood. There is no landline telephone in the house and the mobile phone has no credit and has been disconnected.

Scenario 2:

Mother, Jo Black, presents with 5 year old daughter, Jenna, who has discomfort when urinating and is complaining of general pelvic soreness. Mother quietly tells you that she is concerned as her daughter has not been sleeping for the past six months, has been becomes very clingy, has frequent nightmares and that the teacher at her preschool has mentioned that her behaviour there has recently deteriorated – not socialising as well as she has, and refusing to have afternoon rests.

Her parents are separated. The mother lives with Jenna and her 9 year old son, John, from a previous relationship. Jenna's father has overnight contact visits every second weekend. These visits have been happening for the last 6 months since the separation. Jenna cries for hours before she goes on these visits and tells her mother that she doesn't want to go and that she doesn't like the staying with her dad. When her mother asks why, she says nothing and cries more vigorously but still sends the child on the visit each fortnight as they are court ordered. Jenna has stayed with her father the previous weekend.

Dad, Walter Black, is 32 years old and lives alone.
During examination, child is very distressed and even her mother is unable to comfort her. She does not want people to look at her lower abdominal, pelvic and genital areas and refuses to give a urine sample.

Address: 32 Blaxland Ave, Ample Hill 4997. Tel: 90986523

E7

Child Safety – Health Professionals Capability Requirements and Reporting Responsibilities

Human Resources Policy

Effective Date: April 2008

1 PURPOSE

To ensure that all health professionals are aware of their roles and responsibilities in recognising, reporting and responding to children and young people who have been harmed or who are at risk of harm.

2 APPLICATION

This policy applies to all health professionals. More specifically, it applies to those health professionals who as part of their normal duties are likely to engage with or deliver services to children and young people and/or adults who have parental/carer roles and responsibilities in relation to children and young people.

3 GUIDELINES

Guidelines may be developed to facilitate implementation of this policy. The guidelines must be consistent with this policy.

4 DELEGATION

The "delegate" is as listed in the Queensland Health Human Resource Delegations Manual as amended from time to time.

5 REFERENCES

- *Health Act 1937*
- *Child Protection Act 1999*
- *Public Health Act 2005*
- Recruitment and Selection policy
- Circular 44/05 – Child Safety – Mandatory Requirements for Health Professional's Capability (Skills and Knowledge Maintenance) and Reporting

6 SUPERSEDES

- IRM 3.19 Child Safety – Health Professionals Capability Requirements and Reporting Responsibilities

7 POLICY

7.1 Background

Queensland Health is committed to the protection of children and young people from harm. In 2004, the Crime and Misconduct Commission (CMC) Inquiry into Abuse of Children in Foster Care made recommendations specific to Queensland Health.

The recommendations were in relation to:

- Registered nurses and medical staff developing and maintaining an appropriate level of individual competence in the area of child safety and the recognition and reporting of suspected or likely child abuse and neglect.
- Mandatory reporting requirements where reasonable suspicions of abuse or neglect are identified.

In accordance with the CMC recommendations, the *Public Health Act 2005* has been amended to require all Registered Nurses and Medical Officers to immediately report any reasonable suspicion of child abuse and neglect directly to the Department of Child Safety.

This policy requires all health professionals, who in the course of their normal duties formulate a reasonable suspicion that a child or young person has been abused or neglected in their home/community environment, to immediately report their suspicion to the Department of Child Safety. This reflects the requirements of Section 22 of the *Child Protection Act 1999* and also the duty of care principle

Section 22 of the *Child Protection Act 1999* provides protection from liability for any person, acting honestly, who notifies or gives information about suspicions of abuse or neglect to a child.

7.2 Mandatory Reporting Requirements

Health Service Districts are to ensure that all relevant health professionals are aware of the requirements to report all reasonable suspicions of abuse and neglect of a child to the Department of Child Safety.

Contact details for Local Child Safety Service Centres of the Department of Child Safety are available through the intranet site at http://qheps.health.qld.gov.au/csu

The reporting format (form SW 010) is contained in “Report of a Reasonable Suspicion of Child Abuse and Neglect” booklet available in all Health Service Districts. Advice or support for clinicians on reporting reasonable suspicion of child abuse and neglect can be obtained from Line Managers, District Child Protection Advisors or Child Protection Liaison Officers. Contact details for District Child Protection Advisors and Child Protection Liaison Officers is available through the intranet site at http://qheps.health.qld.gov.au/csu/districtcpacplo.htm

A flowchart of the reporting process is outlined in Attachment One.

7.3 Capability Requirements – Skills and Knowledge Maintenance

The reporting requirements are an important part of the role of health professionals. It is recognised that many Queensland Health employees may not be experienced in recognising indicators of actual or potential child abuse or neglect. All relevant health professionals are required to complete a self assessment of capability tool to assess their own capability to identify actual or potential child abuse or neglect.

The outcome of the self assessment of capability tool indicates to a health professional if they should undertake further education and training to fulfil the reporting responsibilities. The Self Assessment of Capability tool and the self directed education program can be accessed through the Queensland Health Maternity, Child Health and Safety Branch intranet site at http://qheps.health.qld.gov.au/csu/edumodule.htm.

7.4 Capability Requirements – Education and Training Programs

The education and training program involves two target groups.

7.4.1 New Health Professional Staff

All newly employed health professionals are provided with introductory information on child safety and the reporting of suspected child abuse and neglect.

This information is provided in the Child Safety Orientation DVD, as well as through local district based processes. It is mandatory for the following staff to view the Orientation DVD:

- Doctors and Registered Nurses;
- all health professionals who are involved in the provision of services to children and young people; and/or
- all health professionals who are involved in the provision of services to adults who have parental/carer roles and responsibilities in relation to children and young people.

This is managed through the inclusion of a broad overview of child protection as a mandatory component in all District clinical induction programs. The Queensland Health Maternity, Child Health and Safety Branch has made available a suite of appropriate documents and resource materials suitable for inclusion in local induction programs. Further details of the resource materials are available by contacting the Queensland Health Maternity, Child Health and Safety Branch.

7.4.2 Existing Health Professional Staff

All existing relevant health professionals who are likely to engage with, or provide care to children and young persons in the normal course of their duties within Queensland Health may be required (if indicated by their self assessment of capability) to complete a self-directed education package that outlines the expected levels of knowledge, practical skill and attitudinal behaviours that need to be achieved.

The self-directed education program has been designed by Queensland Health to provide employees with the appropriate skills and knowledge to fulfil their responsibilities.

The self-directed program provides employees with:

- An understanding of their legal responsibilities.
- The skills and knowledge to recognise abuse and neglect indicators.
- An understanding of the reporting process if the staff member considers that a reasonable suspicion exists.

The "Child Abuse and Neglect" education module and Participants Guide are available through the Queensland Health Maternity Child Health and Safety Branch intranet site. The content of this educational resource is also made available to interested tertiary education facilities for inclusion in the relevant undergraduate/pre-registration programs.

7.5 Capability Requirements – Role Descriptions

The following statement on child safety responsibilities and mandatory requirements was approved for inclusion in the Primary Duties sections of role descriptions for any health professional role where part of normal duties may involve the delivery of a service to children and young people:

> *All relevant health professionals (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or young person has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to the Department of Child Safety.*
>
> *All relevant health professionals are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.*

7.6 Ongoing Capability Assessment

Relevant health professionals are to complete the capability self assessment process at least yearly. Managers are encouraged to consider the assessment process as a component of the health professional's performance appraisal and development plan.

Each health professional is:

- Personally accountable for their self assessment against the capability statements as outlined in the "Child Abuse and Neglect" education module and Participants Guide.
- Responsible for maintaining their level of capability in relation to these obligations. This is to occur by revisiting the level one training resource where they identify any need for refreshing their skill levels.
- On completion of their self assessment staff are required to complete Lattice form (HRO39) 'Child Abuse and Neglect Self Assessment and Capability' with their line manager. The completed form is forwarded to District Human Resource services, to enable the data to be placed on the Lattice database. A

report from this database is provided to maternity Child Health and Safety Branch annually.

If additional training needs are identified, either through the individual's performance appraisal and development plan or the self assessment process, details for ongoing training and education sessions should be accessed through the Queensland Health Child Safety Unit.

8 APPLYING THE POLICY

8.1 Reports of Reasonable Suspicion of Child Abuse and Neglect

When a report of reasonable suspicion of child abuse and neglect form is forwarded to the Department of Child Safety, a copy of the report is to be forwarded to the nominated Health Service District Child Protection Advisor or Child Protection Liaison Officer.

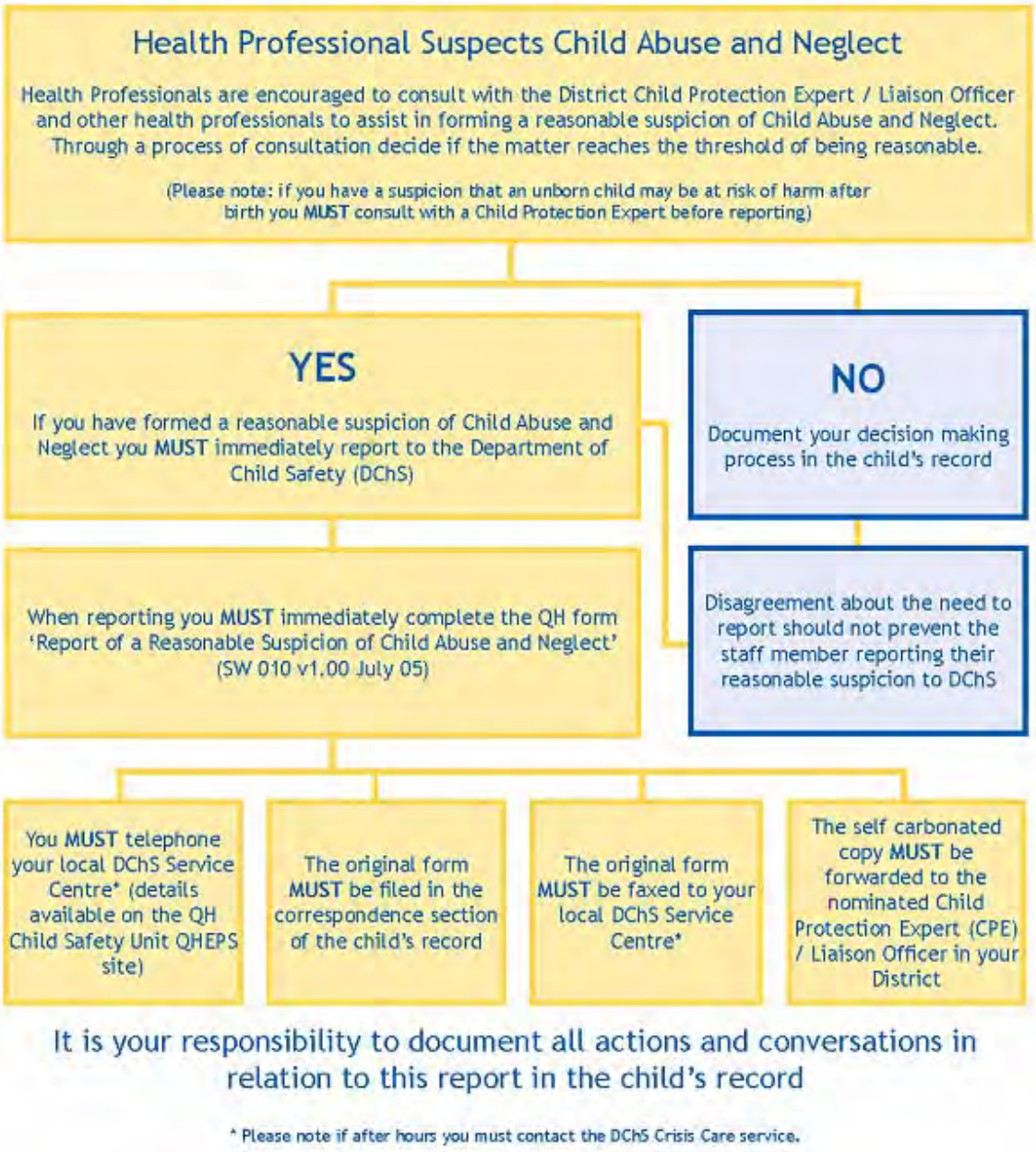
9 HISTORY

This policy dated April 2008 was developed as a result of HR Policy Framework consolidation.

Child Safety Unit
Queensland Health

Queensland Government
Queensland Health

How to report a reasonable suspicion of Child Abuse and Neglect



It is your responsibility to document all actions and conversations in relation to this report in the child's record

* Please note if after hours you must contact the DChS Crisis Care service.

Standard # QH-IMP-078-3:2012

Protecting Children and Young People Policy

Implementation Standard for Care and Treatment Order for a Child

1. Purpose

This Implementation Standard identifies the minimum requirements that evidence the implementation of the Care and Treatment Order for a Child component of the Protecting Children and Young People policy and identifies individual positions accountabilities and responsibilities in relation to Care and Treatment Order for a Child.

2. Scope

This Implementation Standard applies to all Queensland Health Health Service Districts including the person in charge of a health facility and designated medical officers.

3. Supporting documents

Authorising policy:

- Protecting Children and Young People Policy

Related Standards

- Implementation Standard 'Information sharing in child protection'
- Implementation Standard 'Consent in child protection and management of complex care cases and end of life decision making'
- Implementation Standard 'Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team'
- Implementation Standard 'Reporting and responding to a reasonable suspicion of child abuse and neglect'
- Implementation Standard 'Conducting child sexual assault examinations'

Forms and templates

- Queensland Health Care and Treatment Order for a Child

form

- Queensland Health Extension of Care and Treatment Order for a Child form
- Queensland Health Advice of a Care and Treatment Order for a Child (Parent(s) – Child) form
- Queensland Health Advice of an Extension of Care and Treatment Order for a Child (Parent(s) – Child) form

4. Related documents

- Care and Treatment Order for a Child Information Booklet

5. Requirements

5.1 Appointing a designated medical officer

5.1.1 The person in charge of a health facility shall appoint by written instrument, a medical doctor as a designated medical officer only where they have the necessary expertise or experience to be a designated medical officer (*Public Health Act 2005*, s188). Where the person in charge of a health service facility is a medical doctor, that person is taken to be a designated medical officer while that person is in charge of the facility.

5.2 Referring a concern to a designated medical officer

5.2.1 Where a staff member becomes aware of or reasonably suspects that a child at a health service facility has been harmed or is at risk of harm, AND is likely to leave or be taken from the facility and suffer harm if immediate action is not taken, AND efforts have been made to gain parental cooperation to secure the child's immediate safety AND it is not possible to use the custody provisions of the *Child Protection Act 1999*, the staff member shall immediately contact a designated medical officer to determine if the matter reaches the threshold of a Care and Treatment Order for a Child ("*order*").

5.3 Making a Care and Treatment Order for a Child (*Public Health Act 2005*, s197, s206, s207, s209, s212)

5.3.1 Where a designated medical officer becomes aware of or reasonably suspects that a child at a health service facility has been harmed or is at risk of harm, AND is likely to leave or be taken from the facility and suffer harm if the designated medical officer does not take immediate action, the designated medical officer shall make a Care and Treatment Order for a Child (*Public Health Act 2005*, s197).

5.3.2 The *order* shall commence from the time it is made and end 48 hours after the time it was made.

5.3.3 A further *order* shall not be made for the child in relation to harm, or a risk of harm, arising from the same event or circumstances that gave rise to the *order* (refer to 5.6 for extending care and treatment orders).

5.3.4 A designated medical officer may make a subsequent order for harm or risk of harm that arises from an event or circumstances that happen after the end of an earlier order.

5.3.5 Upon request from a parent/guardian, a designated medical officer shall allow a child under the *order* to be examined by another doctor at the facility.

5.3.6 The designated medical officer shall ensure that only medical examination or treatment reasonable in the circumstances is administered to the child.

(NOTE: Under a Care and Treatment Order for a Child, a child may be medically examined or treated without the consent of the child's parents/guardians to the examination or treatment.)

5.4 Recording the order (*Public Health Act 2005*, s197, 3)

5.4.1 The designated medical officer shall immediately record the order in writing by completing the Queensland Health *Care and Treatment Order for a Child* form. The written record shall include:

- details of the child's condition
- the reasons for the order
- the name of the facility where the child is held
- the time that is 48 hours from the time the order is made.

5.5 Communicating the order (*Public Health Act 2005*, s197, s198, s199, s200, s212)

5.5.1 The designated medical officer who made the order shall communicate the *order* effectively.

To effectively communicate the *order*, the designated medical officer shall:

- where appropriate given the child's developmental stage, explain to the child in general terms the purpose and effect of the order;
- notify the person in charge of the health facility and the Chief Executive of the Department of Communities Child Safety Services of the *order* as soon as practicable. This notice shall include:
  - details of the harm or risk of harm of which the designated medical officer is aware or suspected by the designated medical officer
  - the time that is 48 hours from the time the order is made when the order ends
  - the name and work contact details(i.e. address and telephone number) of:
    - (i) the designated medical officer; and
    - (ii) if notice has been given under s191(2) *Public Health Act 2005* report of reasonable suspicion of child abuse and neglect – the professional who gave the

notice if the designated medical officer has these details

— to the extent it can reasonably be obtained:

(i) the child's name, date of birth and residential address or another address at which the child may live; and

(ii) the name and residential address of the parents/guardian of the child or another address at which the parents may be contacted.

- explain the *order* to the parent/s of the child as soon practicable. This communication shall include:
  - telling at least 1 of the child's parents about the order including the matters contained in the written record of the order
  - telling the parent that it is an offence to remove the child from the health service facility while the order is in force
  - providing the parent with a Queensland Health Advice of a Care and Treatment Order for a Child (Parent(s) – Child) form. File a copy of this form in the child's chart
  - telling the parent that the parent may choose to have the child examined by a doctor chosen by the parent
- advise a doctor chosen by the parent of the examination or treatment undertaken for the child
- advise the District Child Protection Advisor or Child Protection Liaison Officer.

5.5.2 The designated medical officer need not comply with the above subsection (5.5.1 dot point three) if the officer reasonably believes that (a) someone may be charged with a criminal offence for harm to the child and the officer's compliance with the subsection may jeopardise an investigation into the offence; or (b) compliance with the subsection may expose the child to harm.

5.6 Extending the order (*Public Health Act 2005*, s201)

5.6.1 A designated medical officer (who may or may not be the officer who gave the order) may extend the order where they are aware of or reasonably suspect that a child at a health service facility has been harmed or is at risk of harm, AND is likely to leave or be taken from the facility and suffer harm if the designated medical officer does not take action to extend the order.

5.6.2 A designated medical officer shall consult with another designated medical officer prior to an extension of the order. A designated medical officer shall only extend the order if the second designated medical officer agrees that the order should be extended.

5.6.3 The extension of the order shall be made within *48 hours* after the order was first made to a time that is not more than *96 hours* after the order was first made.

5.7 Recording the extension of the order (*Public Health Act 2005*, s201, 4)

5.7.1 The designated medical officer shall record the extension of the order in writing by completing the Queensland Health Extension of a Care and Treatment Order for a Child form. The written record shall include:

- the designated medical officer's name and work contact details (i.e. address and telephone number);
- the reasons for the extension of the order;
- the name, address and telephone number of the designated medical officer consulted by the designated medical officer extending the order;
- a statement that the designated medical officer consulted agreed that the order should be extended;
- the time to which the order is extended.

5.8 Communicating the extension of the order (*Public Health Act 2005*, s202, s203, s204)

5.8.1 The designated medical officer who extended the order shall communicate the extension of the order effectively. To effectively communicate the extension of the order, the designated medical officer shall:

- notify the person in charge of the health facility of the extension of the order as soon as practicable. This notice shall include the details as described in section (5.7.1)
- notify the chief executive of the Department of Communities, Child Safety Services of the extension of the order. This notice shall include the details as described in section (5.7.1)
- explain the extension of the order to the parent/s of the child. This communication shall include:
  - the reasons for the extension
  - the time when the order ends
  - a copy of the written reasons for the extension of the order upon request by the parent
- advise the district Child Protection Advisor or Child Protection Liaison Officer.

5.8.2 The designated medical officer need not comply with the above subsection (5.8.1 dot point three) if the officer reasonably believes that (a) someone may be charged with a criminal offence for harm to the child and the officer's compliance with the subsection may jeopardise an investigation into the offence; or (b) compliance with the subsection may expose the child to harm.

5.9 Enforcing the order (*Public Health Act 2005* s205)

5.9.1 A designated medical officer may use the help and force that is reasonable in the circumstances to hold a child at a health service facility or transfer a child to another health service facility.

5.10 Releasing a child prior to the end of an order (*Public Health Act 2005*, s206, 2, 3)

5.10.1 A designated medical officer may release a child before an order ends if the designated medical officer is satisfied the reason for the order no longer exists.

5.10.2 In releasing a child, the designated medical officer shall make a written record of the release including the following details:

- the reasons for the release
- the time of the release
- the person into whose care the child is released.

5.11 Transfers while under an order (*Public Health Act 2005*, s211)

5.11.1 A child shall be transferred from one facility to another only where a designated medical officer determines it is necessary to transfer the child to, and hold the child at, another health service facility to appropriately medically examine or treat the child.

5.11.2 The designated medical officer shall advise the person in charge of the other facility of the proposed transfer.

5.11.3 The designated medical officer shall give the child's parents and the chief executive of the Department of Communities Child Safety Services notice of the transfer as soon as practicable after the designated medical officer decides to transfer the child.

5.11.4 The designated medical officer need not comply with the above subsection (5.11.3) if the officer reasonably believes that (a) someone may be charged with a criminal offence for harm to the child and the officer's compliance with the subsection may jeopardise an investigation into the offence; or (b) compliance with the subsection may expose the child to harm.

5.12 Clarifying legislative requirements *(Public Health Act 2005, s186)*

5.12.1 Where a staff member is concerned about an inconsistency between *orders* of the *Public Health Act 2005* and the *Child Protection Act 1999*, the staff member shall comply foremost with the requirements of the *order* under the *Child Protection Act 1999*.

6. Review

This Standard is due for review on: 24/08/2013

Date of Last Review: N/A

Supersedes: N/A

7. Business Area Contact

Child Health and Safety Unit, Primary, Community and Extended Care Branch

8. Responsibilities

Position	Responsibility	Audit criteria
Policy Custodian	Oversighting of implementation of policy. Review of Policy as per schedule. Provision of information and direction to internal and external stakeholders regarding policy.	Policy review is conducted as per schedule. As required/ requested, record of communication regarding policy and inclusions are maintained.
District CEOs or delegate	Implementation of policy within the district. Appointing of a designated medical officer.	Compliance reports to the policy custodian are provided as requested. Audit of record of delegation.
Designated medical officer (DMO)	Designated medical officers are authorised to issue a Care and Treatment Order for a Child.	Record of Care and Treatment Orders for a Child.
Child Protection Advisor	Provide assistance to staff when reporting or responding to a reasonable suspicion of child abuse and neglect and formulating assessment of risk of harm. Communication to the designated medical officer if identified need for a Care and Treatment Order for a Child.	Staff are assisted with the formulation of a reasonable suspicion of child abuse and neglect and risk of harm, and the subsequent report to Child Safety Services. Documentation of local communication.
Child Protection Liaison Officer	Provide assistance to staff when reporting or responding to a reasonable suspicion of child abuse and neglect and formulating assessment of risk of harm. Communication to the designated medical officer if identified need for a Care and Treatment Order for a Child. A Queensland Health contact point for other agencies in regard to child protection issues.	Staff are assisted with the formulation of a reasonable suspicion of child abuse and neglect and risk of harm, and the subsequent report to Child Safety Services. Documentation of local communication. Local level communication between Queensland Health and partner agencies.
All Queensland Health staff	Formulate a reasonable suspicion of child abuse and neglect and risk of harm where appropriate	Local level audit of responsibilities

9. Definitions of terms used in this policy and supporting documents

Term	Definition / Explanation / Details	Source
Care and Treatment Order for a Child	Means an order made by a Designated Medical Officer (DMO). This order enables a DMO to direct that a child be held at a health service facility for an initial period not exceeding 48 hours if the DMO reasonably suspects that the child has been harmed, or is at risk of harm, AND, that the child is likely to be taken from the facility and suffer harm unless immediate action is taken. The order may be extended for an additional 48 hours, only with the agreement of a second DMO.	*S197 Public Health Act 2005*
Child	For the purposes of this document, a child is 'an individual under 18 years of age'.	S8 *Child Protection Act 1999*
Child in need of protection	A child in need of protection is a child who: a. has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; AND b. does not have a parent able and willing to protect the child from the harm.	S10 *Child Protection Act 1999*
Designated Medical Officer	Means a doctor appointed as, or who is, a Designated Medical Officer. If the person in charge of a health service facility is a doctor, the person is taken to be a Designated Medical Officer while the person is in charge of the facility. The person in charge of a health service facility may, by written instrument, appoint a doctor to be a Designated Medical Officer if they have the necessary expertise or experience.	S188 *Child Protection Act 1999*
Guardianship	In accordance with the *Child Protection Act 1999*, a person who has, or is granted, guardianship of a child has the powers, rights and responsibilities to attend to: • a child's daily care • make decisions that relate to day-to-day matters concerning the child's daily care • make decisions about the long-term care, welfare and development of the child in the same way a person has parental responsibility under the *Family Law Act 1975.*	*Child Protection Act 1999*
Harm	Harm, to a child, is any detrimental effect on the child's physical, psychological or emotional wellbeing, 1. that is of a significant nature; and 2. that has been caused by - • physical, psychological or emotional abuse or neglect; or • sexual abuse or exploitation	S158 *Public Health Act 2005*
Health service facility	Means –	S158 *Public Health*

	a. A facility that provides a public sector health service within the meaning of s2 *Health Services Act 1991*; or b. A private health facility; or c. Mater Misericordiae Public Hospitals	*Act 2005*
Medical examination	A medical examination is a physical, psychiatric, psychological or dental examination, assessment or procedure and includes forensic examination and an examination or assessment carried out by a health practitioner.	*Child Protection Act 1999*
Parent	A parent of a child is – 1. The child's mother, father or someone else having or exercising parental responsibility for the child; or 2. The Chief Executive Child Safety Services, for a child who is in the custody or guardianship of the Chief Executive Child Safety Services under the *Child Protection Act 1999* The following also applies: 1. A parent of an Aboriginal child includes a person who, under Aboriginal tradition, is regarded as a parent of the child. 2. A parent of a Torres Strait Islander child includes a person who, under Island custom, is regarded as a parent of the child. 3. A reference in this part to the parents of a child or to one of the parents of a child is, if the child has only one parent a reference to the parent.	S159 *Public Health Act 2005*

10. Approval and Implementation

Policy Custodian

Executive Director, Primary, Community and Extended Care Branch

Responsible Executive Team Member:

Deputy Director-General Policy Strategy and Resourcing Division

Approving Officer:

Michael Cleary, Deputy Director-General,

Policy, Strategy and Resourcing Division

Approval date: 16 May 2012

Effective from: 14 May 2012

Queensland Government

Child Health and Safety Unit

How to report a reasonable suspicion of Child Abuse and Neglect

Health Professional Suspects Child Abuse and Neglect

Health Professionals are **recommended** to consult with the District Child Protection Advisor / Liaison Officer and other health professionals to assist in forming a reasonable suspicion of Child Abuse and Neglect. Through a process of consultation decide if the matter reaches the threshold of being reasonable.

(PLEASE NOTE: if you have a suspicion that an unborn child may be at risk of harm after birth you are required to consult with a Child Protection Advisor before reporting)

YES

If you have formed a reasonable suspicion of Child Abuse and Neglect you are **required** to immediately report to Child Safety Services

When reporting you are **required** to immediately complete the QH form 'Report of a Reasonable Suspicion of Child Abuse and Neglect' (SW010)

You are **required** to telephone your Child Safety Regional Intake Service* (details available on the QH Child Safety Unit QHEPS site)

You are **required** to fax the original form to your Child Safety Regional Intake Service*

You are **required** to file the original form in the correspondence section of the child's record

You are **required** to forward the self carbonated copy to the nominated Child Protection Liaison Officer in your District

NO

Document your decision making process in the child's record

Disagreement about the need to report should not prevent the staff member reporting their reasonable suspicion to Child Safety Services

It is your responsibility to document all actions and conversations in relation to this report in the child's record.

* Please note if after hours you are **required** to contact the Child Safety After Hours Services.

Queensland Health
Child Health and Safety Unit,
Primary Community and Extended Care Branch
Review of SW010 report forms 2009-10

Background

The *Public Health Act 2005* makes it mandatory for professionals, defined in the Act as doctors and registered nurses, to immediately notify Child Safety Services (CSS) directly of all reasonable suspicions of child abuse and neglect. It is an offence for professionals not to report reasonable suspicions of child abuse and neglect cases directly to Child Safety Services. Queensland Health (QH) policy places a duty of care responsibility on **all** health professionals to report suspected instances of child abuse and neglect to the Department of Communities Child Safety Services. This duty of care responsibility rests in the common law principle which requires all health professionals to exercise proper professional care in performing their duties and responsibilities to prevent harm of any nature to their clients.

In 2005 the QH Child Safety Unit introduced a number of initiatives to assist health professionals in recognising, reporting and responding to child abuse and neglect.

One of these initiatives was the introduction of a standardised form for QH staff to report a reasonable suspicion of child abuse and neglect to the Department of Child Safety (now Department of Communities Child Safety Service) - *Report of a Reasonable Suspicion of Child Abuse and Neglect*-form SW010.

In 2007, the Maternity, Child Health and Safety Branch undertook the first comprehensive review of the QH's 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form (SW010). Recommendations from that review led to amendments to the report form and the development of specific resources to support health professionals in recognising, reporting and responding to child abuse and neglect.

This 2009 - 10 review was undertaken by the Child Health and Safety Unit with the objectives of:

- Assessing the quality and content of these reports, to ascertain if they are meeting legislative requirements and reflect an understanding of reporting responsibilities

- Identifying current practices, issues and weaknesses in these reports which highlight gaps in current reporting processes and which are areas for further educational development

- Gaining an understanding of reporting trends across QH Health Service Districts.

Methodology:

The review had two components:

1. A reporting profile: information was sought from the Health Information Centre as to populations of children (0-17 years) across the state and in each district. These were then compared with the number of reports made by QH staff from within that district to establish a reporting trend.

2. A retrospective review of **written** reports was undertaken using an audit tool specifically developed for the review.

The 37 QH Child Protection Liaison Officers (CPLO's), working across the fourteen health service districts plus the Children's Health Service, were asked to provide the following:

- The number of reports made in that service by QH staff for the period 1 January 2009 to 30 June 2009
- 15 written reports (SW010s) in sequence, and
- The intake screening outcomes of these reports as determined by Child Safety Services.

For those reports where the screening outcomes were not able to be ascertained by CPLO's assistance was sought by the Child Health and Safety Unit from the Department of Communities to obtain the outcomes.

Note: In undertaking this review, acknowledgement needs to be made that CSS screening outcomes will have included verbal information provided to the CSS, and this is not contained in the scope of this review.

The audit tool utilised to evaluate the reports provided was developed from a literature review of the area, an appraisal of legislative requirements, and the tool that was utilised in the 2007 audit. Each of the reports was evaluated using this tool, with information fields specifically relating to legislative requirements and QH policy. Approximately 40 per cent (40%) of the sample was reviewed by three reviewers to ascertain consistency in response. A copy of the audit tool is located as **Appendix A**.

Description of the sample:

The audit sample size was comprised of five hundred and thirty reports which constitute approximately seven percent (7%) of the seven thousand five hundred and six reports made each year by QH to CSS's.

Population and pattern of reporting:

The number of children and young people (aged 0 – 17 years) in Queensland was 1,046,578 in 2008. [1]

- QH staff are reporting at a rate of **7.3** children per one thousand (**0.73%)** in the age range 0-17 years; compared to **5.1** per thousand (0.51%) in 2007.

The following districts are reporting at a rate statistically **higher** than the QH average (0.73%):

District	2009
Cape York	2.96%
Mt Isa	2.52%
Townsville	1.00%
Central Qld	0.87%
Mackay	0.87%

The following districts are reporting at a rate statistically **lower** than QH average (0.73%):

District	2009
Metro South	0.44%
Gold Coast	0.46%

- Thirty-seven point five percent (37.5%) of reports made to the CSS's are being screened in as notifications. This compares with findings from the previous audit in 2007 where fifty-two percent (52%) of reports were recorded as notifications.

Note: The Commission for Children and Young People and Child Guardian report: 'Child Guardian Report: Child Protection System (2008-09)' indicates there has been an increase

in the number of Child Concern Reports (CCR) and a decrease in rates of Notifications recorded by the Department of Communities (Child Safety Services). [2]

Key Findings of the audit:

Presentations

Fifty percent (50%) of reports came from hospital presentations with the remainder from Community and other sources, for example the Youth Detention Centre, as shown in Figure 1.

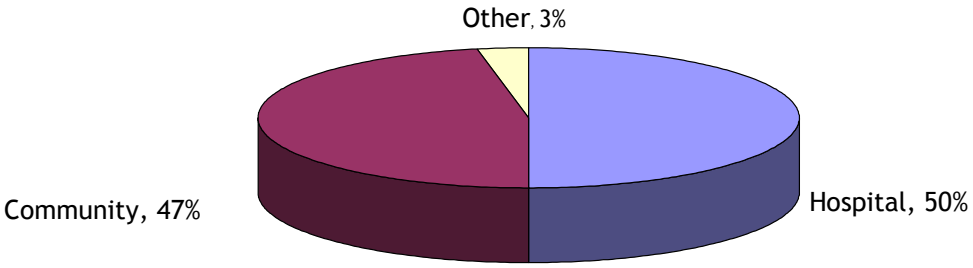


Figure 1: Origin of report

Significant numbers of reports were received from the following services Accident and Emergency departments, Adult Mental Health and Maternity Services, with smaller numbers of reports from eight other services including Paediatrics, Child and Youth Mental Health Services, Child Health, School Based Youth Health Nurses as shown in Figure 2 below.

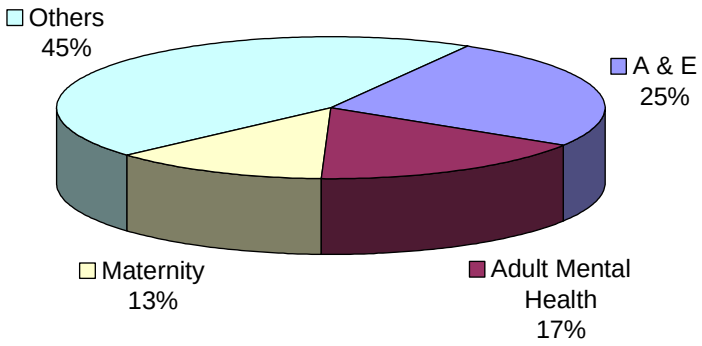


Figure 2: Specific Health Services

Professional stream: The reports were made by the following professional streams:

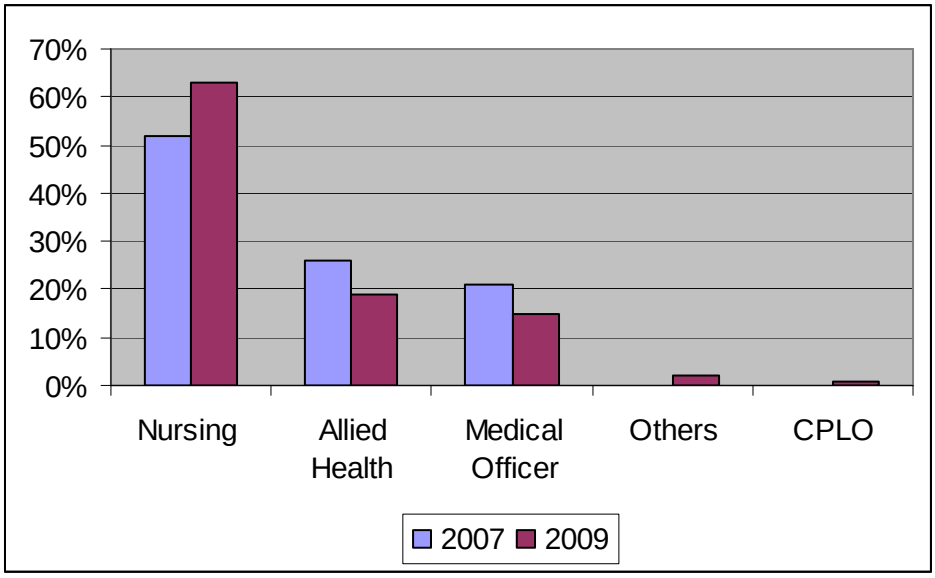


Figure 3: Reporters Professional Stream.

Aboriginal and Torres Strait Islander status:

In 2007 six point three percent (6.3%) of 0-17 year olds in Queensland were Aboriginal and Torres Strait Islander. [3]

Nationally, Indigenous children are more than seven point five percent (7.5 %) times as likely as other children to be the subject of substantiation of child abuse and neglect. [4]

In Queensland, Aboriginal and Torres Strait Islander children continue to be over-represented in all aspects of the child protection system, and this is reflected in the following:

- The Commission for Children Child Guardian Report: Child Protection System 2008-2009 reports that the number of Aboriginal and Torres Strait islander children subject to a substantiation of harm or neglect in 2008-2009 increased by eight percent (8%) compared to 2007-08.
- In this review, Aboriginal and Torres Strait Islander children represent twenty-three percent (23%) of total reports made by QH professionals to Child Safety Services. This demonstrates little variation since the 2007 review.
- Some sites had variable proportions of Aboriginal and Torres Strait Islander children represented between the 2007 and the 2009 audit, including:

- Charleville: In 2009 – sixty percent (60%) of reports in Charleville were Aboriginal and Torres Strait Islander as compared to forty per cent (40%) in 2007.
- Roma: In 2009 – thirty-three percent (33%) of reports in Roma were Aboriginal and Torres Strait Islander as compared to fifty-three per cent (53%) in 2007.
- Other districts demonstrated only minor variations in Aboriginal and Torres Strait Islander reporting.

Demonstrated a reasonable suspicion

- Seventy -five percent (75%) of reports were assessed as demonstrating a reasonable suspicion of child abuse and neglect.
- Of the twenty- five percent (25%) of reports that did not demonstrate a reasonable suspicion, the reports were from the following services:
    - Accident and Emergency services (33%)
    - Adult Mental Health services (25%)
    - Maternity Services (20 %)
    - the remainder of the reports were from a range of services including Child Health, Community Health, Population Health and others.

Legislation:

Section 191 of the *Public Health Act 2005* places a requirement that a health professional must provide the specific details about the child and suspicion of harm/neglect when making a report to CSS. QH have incorporated these details into the 'Report of a reasonable suspicion of child abuse and neglect' form (SW010).

Key findings from the audit of compliance to legislation include:

- sixty-five percent (65%) of reports included all details required by the legislation
- thirty-five percent (35%) of reports did not meet all legislative requirements by failing to document:
    - details of harm or likely harm
    - fax and/or phone details eg. the fax number or time the report was faxed to CSS
    - the name of Child Safety Officer spoken to as part of verbal reporting process.

Of the reports that failed to document all legislative requirements six point four percent (6.4%) demonstrated significant deficits, including:

- one percent (1%) of reports were forwarded to the District Child Protection Liaison Officer and not to CSS
- no age or date of birth of reported child.

One report demonstrated a greater than seven (7) day period between the verbal report and the provision of the report form to Child Safety Services. It is a legislative requirement that all verbal reports must be followed up with a written report to the Department of Communities Child Safety Services within seven (7) days, even if it is considered that the suspicion is no longer reasonable. [5]

Policy:

A recommendation from the 2007 audit led to several amendments to the report form. These included placing prompt questions in the free text area of the form to assist staff to articulate their concerns for the child in a more child focused manner. These prompts include the identification of risk and protective factors and requesting health professionals to identify any services where a child, young person or family may be referred for assistance. See **Appendix B** for copy of current report form**.**

In relation to the content of reports meeting policy, a comparison with 2007 review is shown in Figure 4.

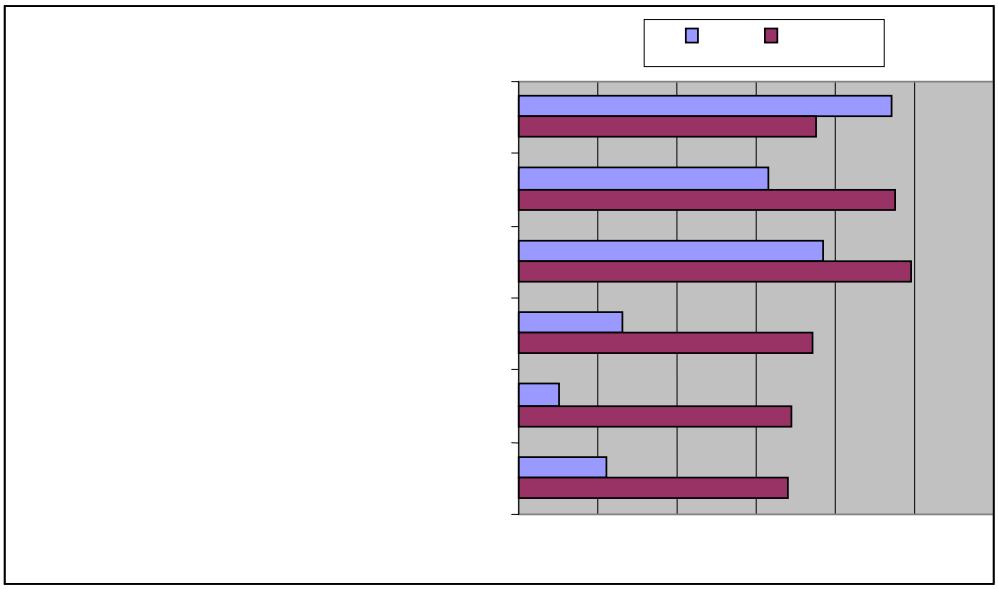


Figure 4: Elements of Policy met in SW010 Reporting Form

A policy requirement is that only one child is reported per form. This occurred in one hundred percent (100%) of the sample in 2009 as compared to eighty –two percent (82%) of the sample in 2007.

In eight reports (1.5% of the sample) QH staff made reports to CSS information that was provided to them by another person, for example another QH staff member or a person from another agency.

Section seven of the report form, '*Queensland Health's Response'* has not been interpreted in a consistent manner and therefore it is difficult to accurately reflect referral patterns or make any comments regarding the use of this section of the form.

In eleven reports (2 %), the screening outcomes were unknown as no record of these reports could be found in CSS records.

Discussion

A significant finding of this review has identified that staff from a greater range of QH services are considering the safety of children and young people in their clinical assessments.

An objective of the audit was to assess the quality of the information provided by health professionals in their written reports, with a view to identifying educational opportunities for development and improvement.

An area of concern is that there is a decrease in the percentage of reports that identify situations that meet the threshold of a reasonable suspicion from ninety-four percent (94%) in 2007 to seventy-five percent (75%) in 2009. It is important to note however that the audit only reviews the information provided on the QH '*Report of a reasonable suspicion of child abuse and neglect form*' (SW010), and additional information may have been provided by a health professional in the verbal component of their reporting.

Of the reports that do not demonstrate a reasonable suspicion, the audit identified the health service areas where these reports predominately originated, and these services include Accident and Emergency, Adult Mental Health and Maternity services. In many reports health professionals from these services had limited contact with a child or young person and were making a report based on the presentation of an adult and the concerns that this presentation may have on the safety of a child. The audit findings demonstrate that adult based service areas have an increased awareness about child protection concerns in their assessments of their adult clients. The findings support development of specific

resources to assist staff to articulate and identify parent's strengths and the impact that the ability of the parent to parent has on a child's safety and development.

Section 191 of the *Public Health Act 2005,* and QH policy, places a requirement that a health professional must provide the following details when making a report to CSS including:

- the child's name
- the child's date of birth
- the place where the child lives
- the names of the child's parents
- the place or places where parents live or may be contacted
- details of harm or likely harm of which the professional is aware or that the professional suspects
- the professionals name, address and telephone number
- details of child safety service contact, includes name, initial phone call & fax date & time.

QH have incorporated these details into the 'report of a reasonable suspicion of child abuse and neglect' form (SW010).

The audit findings have identified that staff are fully completing these details in sixty-five percent (65%) of the reports; a requirement is that this information should be fully completed one hundred percent (100%) of the time. Whilst staff may be providing the information as a part of their verbal report, there is a requirement to record all information provided to CSS and the sections on the SW010 form enable the information to be recorded by staff.

The age or date of birth of the child or young person is a significant omission as this information could assist in determining the vulnerability of a child, specifically the younger the child the more vulnerable the child is likely to be due to a lack of communication or motor skills.

A small number of reports were made by staff to Child Protection Liaison Officers (CPLO) which demonstrates confusion by some QH staff of the reporting processes and the roles and responsibilities of CPLO's within QH and Department of Communities CSS.

The legislation under *s192 Public Health Act 2005* specifically requires that written follow up notice of an oral report must be provided with seven days, and QH policy supports this requirement. On one occasion in the sample this requirement was not met.

The 2007 audit recommendations led to several amendments to the SW010 report form. These amendments included placing prompt questions in section five of the report form, '*Detail of the report'*, to assist staff to articulate their concerns for the child in a more child focused manner, including the identification of risk and protective factors and requesting health professionals to identify any services where a child, young person or family may be referred. See **Appendix B** for copy of current report form**.**

The 2009 audit demonstrates that staff have improved significantly in the information provided in this section. Improvements have occurred in the details of the child's condition, risk and protective factors, vulnerability and / or safety of child and the focus of the information on the child who is subject to the report. There remains room for improvement as a number of reports continue to identify concerning behaviours of the parent (e.g. mental health, drug or alcohol use) without referring to the consequences or impact of these behaviours on the child.

There has been a marked improvement in relation to legibility (with less then 2% of reports unable to be read) and only 5% of reports contain the use of "jargon, abbreviations or medical terminology".

In 2009, as occurred in 2007, there are a number of report forms that were not able to be located by CSS. The reason for this is unclear.

The detail and quality of the information provided by a reporter is critical to the quality of the decision-making by CSS. This audit demonstrates that there are improvements to be made in the quality of the information provided in the written reports made by QH staff.

The most significant area for improvement identified is in supporting staff to articulate their reasonable suspicions of harm as required by legislation and policy. The audit has identified the health services that are a priority for consideration.

Recommendations:

From the audit the following recommendation is made:

- Convene a working party of key stakeholders led by Child Health and Safety Unit and include Mental Health Directorate, relevant Clinical Networks, Child Safety Clinical Chairs, Child Safety Network coordinators, District CPLOs and Child Protection Advisors to:
    - Review and amend the current SW010 in relation to findings from the audit to improve reporting compliance.
    - Review current educational resources to support staff in their legislative reporting responsibilities, including the specific need for clinical areas

identified throughout the audit process i.e. Accident and Emergency, Mental Health and Maternity Services.

[1] ESTIMATED RESIDENT POPULATION by Health Service Districts (2008), Sex and Single Year Age, Queensland as at 30 June 2008 (preliminary) Australian Standard Geographical Classification (ASGC) 2008 Edition

[2] 'Child Guardian Report: Child Protection System 2008-09' Report available on the following link: http://www.ccypcg.qld.gov.au/pdf/publications/reports/child_guardian_report_08-09/CG-Report-2008-09-full.pdf

3 2008 populations by Aboriginal and Torres Strait Islander status were unavailable therefore estimates based on ESTIMATED RESIDENT POPULATION (2007), Office of Economic and Statistical Research.

[4] Australian Institute of Health and Welfare; Child Protection Australia 2008-09

[5] s192 Public Health Act 2005, [Online] available at:http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf