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TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE TIMOTHY FRANCIS CARMODY SC, Commissioner

MS K McMILLAN SC, Counsel Assisting
MR M COPLEY SC, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 1) 2012

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

BRISBANE

..DATE 22/08/2012

Continued from 21/08/2012

..DAY 8

THE COMMISSION COMMENCED AT 10.06 AM

DAVIES, CORELLE called:

COMMISSIONER: Thank you. Good morning, Ms McMillan?

MS McMILLAN: Good morning. Yes, Mr Selfridge will be here in a moment.

COMMISSIONER: Right. Otherwise appearances are as yesterday?

MS McMILLAN: Yes, thank you, Mr Commissioner.

Ms Davies, you remain on your former affirmation from yesterday. Now, I was asking you some questions about perinatal support offered to mothers through Queensland Health and you were giving us some details of that. Can I then move on to - are you aware of examples of babies being removed from a hospital shortly after birth by the Department of Child Safety point blank? Are you aware of those?---Yes, I am.

All right. Do you again from your own knowledge or from anecdotal evidence understand that this occurs where the mothers may have limited understanding or prior knowledge apparently of what's about to occur?---I have heard on occasions that has occurred. I do believe that they are limited occasions. Ideally we would have worked or the maternity service would have worked with the child safety officer around the plan to remove that child. We have now developed, I think, really good working relationships so that we don't have that traumatic situation of a baby being removed without prior knowledge so that the parents are or the mother is well aware of what's going to happen.

Again from your knowledge, is that knowledge imparted to her by Queensland Health employees or is it from the department?---Usually from the department.

In your experience, has there been an increase or decrease in the numbers of newborn children removed from their mothers shortly after birth in the last, say, 10 years?---I don't have any data, I'm sorry, to actually speak to that.

All right, thank you. Now, I wanted to ask you some questions - you would obviously be aware of the foetal alcohol syndrome which occurs in babies and then obviously later in life?---Yes.

As I understand it, it has intellectual impacts. It can have physical characteristics, is that right, facial features - - -?---Correct.

- - - that may be abnormal and, of course, there are other behavioural issues that occur and these are often not noted

until the child is perhaps what, eight or nine?---Possibly earlier, usually with engagement with the school system when those developmental or intellectual delays are actually identified.

Are obvious?---Yes.

Yes, okay. Now, does Queensland Health have any particular initiatives to deal with - I'll call it FAS?---I wouldn't call it a particular FAS program. It is more a developmental paediatric program so any child regardless of their diagnosis or the causation factors would ideally be identified in the early years against their developmental - have been assessed against developmental milestones. If we were concerned about the mother's behaviour during pregnancy which might lead to that diagnosis, then from a child health and the developmental paediatric perspective there would be more intense follow-up.

All right. Now, this paediatric follow-up - is that what you referred to yesterday in your evidence about these outreach services, the clinics?---Well, developmental is more, yes, the community based clinics. In some of our communities, especially remote communities, they can be an outreach service that's delivered not necessarily by Queensland Health but also through other agencies like the Royal Flying Doctor Service, et cetera, where we would hold maternal and child health clinics to actually provide those developmental checkpoints.

Well, that's what basically, sorry, I wanted to ask about, remote communities?---yes.

I'm particularly thinking of indigenous remote communities? ---Yes.

How available are you aware that there's this sort of paediatric service available to families?---My understanding is it is available, but it's never enough. There could always be more but what more looks like in our current environment is difficult to ascertain, but we endeavour to provide that universal service with appropriate secondary referral if we can.

When you say difficulty in understanding it in the current environment, do you mean the current budgetary constraints? ---Correct.

Is that your understanding?---And also the complexities of some of the communities. Queensland Health was involved or Queensland was involved with a Rio Tinto project some time back which was looking at reduction of behaviours in pregnancy of women especially around drug and alcohol use and the findings from that project were really - there were not anything we didn't expect, but we found that in the remote communities - and this was shared by Western Australia and Northern Territory also - that the message about reducing those behaviours or limiting those

behaviours during pregnancy for a better outcome for the child were positively delivered through a consistent care provider, so one that's known to the community and one that's known to the family. They were also delivered the best - - -

Sorry, what sort of care provider is that?---As in a child health nurse or an indigenous child health worker so we had consistency. So the fly-in, fly-out services when they're different people often have a detrimental effect to that relationship of delivering that positive health message.

And that would be logical, wouldn't it - - -?---Absolutely.

- - - because it would be different to build a rapport, I imagine, if you're seeing a different worker each time? ---Absolutely, that's correct. So they're more consistent in the care deliverer and the other critical fact of that was the elders of the community actually also taking up that message and delivering strong support to the young mothers about - that drug and alcohol was really not the path to go and how that's delivered in the community is very, very important and those consistent messages.

In terms of understanding the availability of services, particularly in remote communities, indigenous and otherwise, how would it be best to try to track those details? Would it be best, for instance, to approach the Royal Flying Doctors or does Queensland Health keep data? ---We have a data system that's shared across the north. The program is called FERRET.

FERRET?---FERRET. I'm unsure of what - it stands for something but don't ask me what the acronym stands for. It is actually a data-tracking system for immunisations and reminders of follow-up for children so we do have a system and we do share that information willingly with the RFDS services.

And there is no problem with the exchange of information? ---No.

So they don't have any difficulty, to your knowledge, of accessing the information, Royal Flying Doctors, from Queensland Health?---Not to my knowledge.

All right, thank you. We will no doubt follow up FERRET? ---Terrible.

Yes, all right. Now, can I ask you on a different tack: you would be aware, given your nursing experience as well as your current position, of injuries that fall into the abusive head trauma category. Now, am I correct in understanding that colloquially that's known as "shaken baby syndrome"?---Yes.

Am I correct in saying that it's really an excluding diagnosis rather than an including one? By that I mean

expert paediatricians exclude that it's not, for instance, an accidental injury. It hasn't occurred, for instance, by an older sibling, that type of excluding. Is that correct?---To my understanding, yes.

Right; and indeed one of the specialist paediatricians you referred to in the SCAN conference - which is attachment 1, Mr Commissioner, to this witness's statement - is Dr Sullivan, isn't it?---That's correct, yes.

Now, are you aware that apparently there's some evidence to suggest that babies and toddlers are more likely to sustain or die from a severe head injury at the hands of a parent that had been involved in an accidental situation such as a low-speed run over or drowning?---I can't proclaim to be an expect in that area so I couldn't validate that.

All right. Are you aware of any research in Queensland Health about understanding the demographics of parents who it's considered have perpetrated that type of trauma upon their children?---Not to my knowledge.

All right, thank you. Is there any specific initiative again undertaken by Queensland Health in this are?---Not from a policy perspective, but I know from a clinician-led research perspective there may be work done in that area from the expert clinicians in child protection. That's an area. I know that they have a professional development - professional support program that they link regularly around discussing cases.

So this professional support group, who is that comprised of?---In the past, when we first set up the child safety unit within Queensland Health we had an advisory group established which had clinical chairs from the southern, northern and central areas of Queensland and they provided that expert clinical advice to our policy development work. They also meet, and there will be other paediatricians who will be putting in submissions to the commission around their own professional development and discussing cases and presenting de-identified cases in terms of their own development.

So is this a formal initiative undertaken by Queensland Health or is this really a collegiate endeavour by, for instances, paediatricians?---It's a collegiate endeavour but we support it by funding the chair positions.

I see, right. Are they full-time positions?---No. Part of their clinical work is to provide that chair.

All right, thank you. Now, can I just ask this: in terms of - we've heard evidence already where you might have a presentation of a child perhaps at a Queensland Health site but perhaps another presentation through a GP and none of the presentations are in and of themselves to a level that they're a notifiable concern?---Yes.

Now, can I just ask you, is there any availability of Queensland Health to access data that GPs have and vice versa to again see whether there's a consistent presentation of certain types of concerning either behaviour or injuries or anything of that nature?---There's no shared data in that area unless the reports are made to child safety and then it would be made available to Queensland Health if we requested that information.

So it has to again emanate from them to seek data from you and presumably, if they were aware of what GP the child was seeing, to access that?---Correct.

All right?---I do understand there is an informal network, and again, the more qualified paediatricians will be able to attest to this, that there are a number of GPS - we provided our child protection adviser contact details to the private sector so they can be - if GPs are concerned about a child there is the availability of discussing it with a more expert clinician if they so choose.

How is that accessible to say a GP?---It's on our website, the contact details, but there are - at the local level we have child protection advisers in all of our hospital and health services and usually at a local level there is a relationship between the GPs and the paediatricians.

Well, I imagine too a number of them would be VMOs at the hospital too, wouldn't they?---That's true.

Including GPs?---In the more regional centres, yes. In the

more urban centres, not necessarily a relationship with hospital, but they have developed as a support network around children.

In terms of that can I just - VMOs are visiting medical officers, aren't they?---That's correct, yes.

So they're in private practice but they also do work in hospitals and are remunerated by Queensland Health for that?---That's correct.

Sessional work?---Yes.

Now, I want to ask you some questions about mandatory reporting, please. It's correct, isn't it, that after the 2004 CMC report it was recommended that mandatory reporting of child abuse be extended to registered nurses. Correct? ---Correct.

I understand - or did you understand that the rationale was that in rural or remote and indigenous communities nurses have more contact with children than medical practitioners? ---That's correct.

All right, and perhaps even, arguably, in metropolitan areas as well. You're nodding so I take it you agree? ---Yes, I agree, sorry.

Yes, all right. Now, it was also recommended that registered nurses receive appropriate training with their new responsibility. That was recommendation 6.14, Mr Commissioner.

Now, again, in the 2007 CMC review, the implementation of those recommendations, it was noted that it was partially implemented, with 90 per cent of registered nurses being sent information about the new mandatory reporting responsibilities and it was noted that Queensland Health was reporting as intending to provide training for registered nurses. With that introduction, firstly can I ask you are you aware of what training was provided to nursing staff?---I am. The unit that I was in charge of developed that training. It was certainly a challenge, because we're talking upward of 60,000 Queensland Health staff of which a significant component are nurses.

Yes?---We focused the training in the first instance on nurses who were dealing directly with children and families in their normal day-to-day work as the priority area for the roll-out. That's hence not the full roll-out that was reported, because all registered nurses, regardless of whether they work in aged care, et cetera, are still mandated under the legislation, but we focused, as I say, on the family - areas of family and child health first. We looked at what we needed to convey and also the ability to deliver that message in the most concise and consistent way to deliver a concise and consistent response. We developed what we call the three Rs of child safety reporting, which

was what were the responsibilities under the legislation, how to recognise child abuse and neglect and how to report. We developed a suite of resources around each of those, fact sheets, website, training videos, pocket booklets, a whole range of things.

So this is attachment 12 to your statement, I think?---Yes, it is.

The education module 1?---Correct.

So that was what was available both in hard copy?---Yes.

Was it available online as well?---It was indeed, yes.

All right?---We made that available to both public and private sector nurses, because under the legislation it's all nurses, not just nurses employed by Queensland Health.

Yes, okay, and have you done any quality assurance procedures to understand how effective it's been?---We have with the - we developed a consistent reporting form and our audit of the report form - and we've done three audits now - has been fed back to how we refine those training programs and the reporting process to elicit a better quality response from the nurses.

Other than that, have you done again any other follow-up to understand how well versed, for instance, nursing staff are in their responsibilities and understanding of mandatory notification?---Not more broadly than auditing the current reports.

All right. Now, can I just ask you; it's attachment 11 to your statement, in there, there is the snapshot and report of a reasonable suspicion of child abuse and neglect, form SW010. Now, that's the form medical practitioners and nursing staff, for instance, have to fill in. Correct? ---Yes, that's correct.

Now, it's not paginated, but I note that when you're reporting you're required to immediately complete the QH; that's obviously Queensland Health, form, this SW010, and it says you're required to telephone your child safety regional intake service, you're 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 and you are required to forward the self-carbonated copy to a nominated child protection liaison officer in your district. So from reading that, there seems to be three points of contact that a practitioner needs to make. The child safety regional intake service, is that by telephone, as I understand?---It's required in legislation to be a verbal report.

Then you've got to fax that to the same intake service? ---Yes. The legislation requires a written follow-up

within seven days of the verbal report.

Then you've got to file the original in the correspondence section of the child's record?---Correct.

Then send it to the child protection liaison officer in your district?---That's correct.

Now, firstly, why is it not, for instance, by email? One would think that was a far more efficient way to do that than faxing, for instance?---We would agree, but at the time of developing this our email system and the security of our email system was not considered sufficient enough to guarantee the confidentiality of the information.

One might argue faxing is - - -?---True.

- - - no more secure and perhaps less secure?---I would agree, and I think that that's one of the areas that we will continue to work on and develop as we move forward with the whole IT revolution.

Well, particularly with younger practitioners entering Queensland Health?---Yes.

They are so used to using obviously email and other social media sites?---Yes.

One would think that that was a fairly obvious solution, wouldn't you?---Can I say, and you might be shock, horror, a lot of our sites actually don't have email access. They have computer access but they are not actually Internet connected.

So if, for instance, then accessing that module might be quite difficult if you don't have - - -?---That's why we provided it in hard copy as well.

All right. So is it fair to say is that an ongoing issue? ---For some of our community health people who are out and about all the time, they're actually not connected to the Internet as part of their normal daily duties - they might come back to an office base at some stage during the day or even through the week depending on if they're in remote communities and travelling, so the Internet mobility as an issue in terms of delivering this information, so that's why we went down the path of the hard copy with a view that this information could translate into electronic format at a later date, but most of our information in health has started from a paper based system and then moved into an electronic base.

Because within hospitals a lot of the details are now kept electronically, aren't they?---No.

No?---The patient records are mainly - there's only a few sites that have the electronic records at the moment, hence one of our difficulties with the electronic patient medical record that's being rolled out nationally at the moment; not every site has gone electronic.

Is that more the tertiary possibilities - - - ?---Yes.

- - - because I think the electronic - they're bookkeeping? ---That's right.

In terms of that, just looking at that, what compliance have you got? That seems like a fairly onerous responsibility?---We've actually got good compliance.

Yes. What sort of figures have you looked at?---We haven't found there's been a problem with the process at all. The numbers of reports that have come from health to - from Queensland Health to the Department of Child Safety per annum is around 7000. So the feedback from our child protection liaison officers have been that they've found no difficulty. One of the issues has been the potential in fax form doesn't make it to the other end at Child Safety and we're not really sure why that happened, but however there was a verbal report. Probably, the duplication at the other end from Child Safety taking a verbal report and then receiving a written report has probably been where the confusion has happened; whether they're both consistent. So the aim of this was to ask the practitioner to complete the written report with a view to informing that verbal report so that we actually have the same information delivered.

But I suppose you know from your liaison officers, obviously staff consulting with them, but I guess you're unaware of what the percentage of compliance is with matters that might raise viable concern?---We are, yes. Correct.

Can I just ask you, have you been aware of a medical officer or a registered nurse receiving a penalty in relation to failing to report in - - - ?---Not in my time as a child safety director.

What do you think about the fact that it is a statutory penalty for not reporting and whether that's given rise to any risk averse to - - - ?---I think within the medical profession, I don't believe it creates a risk averse behaviour, but within the nursing profession I believe that it has created some risk aversion rather than risk, receiving a penalty or potential deregistration, that sometimes reports are put in that don't necessarily - if it was considered without the penalty may not have been put in, but I can't attest to how many that has happened with.

I suppose if the penalty was no longer provided for in statute, if a nurse, for instance, were found not to have notified a reportable concern then there are professional

disciplinary issues that may, in any case, ensue, may they not?---That is correct and I understand New South Wales after the Woods review did remove the penalty, but still continued with the professional assessment of the professional at the time who did or didn't report.

So in other words if your conduct was of a lesser standard, in your understanding they could still be effectively taken to task by their - - - ?---Absolutely, through their professional group.

Which would now be AHPRA, wouldn't it - - - ?---Yes.

- - - Australian Health Practitioners Registration Association. All right. Now, in terms of - do you know the number or percentage of inquiries to Queensland Health protection liaison officers that meet the threshold for mandatory reporting requirements?---I believe all of them meet the threshold because the assessment has been made according to the practitioner at the time viewing the situation and making a level of assessment. Whether they reach notification level Department of Child Safety we are tracking at the moment. In the first year of our review of the reports, we actually audited, in terms of compliance with the legislation, in terms of the information required to be provided and we also followed up with Child Safety as to what happened with that report to see whether they hit a notification level. It sounds terrible, doesn't it, but whether our report then triggered a notification and further assessment. The first year we hit 30 per cent reached notification level. We aimed the following year to improve that through education and training and more information to our staff around assessing appropriate risk of harm, risk factors, protective factors, et cetera. The second audit we reached 50 per cent, which we were very pleased about, and we continued. My aim next year was to reach 70 per cent. Unfortunately, the third year order we went back to 30 per cent. Anecdotally, I could attribute that to some bad outcomes from the mental health area where children were put at risk or were deemed at risk to parents with a mental health condition and we saw an increasing spike in the number of reports put in from mental health. So we go to risk averse behaviour happening as a result of a couple of bad outcomes, which were not necessarily predictable.

I'm sorry, I'm not quite following you. What were the adverse outcomes?---They were a death - two deaths of children.

I see. So death of a couple of children who were children of parents with mental health issues?---That's correct. Yes.

They had not been notified?---No.

Those issues had not reached a notifiable concern?---Or issues of the children hadn't been identified, but then we

did a major effort of education through adult mental health. One of the issues, especially in adult mental health, because we think of, you know, child protection is the child and youth mental health area, but parents with mental illness, the effect of their mental illness on their ability to parent effectively was possibly not in the domain of the adult mental health clinician. They were treating their patient who had the mental illness. What we wanted them to look at was the broader environment of their client and whether children impacted. For instance, a woman admitted with an acute psychotic episode, was anyone asking the question, "Are there children waiting at the gate of the school somewhere to be picked up?" So we've come a long way with looking at safety plans for children of parents with a mental illness and the COPMI, Children of Parents with Mental Illness Program has done a lot of work at the mental health area in identifying safety plans with relatives and friends around what will happen to the children if mum or dad's mental health condition escalates to the point where they can't look after them. The couple of cases that happened were the children were not seen as an issue because there was extended family looking after them, so they weren't considered, but despite them possibly not being issued, there were bad outcomes and it was - - -

COMMISSIONER: So the bad outcomes give rise to some other reporting in subsequent years?---Correct.

MS McMILLAN: Now, you used the phrase a couple of times "notification level". Is there a level?---There is according to Child Safety's assessment of the information that they receive. So all information that comes from other agencies, apart from - are considered reports. So providing any information, they then assess that report as to whether it becomes what they call a child concern report, so not requiring further investigation, or it becomes a notification level, which requires a level of intake and assessment to see whether there's anything more there.

They measure that against or they test the reports against the statutory threshold?---Correct. And their structured decision-making tool as a sort of decision or guide - - -

What about your report? Is this tested - - -?---Our report - - -

- - - against the statutory threshold as well?---No. It's tested against our having formed a reasonable suspicion that there is significant harm has occurred or will occur.

But you don't look at the other limb as to whether or not it's a viable parent?---That's correct.

You use the same definition of harm as the statute?---Yes.

You report it to Child Safety Services, your suspicions I mean - - - ?---Yes.

- - - under what arrangement, that is, why you report suspicions?---Because the legislation requires us to report submissions.

Suspicions?---Suspicions, sorry. A reasonable suspicion. Again, defining reasonableness and suspicion is sometimes a vexed question, especially with the different areas of abuse. So, for instance, I would say sexual abuse, physical abuse, we have clear evidence or observation that harm has occurred. In the area of emotional, psychological and potentially neglect, sometimes we don't have those actual diagnostic evidence, but putting the picture together and usually the suspicions are balanced with other information that the - - -

COMMISSIONER: I'm just wondering what the point is of you reporting your reasonable suspicions to the department if they don't do anything about them if those suspicions don't reach their threshold which includes a child's - the viability of a parent?---Part of the auditing was also matching, as I say, we reach 30 per cent notification level. What we found though is a couple of reports that we looked and we'd say - we in our team that looked at the report would say, "This probably wasn't really a report level," and when we've found out the outcome from Child Safety it has actually reached notification level and when we've questioned that, it wasn't just about the health information that was provided. It was about the other information they had from other sources which they could then put to that picture and then it reached notification level.

So I wonder - I would like your comments on this - whether or not it would be preferable for instead of reporting your reasonable suspicions which is a conclusion based on facts you report the facts to the department?---I would say part of the report form process is providing facts that have assisted in forming that suspicion.

That's not how your mandatory requirement is worded, is it? ---Not how it's worded, no.

That's what I'm asking you?---Yes.

Do you think it would be better because of the difficulties around what's reasonable and what's a suspicion and because it's an interpretation of facts, would it be better to leave the interpretation of the facts to the experts in the child protection system and make you report the facts, not the suspicion?---I would agree.

That way you would get no failure rate. You wouldn't get any false positives, would you?---That would be the aim, I expect.

Because you have just been reporting the facts and as to what they did with the facts was up to them and depending on the suspicions the chief executive formed based on those underlying facts?---Mm.

So he or she is responsible for forming a suspicion, not you?---I would think that would be a reasonable assumption.

MS McMILLAN: In terms of the concerns reported to the department, can I just ask you - we have heard some evidence that - and I think you commented that you had heard it through watching the inquiry of, I think, 60 per cent of reports to the department come from police, health and obviously education?---Yes.

Now, what do you see - and there's some concern, I think, being evinced about whether there's appropriate self-filtering, if you like. Now, obviously I'm only

asking you about health. What do you say about that?---I have had this discussion through the child safety director's network. I personally believe that the 60 per cent from professional reporters - I know we're focusing on trying to reduce that number, but I believe that especially through health and my colleagues in the other departments as well are doing a level of filtering, are providing a level of professional discretion to the reporting just as a result of our education, nursing and medical and social work backgrounds. The reports, yes, while they aren't all reaching notification level, are a valid information that needs to be provided to a system around a child and family. Now, where that information is collected is another issues for discussion, but I think that the professional reporting - whilst we're focusing on reducing that 60 per cent, I think that there is a level of professional oversight to those reports that needs to be validated rather than we can make that less and less. The 40 per cent that comes from the general public - I haven't heard any discussion around how we might more appropriately advise the general public about the role of child safety. My personal view is when we started back in 2005 with a new department that we called Child Safety we sent a very mixed message to the community around what this department was for. It not the Department of Child Protection. It was Child Safety. So a number of calls are around appropriate car seats, pool fencing, smoking in cars with children, children - a child being smacked in the supermarket. So there is a level of low-level reporting but all of those reports from the public also require that four hours of data entry that reports from professional reporters also require. So I think that the focus on reducing the professional reporting - yes, there needs to be more training and more understanding of risk and protective factors, but there's also another element of work for the department that comes from another area that is less controlled.

COMMISSIONER: I don't understand - sorry, I don't understand how the measurements even relate to each other. For example, why would you measure your success or why would the department measure your success with reporting against their test of a notification which includes completely different considerations. For instance, your act requires you to report reasonable suspicions?---Yes.

Their act requires them to assess information that the chief executive becomes aware of to see whether or not the child is in need of protection. They're completely different questions. Whether a child is at the risk of harm or being harmed or has been harmed is one question? ---Yes.

And that's the only question that you has to ask yourself to form a reasonable suspicion?---Yes.

Whereas the department has to ask itself that question and another question: is the child in need of protection as a

result?---Yes.

So I don't understand why you measure one against the other because one is an apple and one is an orange?---Sorry, I'm not understanding why you mean measure against.

You say you only need 30 per cent. You must meet 100 per cent of your legislative requirement. You only need 30 per cent of the threshold?---We meet 100 per cent of our legislative requirement.

Yes?---So the 30 per cent we're looking at is 30 per cent have met the legislative requirement of the next department so they've met the next door.

Why do you care?---They've gone through the next door.

Why do you care or why does anyone care whether your reasonable suspicion ended up being an actual notification standard because it sounds like you are failing in the sense that you're not hitting the notification level all the time, but why should you have to? You're not asked to by the legislation?---No, we're not so from - in terms of auditing the quality of our reports we would look at - 30 per cent of the reports that we put in ended up with reaching notification level. The other 70 per cent were potentially people, or that's the way we've looked at it, who didn't actually require that knock on the door or that phone call or that follow-up from child safety. Again I agree with what you're saying that it's not necessarily a measure of failure and success, but by auditing our report forms and seeing was the information - because sometimes reaching notification level was about the clarity of the information that we provided. So if our information was jargonistic and didn't make any sense to the child safety officer at the other end who's inputting it into their system, then the onus was on us to improve that information. It wasn't about getting it in as a notification. It was just about clarity.

That's what I mean If you just report the facts without any value-adding or interpretation, maybe that would be a lot clearer to the people - - -?---The frustration is, I suppose, 60 per cent of professional reports don't reach notification level and I do agree with you, "So what?" but in terms of workload and the impact on the Department of Child Safety as a result of that 60 per cent that has been targeted and is an area that we need to continue to work on.

The complaint can't be against the reporter. It must be against the legislation that requires the reporter to make that report?---And that has been our position, that we are fulfilling our legislative requirements by doing so.

But what the department is saying is it's costing us money to investigate those reports that don't reach their threshold?---Or to input that data, but then on some

occasions inputting that data has then added to a cumulative information base that has come from education, police, community sources that then gives that department the richness of information they need to actually make appropriate decisions about that child and family. So there's pros and there's cons in terms of workload and budget versus intelligence around the decision-making coming from all sources.

The other approach would be, as it stands, they have got to assess or at least collate the information they get form all the mandatory and discretionary sources?---Yes.

It costs them four hours per report apparently and the concern seems to be that that can be waste from their point of view because it doesn't mature into a notification. That's not to say the information they got is not useful in another area or would have had to have been collected anyway at the cost of four hours per report. Another way to beat the problem might be instead of getting you to report the facts or suspicions simply for them to plug into your system to see what you have got when they want to rather than you giving it to them when you want to or when you have to?---True, but would that negate the legislative requirement to report then?

Yes, you would have to change the legislative requirement and you would only do that if you trusted the department to check regularly?---True.

But that's their job. The question is how much of their job to protect children who need it; not children who don't but children who do?---Yes.

That's their job. How do they identify those children? At the moment they do it with your help?---Yes.

And they do it with help from all sources. What I'm asking is: would it be better if they simply help themselves and had access to the information that would allow them to draw your own conclusions and simply have access to the information you have? Instead of you giving it to them, they get it from you?
---But how would the child be raised with them?

Sorry?---How would the child or family be brought to their attention?

You put it into your system and at midnight of every day they have a look at your system to see who's new on the system?---Yes, I would've thought that would be more labour intensive going through the thousands - I'm not sure what sort of system - - -

You would put it in a special folder or something?---Yes.

They would just interrogate the folder, wouldn't they, and you would put it in under "child at risk" and you would

have it under the child's identifier and that would be apparent in that folder for that child, "This child has been reported 16 times before" or "It has got 16 entries in this folder. We may have to do something proactive here because although none of the 16 have reached our notification level, the 17th might and we better stop it from happening before it does"? Wouldn't that be possible?---It could be possible from an IT perspective. I think that's quite advanced thinking and, as you say, the ability to find within a huge information source - because I'm assuming it wouldn't just be from health. It would be from education. It would be from police as well.

It would be nice to have it all centralised if everyone sent it to a centralised folder and then you would have one folder per child with a number that records all the information from health, education and all the allied welfare agencies pertaining to that child that was accessible on an updating basis to child protection. Wouldn't that be more pre-emptive and preventative and proactive than what currently happens?---Yes, it sounds reasonable in thought. In application, I'm not sure how it would actually work.

I'm raising it so that people can put holes in it if it has got any?---I think again it's about that we would end up with, as Ms Mulkerin said yesterday, quite a lot of white noise in trying to find the child.

No, you get rid of the white noise. Just give them the red noise and then they can use that for whatever purpose they think it would be useful for protecting children who need it and not spending time protecting children who don't need it or looking to see whether or not - I don't think you can avoid investigation?---No, not at all.

But what you can do is you can limit your investigations. You can narrow and be more targeted towards investigations that will ultimately end up in substantiation. That's what they say?---Yes.

They say it's not just a matter of your reports or their notifications. It's that the notifications have trebled in 10 years but the substantiations have not. So the measurement of success of a tertiary intervention system must be how many substantiations are there and is that a fairly stable number and then the next question is how many have they substantiated. Children in need notifications need to be cared for by the system and for how long? ---Mm'hm.

So there are two questions?---Yes.

Who is in need of protection? Then the question is: how long do they need it for and what will we provide? They're about the only three questions the department needs to ask?---Mm'hm.

It gets lots of information. It's being treated as though it's a repository for everybody's concerns and because they focus attention on doing that because they have been given it, the parcel is with them when the music stopped, they are running out of resources to actually look after and care for the children who really need it because they have spent so much time and energy working out who doesn't need it?---Yes.

Do you know what I mean?---Yes.

MS McMILLAN: Can I just ask you did you do some auditing with Child Safety about what matters didn't reach the notifiable level of threshold? I'm meaning particularly issues relating to emotional harm?---We did and, as I say - - -

What did that indicate to you?--- - - - we got mixed responses that - things we that from an auditing point of view we would have said, "That's quite a low-level report," actually were substantiating notifications because of the range of the other information.

All right. So there's that, but also in terms of things like emotional harm which arguably are more difficult to discern than obviously physical harm and perhaps sexual harm - - -?---Yes.

- - - was that an area that you found in an audit was that Child Safety weren't considering it reached a notifiable concern because it related to issues, say, of emotional harm, whereas from Health's perspective that was a very significant issue and warranted the Department of Child Safety looking further at it?---Yes, I would agree. I think that will always be an area of contention between Health and Child Safety. Emotional, psychological abuse and concerns from a health professional's point of view don't necessarily trigger a response in the statutory system so harm - what we can see as - what we would diagnose will have long-term harm like yesterday when we were talking about newborn babies don't necessarily trigger a response from Child Safety in terms of a child in need of protection. So that is an area that we continue to work with Child Safety on in terms of education and training, fact sheets, practice papers to try and push back into that that emotional and psychological damage is just as damaging as physical and sexual abuse.

Why do you work with Child Safety on that issue? That's not their job, is it?---No, in terms of them determining whether a child is in need of protection and understanding of the harm that has been - - -

So this is a child who doesn't have a viable parent?---Well, even in assessing the viability of the parent in terms of the impact of that parent on the child it may appear that the parent is viable, willing and able but to the detriment of the child. So, for instance, there's a

series of assessing a baby, as we talked about yesterday, in terms of their long-term - their development is harder for non-skilled, non-clinical officers such as child safety officer in the health area to actually make that diagnosis about what's in the best interests of the baby versus, "We've got a mum here that's really caring," but we're seeing a baby that's not developing appropriately. So we would say harm has occurred or is occurring or is going to occur and we would put in a report on that. Whether it triggers a level of investigation is based on the knowledge and skills of the person doing that assessment as well.

Again it seems to me that that's just a legislative (indistinct) the legislation doesn't understand that you know more about the ability of that parent to look after that child because you know more about the nature and consequences of the harm that the child suffers?---I would agree.

Okay. So all you do there is for long-term emotional harm instead of you reporting the facts because they won't mean as much to child safety as they mean to you - - -?---Yes.

- - - that's when maybe you do report your suspicion or conclusions and you tell them not only that it's harm because they won't say, "Harm equals no viable parent as well"?---Yes.

You say, "Not only is this child at risk of harm or has been harmed of this sort but the parents are not going to be viable either. You're not going to have a viable parent either in respect of their harm for these reasons." Why wouldn't you just do that?---We do.

I thought you said you had to work with the child safety people trying to educate them about how to work out what long-term harm - how that impacts on the ability of the parent to look after them. Why not skip that step and just - you're the experts in there. Why try to educate somebody who is never an expert on it?---Because ultimately we're not the decision-maker about the child's - whether the child's in need of protection or not.

No, I know, but if you say to the chief executive, "Look, this child's got this category of harm"?---Yes.

"This is the characteristics of the parent. We think, looking at the harm and looking at the parents, you have no viable parent. We think it crosses your threshold"?---Yes.

Over to them?---Yes.

It's up to them to make the call?---Yes, and they do.

Okay, good, but they have made the call based on your helpful analysis?---They have, yes.

So that's all they need, isn't it? They don't have to make

a re-analysis of your analysis?---I'm sure the clinicians will have more to say, but sometimes the decision isn't necessarily the decision that would be supported by that health diagnosis.

Yes, well, that's what I thought. How do you resolve the cultural difference between departments on these issues? ---We continue to work with them around - - -

What does that mean?---Well, because to help you to understand my perspective, we consider that education and more information is what is required to convince you that my view and my diagnosis and my seeing of the case is the appropriate and right one.

Why? Why is giving somebody more information who you think has already got enough going to help?---Yes, because - - -

Why is that going to help? Shouldn't it be, "Look, you need to respect my opinion more. I'm the professional here. You need to give more respect for what I'm telling you," rather than you saying, "Let me give you more information"?---I would agree with that, but that, "You need to respect me," hasn't gone very far, hasn't gotten us very far, in a number of instances.

Well, that's where legislation might help?---Yes.

It might give your opinion some underpinning, some strength and power that you can't give it yourself?---Yes, I would agree.

MS McMILLAN: Because what I was asking you, doesn't say an expertise - say a mental health nurse with say 30 years of experience, going to value add sufficient - well, one would think greatly to information imparted which might assist in evaluating it to let's say a 22-year-old child safety officer trying to evaluate and understand what the harm posed is?---Correct.

So that (1) you might - your education may well assist in getting them to ask the right questions, so that, "Who is the extended family? Has mum had psychiatric issues before?" So get them to ask the right questions but also understand what the data is that you're giving them, because it may not be readily apparent, may it not - - -? ---In the written word.

- - - to a registered child safety officer?---Yes. Look, I agree, and - - -

COMMISSIONER: It seems to me to be double handling. See, why don't you just become the agent of the department for the purpose of making the call as to whether or not that child needs protection?---I would think that some of our clinicians would agree with that, but we have - - -

That way you've made the decision and therefore so has the chief executive?---Yes.

Game over?---We have vehicles such as the SCAN committee.

MS McMILLAN: I want to come to that, yes?---Yes, but in

terms of that information, the SCAN forums are just those very forums to bring together the highest level of expertise of all agencies to look at a child, look at a report, look at the information, and I have to say, from my discussions with some junior child safety officers, they consider SCAN to be a valuable source of information to them to help them with that decision-making. The more senior the child safety officers the more exposure and more experience they've had in seeing and asking the right questions, but they still can come back and ask their colleagues in SCAN, "What are we seeing here and what do we need to do? What questions do we need to ask, what are we" - and you've got education, police and health all contributing their expertise at that group. So SCAN is absolutely invaluable in that area, and I know we're going to come to it in a minute, but it's an area that's probably been diluted a bit.

All right. Can you tell us what the Queensland child protection guide is?---The other states moved to this quite some time ago, and overseas. We looked at - we had the structured decision-making tool for child safety officers, so an actuarial tool that would guide consistent decision-making within child safety to stop the variations in decisions.

You say "we", is this the child safety directors?---Child safety directors, yes.

Yes, right?---Sorry - that how do we then actually guide in a more structured and consistent way the reports that are coming to child safety without all the agencies using their structured decision-making to which was very much around their legislation, the Child Protection Act. So other - you know, because reports come from everywhere, from community members, from child care centres, from GPs, we looked at a range of, "How do we all consistently understand the definitions of harm, abuse? What does that mean?" because we were all working from our own understanding of that, and when we apply it to - when we see a child and family we're applying our own version of that, if you like. So the child protection - actually a reporting guide was developed through a research centre in America, introduced into New South Wales collaboratively amongst the four partner agencies of health, education, child safety and police and we have adapted that for Queensland and piloted that guide in the Gold Coast and the south metro Brisbane. It provides a - I look it more as an education tool as well as a guide, because every time - if I was an inexperienced registered nurse, just come two years out of my training, I could run through that guide and understand what those definitions mean and plug in various information about the child and family that I'm seeing and it can guide me, so, well, does that reach a threshold for a report, as in significant harm versus needs to be referred off to a community support agency, et cetera.

So it's a prompter as well as a recording of - - -?---It doesn't record, no.

I see?---As soon as you put the information in it's not saved anywhere. So there's no child name to it. You run the guide. You can print it if you want and put it into the child's file as your decision-making framework, but once you close down the program it's then gone.

Wouldn't it be good to dovetail that, though, so it could in fact form part of this SW10 child report if you could save that information? It would save you doing it twice then, wouldn't it?---It's not mandatory to run the guide.

I see?---For people who have had 20-odd years' experience in child protection they don't need to run the guide. It's more for the inexperienced or for the grey areas that we're not quite sure and we need to have some - - -

All right. Do you have any - - -

COMMISSIONER: Sorry, I'm going to ask you a question here?---Yes.

Are you telling me that the reports that you make, your department makes, to the Child Safety Services, can be made by somebody who needs the guide?---Yes, because they're registered nurses.

Right, and does the - but why can't they, instead of doing it personally as and when they think they see it, report up the chain to somebody who can actually make a report on the department's behalf as, you know, the qualified reporter? Wouldn't that weed out - wouldn't that be an opportunity to filter reports that didn't need to be made, didn't need to be spent - didn't need to take time and money being spent on over in safety services?---Yes, I would agree, but the legislation does not permit us to do that at the moment.

Yes?---Yes, so that was one of the things I would be suggesting, especially for the areas of emotional, psychological and neglect - - -

Precisely, and then, instead of just reporting to the department I wonder if we could look at the legislation actually authorising you to be an honorary child service officer for the purposes of actually making - deciding that that has crossed the threshold and that needs to be investigating, not just giving more - see, we're drowning in a web of words here?---Yes.

We've got guides and we've got information about how you make a decision instead of somebody actually making a decision and getting it close to being as right as possible as often as possible. We keep drawing targets and no-one is firing at them?---Yes, and I would argue we have a level of expertise in all of our health services that could actually provide that direction.

I can't see why you can't be authorised agents for the department for the purpose of making the decision in respect of emotional harm, psychological harm, but not in respect of other things, maybe.

MS McMILLAN: In fact, that may assist, mightn't it, for instance, in remote communities where you have a clinician or nurse on the ground but you don't necessarily have any departmental, Department of Child Safety, officer personnel there, so that if they were delegated to do it then you've got someone on site and also available after hours, because in your experience that is a difficulty, isn't it, that there's crisis care?---Yes

You can phone in, but there's not personnel available to come out after hours and make a decision. Correct? ---Correct.

Yes, all right. Now, can I just ask you, what feedback have you got about the effectiveness of this child protection guide?---We've had very positive feedback from our staff. They actually like it in terms of its education value and I think the more - some people have actually formed their suspicion and they use the tool, the guide, to actually validate that decision, which is again to report or not to report, and I think - because one of the things we've always queried is we actually - the legislation doesn't give us permission not to report. It is very much about reporting, and that decision not to report is a really hard one to make when there's a penalty and there's a legislative requirement to report. So I think the guide, to be able to stand up with my peers as a registered nurse and say, "I ran the guide. This is the information I had and this is the decision that was - it did not reach the level so therefore I did X instead of that."

I suppose you've got to balance that, though, against clinical judgment and intuition?---Yes.

That you don't get locked into effectively a tick a box? ---That's exactly right, yes, and that's why we've said it's not mandatory, because there are very experienced people. If it helps, though, clarify the information that we're providing to the Department of Child Safety then that is also a good thing.

All right. Do you know how many care treatment orders have been made by medical officers over the last say five years? ---Approximately 20 - well, my knowledge is about 20, 21 in five years.

So not very many, obviously?---Not very many.

Are you aware of, if you like, tensions between, again, the different legislation? So we know, for instance, that they make - it used to be 96 hours but 48-hour orders. Correct? ---Yes.

Again, because of your legislation it doesn't take into account whether there is a parent willing and able. Correct?---Correct.

Are you aware of tensions, or at least challenges, between that interface if say a child is held in that order for 48 hours and whether that interface is properly and seamlessly occurring then with child safety?---To my knowledge, because we rarely use it, one of the requirements in taking the order is that child safety is notified immediately because we've seen - or there's significant risk or imminent risk to the child.

Yes?---My understanding is that we have - I haven't been advised that there are any issues with that.

Would you consider, though, one of the difficulties might be if you've only got 48 hours and you take the order, then by the time that gets to the department, they decide whether they're going to investigate it, the child is pretty much close to if not discharged. Correct?---There is potential to extend if we haven't resolved that.

But even then, that's not a long lead time, is it?---Usually we get a good response, though, from child safety.

Do you? All right.

COMMISSIONER: Sorry, how many reports does the health department make, or did the health department make, in the last financial year?---The ordinary reports?

Yes. The mandatory reports?---7500. That was from public health, the public health. Out of total health sources it was 13 and a half thousand, or approximately 12 per cent of the total number of reports to child safety, and that 12 per cent has been consistent over our data collection period.

MS MCMILLAN: Now, I want to turn to - - -

COMMISSIONER: Thank you.

MS MCMILLAN: I'm sorry, Mr Commissioner.

COMMISSIONER: No, that's fine.

MS MCMILLAN: SCAN teams. Now, it's correct, isn't it, that they were introduced in 1980 and up until a number of - fairly recent times, they were chaired by health. Is that correct?---It depends. I think - it was before my time, but my understanding is that the chair was decided by the group.

Right?---So it may not have been health.

Right, but now it is chaired, is it not, by a member of

child safety?---The legislation dictates that child safety is the lead agency in SCAN so they provide the coordination function and the chairing function.

All right. I'll come back to that in a moment. You would be aware from the 2007 CMC review again of the 2004 CMC inquiry - page 14 of that report, Mr Commissioner - noted a fundamental conflict between the then Department of Child Safety structured decision-making tool and the SCAN team, effectively suppressing the referral of cases to SCAN teams and thus eliminating the benefits associated with inter-agency case management. What's your view? Does that conflict still exist?---I think to some extent, yes.

In what way? Can you expand upon that?---I think - well, from the feedback I've had from SCAN members, the value of that interagency discussion around the child and family doesn't necessarily contribute to the child safety decision-making in the current format and I'm not sure how or why that's happened over time. I think as child safety - and this is just my opinion - has become increasingly stressed in terms of resourcing the time to - referrals to SCAN, their discussions, the backwards, the forwards, et cetera, is seen as an administrative burden, potentially, and the value of all of the agencies and the professional contributions that all of the agencies can make in the deliberations around that child and family and the recommendations for how to, you know, secure that child's safety or to work with that family around securing a more safe environment are not necessarily considered as they were in the past.

So what you're discussing - is this what you're saying, that SCAN isn't necessarily funnelling through to the decision-making process of the department?---The decision-making process of the department is very much dictated by their application of their legislation.

Well, surely then that very much undermines the utility of the SCAN system, doesn't it?---And some of our clinicians would argue, yes, it does.

Because isn't that, you mentioned before, a very important tool, particularly to inform and assist decision-making, particularly if you've got an inexperienced child safety officer?---Yes, I'd agree.

Or a very complex issue?---Yes.

For example, mental health issues?---Yes.

Or I took you before to what is known as a shaken baby case. One has to be very particular with the facts in that sort of situation and the diagnosis. Correct?---Yes.

So therefore what is you view, given also now that child safety chair that, the SCAN committees, how effective are the SCAN teams in the current age?---Look, in my role as

child safety director for Queensland Health I've had varying reports from varying teams, some that are functioning very well to some that aren't functioning as well as they could. My personal view is that these teams are very relationship based and where we have good, functioning relationships with good, respectful behaviour to others and that they equally come to the table as valuable contributors in the plan for that child and family, then we have excellent functioning teams. That doesn't necessarily happen in every team and also, depending on the resources and the level of seniority of, for instance, the members from child safety. In the past we were seeing because of the high changeover of staff in child safety we had some very junior members coming to the table and I think if I was to put myself in their shoes, I think, you know, coming up against a senior police officer and a senior guidance officer and a senior paediatrician of 20-odd years' experience, I would be feeling very vulnerable in that situation with my limited experience. I think we've moved over time to having more senior members on SCAN from child safety which has aided in the stabilisation of those teams. The review that was done recently and the reformatting of SCAN to only look at notifications, as I think Cameron Harsley in his evidence the other day spoke about, a sort of dilution of the SCAN process, we were seeing hundreds of cases versus probably a very limited number of cases now.

Well, surely if it's only notifications then they've already decided to investigate?---Yes.

Wouldn't you see it as assisting further, particularly if you've got a number of concerns, child care concerns, as they're termed by the department, from education, from the police, perhaps from health, to then whether that gets to the level of a notification?---The provision in the revised SCAN process is that we have information coordination meetings whereby any member agency can raise an issue about a child and not challenge the decision of child safety, but question has all the information been considered, have all the partner agencies provided their advice?

Yes?---To my knowledge, I don't have a lot of information around the effectiveness of ICMs. I have been told by a number of people that (1) they're working fine, others, they're not working very well. So we don't really have consistency.

So ICMs are departments meeting, so if you've got a piece of information that you're quite concerned about, it hasn't reached the notification stage so it's not going to SCAN, you can nonetheless apparently convene a meeting, is that right, under this ICM?---That's correct, yes.

With say the police department and education?---Yes, and you can include other agencies who might be involved with that, like housing or non-government organisations. It's not bound - the ICM process is not bound by the membership

of SCAN.

Right, and you say it's variable as to your understanding of how effective they are?---Yes.

All right. Now, can I just ask you, in attachment 4 there was a paper given by Jan Connors on consensus. One of the things was, "Can we not agree to close a case because we are unhappy with the response? Can we disagree with child safety's assessment of the situation?" Obviously it must be an issue that's live in terms of disagreements between say health and the department as to whether to close a case?---Yes.

Or what further action. Is that your understanding?---Yes, I agree with you, it's a live issue, because the decision to close cases isn't necessary comfortable with some members. As in any group, obviously a consensus approach would be ideal, but in some instances the criteria for closure have been met regardless of people's reservation about closing so therefore the cases are closed.

And the fact that it's chaired by Child Safety, does that have any impact in your understanding of that process?---My understanding is, yes, it does because it's very - obviously if it's administered and chaired by a department then the - and I'll use the word power differential - rests with one department over the others. I know in the past we have floated, when we were looking at a revision to the SCAN system, the potential for an independent chair, for example, to actually balance out that power differential so that all departments and the valuable information that they would contribute would be considered equal rather than one department deciding over another.

So who suggested that?---It came up through the SCAN review and through Child Safety directors we floated the idea. I'm not really sure what happened as to why we weren't - I think it was a resourcing issue and also we pondered who would have the appropriate skills to be an independent chair. I think at one stage we talked about the Commission for Children providing the independent chair, but again the resourcing. Knowing that that's a central Queensland agency, the commission isn't spread out across the state, as Child Safety and the other departments are, however, we actually do that.

Yes?---But I do believe it's worthy of consideration moving forward.

The last thing I just want to ask you a couple of issues about mental health. We know that there's a part of health that is devoted to children and youth, isn't there? It's called the Child and Youth Mental Health Service, surprisingly?---Mental Health Service, CYM.

Now, in relation to children, you would be aware that under the Mental Health Act in relation to adults, there are significant procedures, for instance, about medication, when medication can be administered, particularly if it's not voluntarily - - - ?---Yes.

- - - or treatment and obviously restricted activities. Now, I'm correct in saying, is it your understanding there is no such protection, is there, in relation to children and youths, statutorily, in terms of certain consents being obtained and certain thresholds having to be met in order to administer, for instance, treatment like ECT or - - - ?---It's usually with the consent of the parent or guardian.

All right. In fact, if they're not, to use the commissioner's word, viable then do you think there should be statutory enshrining of children's rights in relation to mental health treatment?---I can't attest to being an expert in this area. I think we haven't usually - there was one case that was brought to my attention whereby the Mental Health Service felt the guardian was not acting in the best interests of the child and that was elevated to the child guardian to actually potentially intervene and become the guardian of the child because the parent had

significant mental health problems themselves. So I'm not sure how - I have no thoughts as to how we might change that when we've got that provision in existence at the moment.

All right. Yes, thank you. I have nothing further.

COMMISSIONER: Thank you. I've just got a couple of questions before I call on you, Mr Selfridge.

You know those 40 per cent of discretionary reports which probably have a high level that don't get to the notification stage - - - ?---Of the health report?

No. You and the other mandatory reporters make up 60 per cent of - - - ?---Yes, yes.

- - - reports to the department?---Yes.

The other 40 per cent come from the public - - - ?---Yes.

- - - or other sources, non-mandatory sources?---Yes.

What do you think about this that instead of trying to educate everybody about what harm is and when a child is in need of protection because that's hard enough for the experts - - -?---Yes.

- - - why not just get everybody to report to a central bureau, like a telephone hotline, everyone who's got a concern reports to this hotline, the hotline - and it's manned or staffed, sorry, 24 hours a day or whatever by people have been trained and experienced in child protection and might be former workers or something like that who act as filters for the department and say, "Yes. Well, thanks for your concern. That's not going to make muster. We'll report it on - we'll farm it out to the right agency," but child protection isn't the right agency, except when it is, and then passes it on as filtered report, a value added report, which is more likely to make notification. What do you think about that idea?---Can I say I agree. I think that - and I've mentioned when we looked at - and as Ms Apelt said the other day, having sat with workers putting in the information that takes up to four hours, my question was, "Why don't you have" - this is sometime ago through the Child Safety Directors Network - "someone on the phone who's actually screening whether it's about a car seat?" and all the rest of it, but the concern was we might miss something.

It mightn't be that - - - ?---That's exactly right. It was about how do we manage the workload. So our process has overtaken - and our risk averse process, and this is my opinion - our risk averse process of capturing everything is standing in the way of actually being able to do the right thing, so why not have a receptionist who can answer the phone and say, you know, "Children under 10 to the" - - -

It's like having a shark net that's full of other fish - - -?---Yes. And you can't find the shark.

- - - and the shark is swimming around it?---That's right.

What you need to do is make sure your net catches what you're after not everything else?---But then I've had some senior child Safety officers with long years of experience say some of those most insignificant calls have ended up in some of the most significant harm they've ever seen.

And they might at some point in time?---Yes, yes.

The question for the department is, really, it's a simple one. As it's currently designed - and it's a simple question - not, "Am I out there to protect all children from harm or not?" It's, "Is this child, this particular child, currently in need of protection?" That's its question?---Yes.

The statute tells it how to work that out and then it tells it what to do if it does decide that that child is in need of protection. It seems that everyone is so in the broader system - I mean, child protection is a system that can be defined narrowly or broadly. There should be a government funded system that protects all children all the time, if that was humanly possible?---Yes.

But the Child Safety Services part of Communities, Child Safety and Disability isn't that agency at the moment, but yet it's spreading itself too thinly, it seems to be doing lots of other things that's not strictly within its remit because nobody else is doing it, but it needs to be done. Do you agree with that?---I would agree.

All right. The other thing I wanted to ask you is coming back to those babies who are taken from their mothers?---Yes.

Just remind me of what you said about that?---If it's decided as a result of a report of an unborn child that the baby or the home environment or the mother's ability to care for the baby - it's usually hopefully decided prior to the birth of the baby and a plan is put into place whereby we would be notified or the maternity service would be notified by Child Safety of their intent to remove the baby following birth and I think we work quite closely through our child protection liaison officers with the department on that. We make sure that we've got appropriate social work support for the family. We make sure that the mother isn't placed in an open ward where we could end up with a terrible event of people coming and taking babies from unknowing mothers; that the mother is aware of this before this happens and, yes, it doesn't make it any less distressing, but we have it in the most controlled environment that we possibly can. So usually those babies - there's some decision that has been made that there the baby would not be safe if it was to be discharged with the

mother, so the baby is usually taken by Child Safety and placed in foster care after birth. There are a number of occasions - it's not frequent, but there are a number of occasions where those decisions have been made.

They're made on the basis of what sorts of risk indicators? ---Usually the mother's ability to mother and an example would be a mother with a mental health condition or an extreme intellectual disability and has no external family support for that baby.

And there's no other parent around?---No. One mother, which I was just talking about this very morning, had something like 17 different partners during her pregnancy. She had an intellectual disability and the decision was made to remove the baby and place the baby in foster care post the birth.

She had a mental disability, did you say?---An intellectual disability.

Intellectual? But you would tell her that?---Yes.

Did she have a guardian?---I'm not aware. I'm sorry.

How does someone with an intellectual disability understand what's happening?---It depends on the level of the intellectual disability.

How do you satisfy yourselves that they do understand? ---That would be up to the individual clinicians and sometimes the message may get through and sometimes the message may - - -

Is that a question that has to be determined before the child is taken?---In the best interests of the child, not necessarily.

So whether the mother understands or not removal is in the best interests of the child according to the expert person then that's what happens - - -?---Yes.

- - - because it would override anyone - - - ?---Correct.

- - - because of the paramountcy principles?---Yes.

So mental and intellectual impairment, is that the major characteristic?---And an extremely volatile and unstable home situation.

How do you become aware of that?---Usually through either the antenatal period that the mother may have a drug and alcohol problem, a mental health problem. It might be an unstable and chaotic relationship and would have raised concern about the unborn child. Child Safety, the aim of the unborn child high risk alert process is that Child Safety would work with that family to secure a safe environment for that baby to go home to. If they are

unable to do that, then they would put an alert on which requires the birthing service to notify Child Safety once the baby is born.

What about those two children or young people you mentioned yesterday who had been within the system themselves - - - ?---Yes.

- - - had, I think, some disability as well and had a child together?---Yes.

Is that the sort of child - would that child be a candidate for this?---Yes.

Did it happen in that case?---Yes, it did.

So what happens to the child?---They're placed in foster care.

By the chief executive?---Correct.

Who takes safe custody of the child pending that?---Sorry?

Who takes safe custody of the child once it's born?---The hospital would look after - well, usually, if the baby is fit for discharge, it usually happens within a couple of days, but the baby would go directly to a foster carer.

And what - - - ?---They don't spend a long time in hospital.

At what point does the chief executive take action; immediately upon birth or after a period of time or - - - ?---It's usually pretty close to the birth. In the days when I practised midwifery, sometimes we had foster babies on the ward for, you know, five or six weeks sometimes, but that doesn't tend to happen because it's not in the interests of the baby to be cared for by nurses changing over every eight hours, so placing them with a foster carer immediately is in the best interests of the baby.

What happens to the mother while the mother is still in hospital and the child - the attachment between the mother and the child, what happens there?---It depends on what the plan is from Child Safety. We don't normally separate mothers and babies because obviously the bonding and the attachment is a very important part of that. If we know that the baby is going to be removed, they usually remove the baby almost immediately after birth.

So it's a quick severance?---Yes, yes.

No delay?---If humanly possible, that's the best.

How many of these children are we talking about?---It's not a significant number. I haven't got the actual figures. It's rare to happen, but I would have to go back to Child Safety to find exactly how many because often that

decision is - - -

Does anyone keep the figures on what sort of characteristics or challenges their parents have by category?---Child Safety would have that.

By category?---Yes.

All right. And does anybody keep tabs on what happened to that child eventually?---I'm assuming at Child Safety since they're in the Child Safety system, whether they're on long or short term orders, ultimately what happens to the baby. In some cases where we've got extreme disability in the mother, I'm not sure about the reunification plans unless there's some other family member that's willing to take on that guardianship role.

All right. You're not a lawyer, are you?---Pardon?

You're not a lawyer?---No.

No. Okay?---Don't hold that against me.

No, I won't. It's probably considerably in your favour. I'm looking at the legislation now. It's section 21A, I think, that deals with unborn children?---Yes.

Which is interesting. I don't know why they don't call it a foetus because there's no definition of unborn children in the legislation?---Yes.

I don't know what an unborn child is because a child is defined as a child between zero and 18. However, let's assume there is such an entity as an unborn child, in respect of unborn children, the chief executive - and it's hard to see how the legislation could talk about before the birth of the child when a child is defined to include a living being. The chief executive reasonably suspects a child, the unborn - so reasonably suspects that on birth - - -?---Yes.

- - - the child may be in need of protection?---Yes.

Who looks after the protection of the truly unborn child? That's before delivery?---I'm assuming as part of antenatal care the safety and wellbeing of the mother and the baby, unborn, are paramount.

But the department is in a situation where the chief executive reasonably suspects that the child will be in need of protection at birth. That's what the legislation favours?---From birth.

From birth?---It would be from birth.

Yes, "After he or she is born," it says?---After, yes.

But nobody seems to have any statutory responsibility for

deciding whether or not the child, unborn, is then currently in need of protection, that is, at risk and doesn't have a viable parent to assist. I suppose that might be more applicable in the neglect situation, that is a pregnant woman - - - ?---Yes.

- - - may not be able to meet the needs of the unborn child, I suppose, is the situation we're - - - ?---Yes. I was contacted once by an obstetrician who was concerned about the mother's decision-making around a normal birth following a Caesarean section and wanted to know if this section of legislation applied to that, as in to change that mother's decision, as in if you proceed with this, we can take your baby after birth. It was a very interesting time legally in terms of interpreting that. Basically, the decision was that it wasn't about a mother decision about her medical care that this applied to. This was about - although, loosely speaking, you could say someone who's smoking and drinking and in an unsafe situation is putting their baby at risk after - - -

A violent domestic situation, for example - - - ?---Yes. Correct.

- - - who can't protect herself or her unborn child?---Yes.

I see that the section is designed to - or expressly says, "Look, we're trying to protect the safety of the child, not interfere with the rights of the mother," in this - - -? ---Yes.

- - - and we've got to balance it, but it seems to draw attention between indigenous and non-indigenous, Ms Ekanayake, you might want to think about this, because while it seems that the chief executive can take action with or without the consent of the pregnant non-indigenous mother, insofar as indigenous or Aboriginal and Torres Strait Islander pregnant women are concerned, it has to be with their consent for the recognised entity or the recognised entity has to be consulted - - -?---Yes.

- - - and only if the pregnant woman agrees to the consultation taking place. What happens there in practice? ---I'm not aware of any variation as a result of that, but I think to engage - the recognition that the recognised entity could work as a representative of the indigenous mother also - - -

But if she doesn't want the recognised entity to play that role, she can - - - ?---Yes. She doesn't have to.

- - - veto it?---That's correct.

Right. You don't have any figures on that, I suppose, do you?---No.

But if she vetos the recognised entity being consulted then she's in the same position as the non-indigenous person -

pregnant woman. Okay. I understand. All right. Now, Mr Selfridge.

MS McMILLAN: I just have one question arising.

COMMISSIONER: Yes.

MS McMILLAN: If a mother is affected by drugs or alcohol and that may well impair her ability to consent, does health see it as their role to advise the department of that?---Consent to what, sorry?

To the relinquishment, for instance, of the baby?---We would be discussing with them on an ongoing basis, depending on the contact and the antenatal period, the mother's ability to comprehend what's happening.

Would you see it as a responsibility on a health care provider's part to say, "Well, look, we think there's issues here about an ability to consent"?---Yes, absolutely.

All right. Okay.

COMMISSIONER: Do you know if there's a disparity, or substantial disparity I mean, between the number of reports you make under this provision to the chief executive and the number of times the chief executive takes that removal action?---I understand removal is not frequent, but report about a concern about an unborn child is - and I'm not sure of the exact percentage of our reports that it concerns, but probably in the majority of cases the case management - and we would be working also with Child Safety around support for that mother post birth, so it is about having a plan post birth. So, for instance, we might refer that mother to our intensive family support, family care program, which means she's getting regular contact from a child health nurse.

I was more interested to know whether there was any disparity between the number of times that the health practitioners say, "Look, we think this child may be in need of your protection," and the chief executive disagrees?---Yes. I could find that out. I don't have those figures to hand.

Yes.

MS McMILLAN: Yes.

COMMISSIONER: All right. Thank you. I'll give everyone a break, Mr Selfridge, before you - - -

MR SELFRIDGE: Yes, thank you, commissioner.

THE COMMISSION ADJOURNED AT 11.38 AM

THE COMMISSION RESUMED AT 11.48 AM

COMMISSIONER: Yes, Mr Selfridge? Just say where you are from and what - - -

MR SELFRIDGE: Certainly.

COMMISSIONER: Yes, thanks.

MR SELFRIDGE: My name is John Selfridge. I'm representing the State of Queensland in the proceedings. Ms Davies, there's been much said through the course of the commission about mandatory reporting and issues of self-filtering or not, as the case may be?---Mm.

In terms of any filtering within Queensland Health itself and filtering of reporting processes, there is some form of filtering because when we look at your documents and look at the statement that's been tendered on your behalf, it's quite clear that you discuss at paragraphs 29 through to 38 about what the process is attached to self-filtering and in particular that flow chart which is attachment 14, commissioner. That's in paragraph 63.

Do you have that report?---Yes, I do.

Could I just ask you to turn to that flow chart that you have provided as attachment 14? Do you have that before you?---I do.

Now, when you look at that flow chart, use of wording such as, "Health professionals are recommended to consult with district child protection advisers and liaison officers and other health professionals to assess in forming a reasonable suspicion," and so on and so forth?---Yes.

You talk about consultation prior to a decision being made in relation to threshold, that threshold being reasonable suspicion?---Yes.

Right. That's something that I'm sure you would advocate as very much part of the Queensland Health process and evaluation in relation to suspicion of child abuse and neglect?---Yes.

Yes. Now, the flow chart speaks for itself. It's self-explanatory, but it obviously goes on then in two different forms whether or not there's a suspicion and it also touches upon the unborn child issue that the commissioner asked you some questions prior to the adjournment?---Yes.

It's down in tabular form, third line, any child health worker processes that they should engage in prior to making any reports to the Department of Communities?---Yes.

Is there anything you would like to expand upon in relation to that to tell the commission as to your knowledge and/or understanding of how that works?---Well, this was developed as part of our implementation of the mandatory reporting requirement that we looked at a process of decision-making and how we would formally provide that information to those staff in the most simple format, meaning a flow chart. We can only - the legislation requires that it's up to the independent view of the clinician to report or not to report so that's why we could only really put in there "recommended" and we strongly recommend and I'm pleased to say that that is utilised on most occasions from my own inexperienced staff, that they would consult with either our child protection advisers or liaison officers of their senior managers who have more experience than them, knowing that at any time in the health system we have newly graduated and inexperienced staff and, as they progress through to become more experienced, what would be the best way of supporting them to make that decision and have a consistent approach.

Yes, and in bold type just under the top heading it's clear that staff are required to consult with their child protection adviser in relation to unborn children and risk of harm to unborn children?---Yes.

And again at the bottom - asterisked at the very bottom of that page it says, "Please note if after hours, you are required to contact the Child Safety after-hours services"? ---Yes.

Whose after-hours service?---That's the Department of Child Safety after-hours services. So it means that 24 hours a day we can make a report to Child Safety. It's not limited by office hours.

So are we talking about crisis care?---That's correct, yes.

The 24 hour telephone line that's been spoken about? ---That's correct.

COMMISSIONER: Why is there a difference between a recommendation in respect of reasonable suspicions of abuse or neglect and the requirement in respect of unborn children?---Because reporting of unborn children isn't mandatory under the legislation so we do say because this is an exceptional area, we do require them to consult with a more experienced person when reporting an unborn child.

But is this out of respect for the dignity of the mother? ---No, it's out of the knowledge and skills of the person reporting because knowing what might happen to a child isn't necessarily - so obstetric staff that will be seeing that mother antenatally may have the child protection knowledge and skills to determine what the risks of that child may be after birth.

If it's not for the dignity of the mother, is it to save

the time and effort of the chief executive?---Of Child Safety?

Yes?---Correct, yes.

So we filter for him there or her there?---Yes.

Why is it how to report a reasonable suspicion of child abuse and neglect? The legislation says "all neglect". This suggests that you need both to report, doesn't it? ---That wasn't the intent, no. It can be and/or.

It says "or" in the legislation?---Yes.

So and/or is often implied, isn't it, because if you have got a disjuncture that says "or", then "and" is just belts and braces?---Yes.

Maybe that can do with a little bit of refinement just not to be confusing?---Thank you.

MR SELFRIDGE: Now, carrying forward to the discussion in relation to at this moment in time the current SCAN system, there's been a lot said about this. I don't need to rehash that which is already before the commission, but you made a comment earlier about how your consideration is absolutely invaluable. That's what you suggested. Even in its current format?---I think administrative processes can sometimes be to the detriment of a collaborative team. As soon as we enshrine something in legislation - and we have incredibly thick rule books and procedure guides - it can actually stifle that open communication around what's in the best interests of the child and family. So over time I wasn't a party to how SCAN teams worked prior to the CMC, but my understanding was that there was a lot more collaborative approach to it rather than the administrative approach that we have currently.

COMMISSIONER: Do you think the prescriptive approach creates a problem more than the results?---I do; I really do. I think in terms of frank and fearless conversations - and I know I've spoken to a number of child protection experts who can go in - and I suppose it's from lawyers, doctors happy to go in and have that robust discussion and come away disagreeing but quite content that we've had the robust discussion. So it isn't about everybody agreeing all of the time but I think that administrative processes stifle that conversation because they - basically we have to come up with a collective view, collective recommendations and everybody has to agree and that's not necessarily in the child protection area the way that it pans out because it so variable and there are so many factors that need to be considered and everybody comes with their filter of their own professional background to look at that.

And they might be forced to say they agree when they actually don't?---And sometimes the functioning teams are

basically because people don't have the energy any more to argue and that's probably not in the best interests of what the intent of the process was about.

MR SELFRIDGE: Just picking up on that very point, that administrative point, administrative processes sometimes can be to the detriment. You term the current system as SCAN and in your statement there's been a refined model of that service delivery and you obviously heard Superintendent Harsley talk about a deletion under this partnership and action and the change in late 2010. He also suggested again that robust discussion is healthy. Is that the point that you're trying to get across?---Yes, absolutely.

That has been lost to some degree?---Well, it's been restricted in the number of children that are discussed, as in the focus now is only on children that have reached notification level and sometimes, I think, prior to that that discussion has added value to the information regardless of whether it had reached notification level of not. So at the moment we've refined it down to the very point end of what Child Safety is involved with because it's reached notification level versus what collectively all of the agencies could add in terms of a case-management plan for that child. So I understand, yes, that Child Safety - they're legislative requirement is for the very pointy end of the tertiary system and I suppose one of the arguments that we had as child safety director was, "All of you can all meet about those children but we don't need to be there because it's nothing to do with us," but as a result of those discussions, it may be that that information does add to that assessment of whether the child is in need of protection versus not in need of protection so - and I think that's the ICM process, yes, was a process - identified an area that we still can talk about these very complex cases but they're not formally in the SCAN system so we've created a parallel system, if you like, with probably basically the same people discussing the same cases but they're in or they're out so again - - -

Under a different structure?---Yes, and I'm not saying it - - -

That's the irony, isn't it?---Yes, it is.

Okay. Moving on then to Evolve, you make mention of Evolve and there was some discussion yesterday in relation to it. You make mention of Evolve at paragraph 42 and then again there's a sort of synopsis of it at paragraph 89. Could I just ask you to turn to paragraph 89 because it's a lot more descriptive and prescriptive?---Yes.

One of the issues that's before the commission relates to those children that are described as having higher complex needs. I'm talking about adolescents. We're talking about adolescents?---Yes.

That's my understanding of the services that are offered through Evolve. Is that correct?---It's not for adolescents. It's actually for a range of ages. The average age I think I mentioned yesterday was around nine, nearly 10 years of age, but obviously the predominant numbers because of the behaviours and the number of children in care at the moment are in the adolescent end.

Yes?---What we would envisage over time as those children age out of the system and if we can get in earlier with the therapeutic interventions and support that's required, we're possibly not going to see the higher end of the adolescent area.

So Evolve in its current format - those therapeutic services are being offered through Evolve?---Yes.

That would still remain, but it would just be offered to a different client age group?---Yes.

Is that the suggestion?---With a view to preventing a lot of the behaviours that we're seeing now in the client cohort because it's relatively new, five or six years old, but as the Evolve program progresses in 10 years' time it would be good and we're envisaging that that will push back earlier at a younger age.

In a preventative, proactive type manner?---Yes, definitely.

And you say from your perspective that it's been a success in the main, Evolve?---A success in terms of measurement at the moment with the current clients. The average length of time in therapy is approximately 18 months to two years with a small cohort requiring further care after two years. As I said earlier this week, we would be interested in following up with these children who were in the system four or five years ago to see where they're at, at the moment. That may be difficult because they've exited care so they may not be known to the system, but it would be great if we could look at a longitudinal study as to what's happened to them.

What are we talking about numbers-wise?---Numbers - - -

Even your best - - -?---Of how many children I have, the figures.

Yes?---Yes. The numbers at the moment - so in 2010 Evolve - this is just the Queensland Health component. This is not Evolve Disability Support Services. I don't have data of theirs - had 362 children and young people of whom 62.4 per cent were male and at presentation their ages were on average 9.7 years of age with the majority - the age range going from five to 15.

Which document are you reading from there?---No, this is just background.

Okay?---And of those 30 per cent of the children came from an Aboriginal and Torres Strait Islander descent and most - - -

These are children actively involved in the - - -?---In the program.

Evolve program, yes?---Evolve.

Yes?---That was in 2010.

Yes?---In 2011 it increased to 420 children.

So we're talking significant numbers of children?---Yes, we are, of whom again 60-plus per cent were male and we had an increase of 4 per cent in the Aboriginal and Torres Strait Islander and the age range was pushed back from four to 15 but still the average age was around nine to 10 years old. So we've seen consistency over the two years. I haven't got 2012 at this stage.

Sorry, Ms Davies, did you say there was an increase of 4 per cent in indigenous representation?---Yes, it went from 30 per cent in 2010 to 34 per cent in 2011 and in 2011 we provided training to 6029 carers and partner agencies and key stakeholders and that training was based on the effects of trauma, abuse and disrupted attachment and again that was, as I say, education, kinship care and foster carers, non-government sector and health staff.

Sure; and this is three of the core agencies that are involved?---Correct.

Yourselves, education and - - -?---And disability.

Yes?---Disability Services.

In terms of where these children are at now because it's obviously a very - in its relative infancy, pardon the pun. About the last five or six years you say it's been operational?---Yes.

In terms of where these children are at now - I know we've touched on it briefly. Is there any way for you to ascertain or to obtain information - - -?---We only have information at the moment - and the evaluation reports tend to focus on the outcomes of children in the system at the moment, whether they have met their key performance indicators which have been developed through the program which talk about - and they focus on the overall wellbeing of the child, the level of the child's involvement in their own plan, the carers' wellbeing, so whether the carers are feeling confident as well, their placement stability, the engagement of the child in educational and vocational activities and how their relationship with their carer has progressed and the broader stakeholder communication with their teachers and anybody else in the sort of ecology

environment of the child. So it tends to be very much focused on evaluating the outcomes currently, but now that we've had children exit, say, five or six years down we haven't done that project. I know there's great interest from the Children's Research Centre in Victoria and from one of the universities in New South Wales with some of our eminent research paediatricians and psychologists to actually do a longitudinal study on this because it's quite unique in Australia, this program, and they're watching - again, as I mentioned, it's a very expensive program and we do need to evaluate in terms of long-term outcomes whether that investment - it sounds very hard - whether that investment - - -

Has been productive?--- - - - has been productive and we have produced functioning people to progress on with their life.

Sure; and just the last thing on that topic - you said you provided training or Evolve provided training to 6029 carers?---Yes.

What do you mean by that? What type of training and for how long?---In the evaluations which we will be providing in our health submission to the commission it was interesting that carers - when they're asked, "Why did you want to become a foster carer" - because again to meet their expectations of what they expect to get out of this relationship a lot of carers actually were not aware of some of the difficulties with fostering children and the effect the abuse and neglect had on those children's behaviour.

Can I stop you just for one minute?---Yes.

Just so we're clear, these carers - in the main we're talking about carers who are caring for those children, whether they be three or four years, as suggested to the commissioner yesterday - you have got some younger children now?---Yes.

The average is nine, as described?---Yes.

These are carers who are caring for children with extremely deep emotional and psychological issues?---Yes, and the psychologists would argue that any child taken from their biological parents regardless of what background they came from have experienced some psychological and emotional trauma. So regardless of their good behaviour - they may be well behaved - they have still suffered trauma which will at some stage appear in some form later in life, whether it's about their ability to have a meaningful relationship, to become a father or a mother or their disconnect with work or - you know, it's part of a joint - - -

It's going to follow them throughout their life?---It absolutely does. So one of the suggestions through the assessment of health needs of children in out-of-home care was the assessment of their psychological wellbeing. We tend to very much look at their physical wellbeing and whether they're growing and developing; whether they're going to school, et cetera, but in terms of their psychological wellbeing, it tends to be an underestimated area. So carers often were coming in and, I think, Foster Care Queensland would attest to that as well, with probably unrealistic expectations of what they were going to get out of this. Some - and I've spoken to some foster carers - felt that, "I'll just take this poor child that mum and dad can't look after and I'll just give him a kiss and a cuddle and we'll make it all right," and then this child behaves peculiarly, kills the family cat, is stealing, is a truant from school and they were not really understanding, "Why is this child behaving - because, hey, I've brought them into my home and it's loving and it's caring and I care about them and they're not reacting and responding in the way that I would expect them to." So the foster care training is very much around, firstly, identifying what their expectations of becoming a foster carer were and then being able to learn the skills to deal with this behaviour. Some of the testaments I've read from foster carers who have been involved with the involvement program had found it absolutely incredibly supportive, "To know there's someone there that I can call when I'm having a terrible day with this child and they will work through with me what I need to do and how I need to control my own emotions and not just basically ring up Child Safety and say, 'Get this kid out of here because I can't do it any more'," and - - -

Which would buy into this concept of self-perpetuating, reciprocal type of - - -?---Absolutely; and the instability of placement and the, "No-one loves me and I've been in 20 places and no-one really will ever love me, so therefore I'm unlovable."

Is there any documentation that you know within the Queensland Health Department that you would be able to access that would be able to assist the commission in any way in relation to: (a) on a wider scaling exactly what Evolve are offering and seek to offer into the future; and (b) - - - ?---Yes, and we were providing that as part of our health portfolio submission. It will almost be a whole chapter on Evolve.

Okay. The second one, I suppose, it's a yes on this one, too, in terms of what training is offered by Evolve to these carers that put themselves on the line, so to speak? ---Yes. Yes, and we can summarise the training program for that as well.

Okay. Thank you very much. No further questions?---No problem. Thank you.

COMMISSIONER: Thank you, Mr Selfridge. Ms Ekanayake?

MS EKANAYAKE: Yes, thank you. Thank you.

Jennifer Ekanayake of the Aboriginal and Torres Strait Islander Legal Service?---Yes.

Ms Davies, you made reference to unborn child high risk alerts in your evidence. ATSILS often respond to mothers and couples' requests for legal assistance when children are removed at birth. I'm just interested, in particular, what is your knowledge of the efforts, or more specific efforts, to respond with early intervention when concerns are initially raised or initially identified in relation to an unborn child?---So early intervention? Ideally, risks would be identified through the normal antenatal period and we do have one of the positive initiatives within health we have as part of a key performance indicator for our Health Services is that we aim to have pregnant women seen at least five times as a minimum - five times in the antenatal period and that still continues to be part of the service agreements with our Health Services because the evidence is clear that the more times we see a woman in her pregnancy, the more chance of influencing her behaviour, her healthy habits, reducing drinking, reducing smoking, increasing healthy nutrition and exercise, et cetera, with a view to delivering a term baby rather than a premature baby and also a baby of reasonable birth weight because babies of prematurity and low birth weight often have poor health outcomes. During that phase of antenatal contact, if a woman is identified as at risk, we have especially through the national partnership agreement for early childhood, education and care, a major initiative of maternal and child health nurses also working with indigenous health workers for our indigenous women to connect with them and connect them to preventative health programs or home visiting, especially - ideally prior, so attending antenatal, and also in following up with them after birth to make sure that those healthy behaviours and activities continue and that they're provided with that parenting support that they need.

The indigenous health workers you refer to, where are they from? Are they from within the department or - - - ?---They're employed through the department, yes.

What are their roles?---Their roles are to work with the maternal and child health staff in providing care and cultural appropriate care to the indigenous women that come into their contact. Some services we contract out throughout the indigenous Aboriginal controlled sector through organisations such as (indistinct) up in the north in the cape and they can also work with our non-government services, such as Royal Flying Doctor Services in providing care to those populations.

Thank you. The commissioner made reference to section 21A. That's in relation to the unborn child?---Yes.

I'm not going to ask you to read it?---No. Thank you.

But at the moment section 21A restricts intervention to only where there is consent from a parent - - - ?---Yes.

- - - from the mother?---Yes.

Whilst we acknowledge the mother's rights, my question to you or I'm seeking your opinion in regard to whether this is child focused, given the significant harm that could occur to the child whilst in utero, for instance FAS? ---Yes. Health professionals tends to always work on a consent basis knowing that to have a relationship with a client is the better way than forcing the treatment, so we would our endeavour through our best endeavours to seek consent and to work with the mother to ensure that the baby is safe and is healthy. I'm not aware of many instances where - and I think most antenatal women are actually quite protective of their unborn baby and want to do what's right. They may not have the power or the wherewithal to do what's right, but they do actually respond appropriately to advice in that area. There's very few that I'm aware of that don't. So the consent issue is we don't see that as a significant barrier to providing appropriate care.

At paragraph 84 of your statement you say that 23 per cent of reports to Child Safety involved Aboriginal and Torres Strait Islander children?---Yes.

Are you aware of the state's 11 Aboriginal and Torres Strait Islander Family Support Services - - - ?---Yes.

- - - and that they are still to respond across issues such as neglect, parenting capacity, substance misuse, DV and also to refer for specialist assistance when needed? Are you aware of those agencies?---Yes, I am. Sorry. Yes.

What kind of referrals?---They would be, again, part of the suite of referrals that we would make for appropriate follow up, as required, according to the needs of the mother.

Given that Family Support Services or the Aboriginal and Torres Strait Islander Family Support Services can receive direct referrals from Queensland Health - - - ?---Yes.

- - - would you have numbers or are you able to point us to a place where we can get those numbers of the referrals that are being made?---The Aboriginal and Torres Strait Islander Support Services would have the numbers and the source of the referrers where they came from because, again, it may not necessarily all be through the public health system. It may be through the community controlled sector and through the Aboriginal Medical Services that they receive referrals also. I believe that they do collect information on what the source of those referrals were, but we don't hold them so I don't know.

How do you see it working, the referral system?---I see it as effective as any referral system. Again, these are consent based referral systems we may refer and we may believe that this is in the best interests of the mother and baby, but whether they choose to progress with that referral is, again, their independent decision. How those referral services engage with the people that have been referred to them, again, it's a relationship based issue; whether they're the appropriate people - because I know, for instance, in the past I was the manager of Aboriginal and Torres Strait Islander Liaison Services and because of their relationship groups, they were actually not the appropriate people to follow up with some people, so it's all very well to say - it's not one size fits all, so it is about finding the right person, the right place and sometimes that doesn't work as well as we would like it to.

Thank you, Ms Davies. I have no further questions.

COMMISSIONER: Okay. Thank you. Ms Wood?

MS WOOD: No questions, commissioner.

COMMISSIONER: Thank you. Mr Capper?

MS DEERE: My name is Deere for the Commission for Children and Young People and Child Guardian. I wanted to look to paragraph 11 of your statement where you've identified changes that came in from 1 July to establish 17 hospital and health services?---Yes.

In your statement you also indicate that that has created a greater flexibility in terms of the ability to innovate and address local priorities?---Yes.

I guess I'm wondering from your perspective, are there any potential ramifications stemming from those changes in terms of the capacity to respond consistently to issues that arise or that emerge in relation to the child protection concerns that might come out?---The introduction of that legislation heralded a great change for Queensland Health, as you can imagine and the role of corporate office. I think, as we've discussed earlier, you know, we're in a cycle of decentralisation with greater local community control and responsiveness to local needs, which I think is a very positive thing. In terms of a systemic approach, the system manager or the director-general has the ability to direct health services through formal directives should that be required. He has the ability to purchase additional services through service agreements for specific services, whether they be child health or surgery or outpatients, et cetera, and so we have the mechanisms and it's now how we would use those mechanisms to actually facilitate any changes that were required. So, for instance, I'm imagining next year when the recommendations come down from this commission that we will be tasked with how we would then implement those recommendations and what vehicle we would then use to communicate or collaborate or

partner with hospital and health services to achieve those changes, but the chairs of the board's report directly to the minister for health - and so he also can influence the direction that those hospital and health services take. I don't see it as a barrier. I think it's just a different way of working.

Okay. In terms of, I suppose, this inquiry making recommendations some months from now - - -?---Yes.

- - - in terms of the new hospital and health services model, if you like, can you foresee any problems for your role as the child safety director?---No, but I think it's, again, a different way of working because I think we've always - can I say we've always worked that way in collaboration with the health services. I've never - even though the role is called a director, I actually don't direct that things happen. We actually work with them to develop the policy, the roll out, the implementation, the education and the child safety unit, which is connected with the child safety director - has always provided a much more supportive and information sharing role. The only times that I have been involved would be if there was an issue at a whole of government level where I would take and represent on their behalf. The change for me is that I no longer can sit at the table and talk on behalf of the hospital and health services. I cannot commit them to doing anything because I don't have the legal authority to do that, but I can commit to consult with them and to bring back a collective view on behalf of that. So, again, a different way of working, but I don't think that there are barriers to it being as effective as it was in the past.

Turning then - assuming from comments you've made through the day that you're familiar with the role of the commission?---Yes.

So can you talk us through the government's accountability mechanisms that exist within Queensland Health for reviewing or responding to any reports that might be generated by agencies with those, such as the commission? ---Currently, when I receive your reports and you're very collaborative about getting those results out early, which is fantastic, we would circulate them and request feedback from the appropriate clinicians in our hospital and health services, so we do provide feedback to you as a collective and not as individuals. Our relationship, however, with things like purchasing arrangements, for instance, between Department of Communities around the health home visiting program for the Gold Coast will be a contractual arrangement directly with that statutory authority and not with corporate office, if that makes sense, but in terms of collaboration around information and reports and responses to those reports, we would still do that as we've always done.

Okay. So I guess do Queensland Health also have accountability mechanisms or government arrangements where

you are proactively going out and seeking information about the needs of children in the child protection system? ---Yes, we do that and I don't see that changing.

Can you give the inquiry a little bit of an idea about how that operates in practice?---The only one that springs to mind is around the child death reviews that come. Those reviews come to me as child safety director on behalf of Queensland Health and then I send that information to the district chief executive officers who are the only ones that have the authority to release information. I don't have that authority. They have that authority to release information to share with the case investigators. As a result of those reviews if there are issues or actions that are required by Queensland Health then we would work with that hospital and health service around those services and needs for the - or the (indistinct) that were found from those reviews. On the whole, the focus of the services, the Child Health Services, does incorporate the child protection - children in the child protection system, so we've never really had to investigate or make sure that things were happening because they happen as part of normal core business in Queensland Health.

Okay. If I point you to a couple of examples from the latest child guardian reports - - - ?---Yes.

- - - and just sort of use those as example to give us an indication of how Queensland Health might react to the information the commission puts out?---Yes.

The 2011 report, as I've said, highlighted that for children with unmet health needs. It was identified that the reason for those in 17.7 per cent of the cases was due to waiting lists and health service availability. So that's sort of one example that the child guardian reports highlighted. Another issue that's been highlighted over the last two years is that children who have a current case plan, so children in out-of-home care, have only reported half as many unmet health needs as those who didn't have a current case plan. When that sort of information, I guess, appears in a report, what are the mechanisms, you know, that you guys take to look at those and say, "What's going to be our response to this"?---I think - I note that you have said back to the commission around this - an unmet health need needs to be more clearly identified because I think originally when the child guardian reports came out, we did have issue with the questions that were being put to children around, you know, "Are your health needs met?" Well, a six or an eight-year-old wouldn't know what that means. So we actually work with the commission on the questions that we would be asking through the community visitor program like, "When you're sick, do you get taken to the doctor?" and the answer would be yes. Asking the child, "Do you have a child health passport?" when they have no idea what that actually means, you're going to elicit a no response more than a yes response. So we've worked long and hard with the commission around the reports

around the health needs. Where there are identified unmet health needs, we have asked for greater clarification of what they actually were and the location because applying that across the state implies that we've got 17 per cent of children whose health needs aren't being met. It's not necessarily by the public health system, but it could also be that they are with foster carers who aren't taking them to the doctor for appropriate treatment; who've had an earache and they didn't get taken to a doctor and that's the last thing that the child remembers. Again, a broad statement doesn't actually elicit a targeted response. The waiting list issue, we looked at that in terms of paediatric waiting lists and it's very small, paediatric waiting lists. However, for some areas like ear, nose and throat, et cetera, there are waiting lists due to the access to specialities, but has the child's health been further harmed as a result of waiting, the answer would probably be know. Again, waiting lists are a measure of appropriate wait against inappropriate wait and whether your health outcomes were impacted by that wait or it was just an inconvenience to wait. So we would work more with the commission around where those unmet health needs were before we would say there's an unmet health need problem and I think we're continuing to do that each time those reports come out. Where are the unmet health needs? What were they related to and who was the best provider to actually meet the needs of that child?

Yes. So I guess using those as examples, what we're hearing is that if those issues were raised in a report - - -?---Yes.

- - - you guys are looking at then and then working through steps - - - ?---Absolutely.

That includes consultation with us or with child safety if there is actually an issue that you see that does need to be addressed?---Yes, and part of the child passport process is identifying the health needs and specialist health needs and actually following up with the foster carers to make sure those appointments are attended, that the ongoing medication needs are met and the ongoing therapeutic intervention, whether it be physiotherapy, occupational therapy, are actually met as well, and that's part of the health assessment process.

Touching on health passports then, is that something that you have data that you've sought from communities so that you can look systemically at what the needs of children are in perhaps particular locations or particularly in remote communities?---We looked at that when we developed the passport process, because there is a lot of evidence around the health needs, the range of health needs, and they can range from very basic health needs that can be met by a chemist or a GP right up to extreme health needs for children with disabilities or congenital abnormalities that require specialist intervention and follow-up. So the range of needs of children in the out of home care system are similar to the needs in the non-care system, however we notice that their health needs are probably exacerbated because of neglect or poor parenting which then pushes them into the more high needs child health areas. So all of those areas, developmental, paediatrics, the specialist paediatrics, again part of the health assessment process and making sure appropriate follow-up by the carers.

As the health passports are being used more readily and the department starts to capture data around those do you think that a regular review process by the department - by Queensland Health would assist in any planning for regional service delivery?---It would, and we'd like that to happen at a local level again in essence over the new hospital and health services as statutory authorities to respond to the needs of the local community and if there are a high proportion of children in out of home care in that community and what their health needs are we would work - at the moment the process of looking at health passports is through an audit process through child safety and through the commission as well who has access to that and then working with Queensland Health staff on what those health passport processes are eliciting at the local level and whether it requires a re-focus of services. I have to say that the passport process has led to a range of variable health services across the state with some of our child protection advisers being heavily involved in the health assessments of children and the follow-up care to others who have looked at engaging the broader general practice sector to do that and then receive the appropriate referrals once they've gone through the normal GP and establishing a primary health care provider, which is really important for these children.

Thinking again more systemically, so while the health

passport is really crucial in terms of individual children's health needs and outcomes for that child, more systemically, I guess, we have advice that ICMS, the integrated case management system, used by the department has only recently, in 2009, been upgraded, if you like, to capture information about the data that's in the health passports?---Yes.

Have you had some feedback or involvement with the department in terms of identifying what fields are included in ICMS to capture information that would be relevant to you as well as the individual - - -?---Not me personally, but I am aware that it was based on again the paper based assessment framework in capturing the needs and the ongoing - the data upgrade was a significant one in looking at what fields could be included and what relevance would be. So it was really in terms of the health passport - the manual process holds most of the information and what is contained in the ICMS is really around making sure that the case management process is being followed in terms of follow-up that has been done. It's not necessarily a diagnostic tool to be able to say what are the problems, it's really about does a child have a health plan in place and is it being followed and is it being regularly checked, was more the fields in the data system.

So with that in mind then, do you think that there would be a benefit in ICMS having that further capacity to actually capture the different health needs of children in the child protection system?---Yes, but I'm not really sure centrally again, a data system, how that would be utilised compared to working through the case worker and the importance of the case worker having that information to hand versus having all that information centrally. I expect if the child was very mobile or was moved or their family moved that it would be beneficial, because you can always have the issue of paper based files being lost. So I think that is something that will be progressed in the future, definitely.

Just to come back again to Queensland Health's role more systemically, do you think that there would be value in capturing that centrally to assist in that planning sort of for regional service and helping the local, you know, hospital and health services know what the needs might be in their particular district or area?---I think our child protection liaison area and child protection advisers would hold that information locally. Again, we don't - we may not see these children. They may be managed through general practice, so it's not as if - we can't assume that all children in care are seen through the public health system.

No, and I guess that raises - - -?---Yes, so holding it in - - -

- - - that role for the ICMS to capture that?---Yes, exactly right.

Which you could then tap into?---Yes. I see what you're saying. Yes, I would agree.

Just to perhaps review the record, yesterday you indicated that 94 per cent of children in care currently have health passports and there was an indication that that had come from the commission. Our understanding - - -?---No, it came from child safety, sorry.

Okay. I was just going to clarify that, because we understand that data is not yet available and it's being worked on?---Yes.

We are going to hear from the Department of Education as part of the inquiry's processes. I wondered if you could talk through whether there are any significant issues in terms of educational outcomes for kids in care compared to those I guess just in the general population and are some of those educational outcomes and the concerns with that related to children's unmet health needs?---I can't profess to be an educational expert so I'd rather defer that question to the education people.

Sure?---Obviously health needs do play a role in the ability of a child to take advantage of learning opportunities put before them, especially in relation to hearing, vision and speech and development. So obviously any of those basic health needs, if we can identify those issues early and address those prior to a child commencing school they are more likely to be able to progress uninhibited through their school life. So I think that children in care have the same proportion of those vision, hearing issues as non children in care, so our general population health and wellbeing process would ideally pick those up early and address them, and children in care would be in that category as well.

I guess with the benefit of the health passport capturing some of that information after going through that assessment process do you think that there would be benefit or it would be reasonable for that information to be made available to schools?---Definitely, and that would be part of - I think that the health passport also informs the education support plan which is also in the child's case notes around their needs going forward and any extra assistance that they might need at school.

Moving away from that then, there have been some discussions and you've given some evidence around processes involved with unborn child notifications?---Yes.

I wanted to just talk a little bit about the process involved in those unborn child notifications, if you can help us out. If the department, I guess, refers a notification to you indicating that the intention is to take a child into care when the child is born can you talk us through what the process is that Queensland Health have

for following up and ensuring that that can take place when the mother presents at the hospital?---I can't talk specifically about the local process, but I know that there are local protocols within the birthing service for managing that information. If a report is raised with child safety and they decide that they want to place an unborn child high risk alert on a mother then that information goes to the birthing service where they think that the mother will be birthing. Some of that is difficult when we're actually not - they're actually not sure whether it might happen. So we have had instances where that alert is shared among a range of birthing services. Often - well, not often - some cases are very - have had no antenatal care so sometimes a report is not raised by a health professional but it may be raised by a community member or a family member, et cetera. So the idea of the alert is to flag with the birthing service that child safety wish to be notified as soon as the baby is born. Ideally, if we receive that alert prior - as part of the alert we like to know how far the woman is along in her pregnancy so when are expecting it, is it six months away or is it one month away or is it next week. Depending on that time we would expect that child safety has decided and collaborates with us what the plan is for that child, as in will they take the baby or do they just want to know that the baby is born so that they can immediately follow up on the mother's situation. For us it does raise concern, obviously, because we need to know what that plan is. We need to know if it's okay to leave that mother and baby alone. Are we talking about a previous terrible event that we require higher levels of supervision? That's taken some time for us to work through with child safety, but I think we have good relationships now, that it is not about debating the decision to take the child it's just how we manage that in the most empathetic way. Ideally the mother will know. The onus is not on the health staff to tell the mother that an alert has been put on. We expect that she already knows that from child safety. That's the whole point. Sometimes in practice that doesn't happen, but I'm not aware of recent times where that hasn't happened. We would then provide support through our social work area to the mother and to the family and we will try to assist child safety to remove the baby as atraumatically as possible. As I say, usually they've worked with the mother so the mother actually knows what's happening, or the family knows what's happening.

I guess if everything is working nicely and you guys have planned and there's been discussions but then the mother absconds, you know, are there ways of, I guess, avoiding that gap and the risk to that unborn child if she shows up three towns away?---Hospitals aren't prisons, unfortunately - well, not unfortunately. They shouldn't be prisons.

I don't mean abscond from hospital, I mean, you know, in that three weeks perhaps lead up, you know, she drives from Bundaberg to Townsville. Is there a way of - - -?---Again, they are the difficulties that we have. It doesn't happen

often but occasionally that happens, but through the sort of network we usually try and make - again, a mother can turn up and give a totally different name, so we may not know - and it's rare but it can happen. So we do the best that we can with the processes that we have in place. It's not a foolproof system but nine times out of 10 it will work. There will be that odd that it doesn't, but that's an unusual case.

Earlier today you talked about possibly a reason for the increase in referrals or of reports to child safety was due to an adverse incident involving a mental health matter. Without going into the details, our understanding of that adverse incident is that involved a tragedy involving a child. Can you talk us through in a general sort of sense what was the policy response of Queensland Health? Aside from the fact that we've seen an increase in reports to child safety, what was the policy response of Queensland Health following that adverse event?---We looked at the time around in mental health the education and training around child abuse and neglect, because again, I suppose it's hard to engage with a service that provides adult services and when they're saying, "Well, we don't provide care to children so it's got nothing to do with us." So it was really about educating them to say that there is a broader environment that we need to consider when we're providing services to adult patients. I think in our education and training video, which is a good 20-minute watch, can I tell you, has an instance there where it's an adult service where a mother is in for some reason and she's very agitated, she needs to get home, she wants to get out. The nurse actually identifies that there's a potential that her children are at risk and that's why she needs to be home. So the children are not the client but the children have been affected by the care that we're providing to that adult. So it has led to a range of - an expansion of our education areas. Our child protection liaison officers were - actually fed back to me how great it was, because they got invited into the adult areas to provide some in-service training. So it was really those instances, which are tragic, yes, but they open the door to people thinking a bit more broadly around children. So, for instance, I'll give you an example of some of our adult tertiary hospitals when we went there about child protection, "We don't treat children. We're not a children's hospital," we say, "Do you provide for care for children under the age of 18?" "Yes." "Okay, well, you do see children so you are part of the child protection system." So really out of tragedy always comes opportunity, unfortunately, to raise awareness of that and to also look at some assessment frameworks which were introduced into the mental health area for looking at - because, you know, as an adult mental health patient we can advise those patients whether they can go to work, whether they should drive a care, so could we not look at whether they have the ability to provide - be the primary carer for vulnerable children, especially under the age of 10, if there's no other carer or a family member that's going to

provide support for them. So it was really broadening the scope of looking at that client and what they can do as part of their normal life, and that's been a positive contribution.

So with that extra training and education and a broadening of knowledge has there been an evaluation and an audit done of the effectiveness of that or are there plans to do so? ---Only looking through our normal audit and where the predominant number of reports came from. So prior to the incidents we talked about mental health was a low - adult mental health was a low reporting area. After it they were an increased reporting area. So the areas that are predominant areas of report are child health, our accident and emergency departments and maternity departments and then the (indistinct) audits identified that mental health was becoming an area. So the positive of the increase in reports - and I have very positive staff who say, "Well, the numbers of reports increasing isn't necessarily a bad sign. It's actually saying we're more aware of children in our work. We're looking more broadly at what we're doing in society as a whole and all the other agencies." So rather than saying this escalation of reports is a bad thing, we're actually looking at the state of needs of children in a much more gross sense, and as Ms Apelt said the other day, you could argue that the more services we're providing to families the more we're going to see. So the more that are in there the more we're going to report. So you could say it's an indicator of a broadening of service provision, not a negative, but how we manage that volume, that's the issue, and how we screen and sieve and all the rest of it according to our administrative processes are the thing that's causing us probably the most angst. The fact that the general public and all of our services are very aware of child abuse and neglect and mistaking wellbeing of children is actually a positive thing.

Just finally, earlier in the evidence today you quite briefly, I think, raised the possibility of the Children's Commission chairing SCAN?---I knew you were going to get me on that one.

There was a suggestion at the time that that possibly didn't go anywhere because of resources?---Yes.

I just wanted to put to you that probably another impediment is the commission's role currently as the oversight body for SCAN. The commission doesn't currently participate in SCAN meetings and does have a responsibility for oversight and monitoring?---That can change.

So I guess you see a potential for conflict if the commission was chairing but then also had that responsibility to report on the success of SCAN?---I actually don't, because the oversight - you could say an independent chair is not contributing, the independent chair is managing and facilitating the sharing of information. In fact, I would have thought it lends nicely

to the oversight of SCAN in terms of a functioning, well oiled machine that considers all of the contributions from all agencies in an equal and valid way, that it doesn't conflict with that, but, I mean, those discussions I'm sure will be had as we move forward.

So as the arbitrator, if you like, the commission, if that didn't go forward as a recommendation, would not have a role in the decision-making, if you like, because - - -? ---No, they don't now. I don't think they have a role now.

No, they're not involved - - -?---No, but in terms of oversight and of SCAN, and that's always been one of our conundrums at child safety director - what does oversight mean? Does oversight mean that they're happening, the teams are happening, they're funded, they're - and yes, tick, tick, tick, tick, or does oversight mean it's functioning appropriately? So I don't say that it's a blend between the two and other options are available, we just - could be debated as to what other source, but the commission is the one that sprang to mind in terms of their independence. That was, I suppose, the interest in going that way.

I don't have anything further, thanks.

MS McMILLAN: You were asked by the representative for the Children's Commissioner in relation to protocols in relation to unborn children and you said that you couldn't speak for local protocols but you understood. I take it by your answer that you indicated that there will be variation between different protocols, in protocols between different areas?---Variation in who's involved because services have different skill mixes of the various areas that look after - so, for instance, in some sites it may be a senior midwife who's involved with the department. In some sites it may be the senior social worker who's involved with that. In some sites it might be the child protection liaison officers. So we haven't dictated who's involved with the removal process and the communication. That's decided at the local level, depending on the skills and the abilities of the staff that are involved with that.

So are you saying that there's not a variation, simply who implements it?---Correct.

All right, thank you?---Yes, sorry.

COMMISSIONER: You used the term before "child protection system" and included in it the hospital to the extent that it looks after persons under the age of 18?---Yes.

And that probably is a fairly common or popular definition of the child protection system, but looking at the legislation as the governing document and defining document on what it is, it seems to me though - and I'm open to argument and submission on this, but it seems to me that what the child protection system currently is in Queensland under the statute, that is, the statutory system, is a system that protects which by definition includes cares for children in need of protection. A child in need of protection is a child who is suffering or an unacceptable risk of suffering or even has suffered defined forms of harm which include abuse or neglect and doesn't have a viable parent so that, having satisfied those conditions, the system allows you entry?---Yes.

It's not something you would line up to buy a ticket for but it lets you in, but it doesn't let anybody else in. It only lets in children in need of protection who must comply with those conditions of abuse or neglect, caused harm and doesn't have a viable parent. So when you look at it and you compare it with other systems around the country or elsewhere, its base is quite narrow?---Mm'hm.

Now, the social science around looking after children, if you like, in preference to protecting children would say that the way you do that is you support families. You give them good access to universal services and for those who need it targeted intensive secondary services?---Correct.

But when you do that, you're putting child protection in a broader framework which includes family support and really child welfare aspects?---Yes.

The concept of child welfare or wellbeing is a much broader concept than child protection at least as we understand it by reference to our legislation?---Yes.

Although the act talks about the preferred way of protecting a child is by supporting the family, it's not talking about supporting families as the child welfare system would see it to avoid a child being in need of protection. It's assuming the child is in need of protection and then saying, "You should protect this child by supporting the family"?---Yes.

Obviously they should have been doing that as well for the benefit of the child much earlier?---Yes.

So we need to always remember that the system that we call the child protection system is provided only to those children who are qualified for entry?---Correct.

That is, who is harmed, at risk, unacceptable risk of harm and have no viable parent. So when someone says to you, "Are you part of the child protection system as a health practitioner?" what's your answer?---I'd say, "No."

Good answer?---We are part of the child health and wellbeing and my area intersects or interfaces with the child protection system.

A lot of these statements of principle and best practice, fitness for purpose by child protection experts which would place ideally child protection in the broader child wellbeing framework to get preventative and early intervention happening are talking about a completely different child protection system to the one we have got?---But the interface and the flexing in and out, as according to me, as Ms Mulkerin said yesterday, is not static. It's not linear. So how we respond and react in that child health and wellbeing and how the child protection system responds and reacts and the interface between the two is probably a dilemma that everyone faces.

Let's tease that out a little bit. Would it be more accurate to say that how well the child welfare, wellbeing and family support system functions will determine how much work you have to do at the tertiary end of the child protection system properly defined?---Absolutely.

Not the other way around?---Yes.

All right. I think we will leave it there if no-one else has got any more questions unless - have we got another witness?

MS McMILLAN: Yes; yes, we do.

COMMISSIONER: Mr Copley, would you prefer to start in the last 10 minutes? It's up to you?

MR COPLEY: We might as well.

COMMISSIONER: May as well.

MR COPLEY: Yes.

COMMISSIONER: Okay. I thought you were going to say that. I shouldn't have asked. I won't stand down. We will just change over if that's okay.

MR COPLEY: Yes?---Thank you.

COMMISSIONER: Thank you very much for coming. I really appreciate the time that you have spent and the information you have provided, Ms Davies. Thank you?---Thank you very much, commissioner.

WITNESS WITHDREW

MR COPLEY: Mr Commissioner, I call Ian Duncan Hunter Stewart.

COMMISSIONER: Yes, thank you.

STEWART, IAN DUNCAN HUNTER sworn:

THE ASSOCIATE: Please state your full name, your occupation and your business address?---I am Ian Duncan Hunter Stewart. I am the deputy commissioner of the Queensland Police Service responsible for regional operations and I work at 200 Roma Street, Brisbane.

COMMISSIONER: Thank you, deputy commissioner; welcome? ---Thank you, commissioner.

MR COPLEY: I tender the statement of Ian Duncan Hunter Stewart which was sworn on 10 August 2012 and is 18 pages long and hand up a copy for you, Mr Commissioner.

COMMISSIONER: Thank you. No reason why any of it should be suppressed, Mr Copley?

MR COPLEY: No.

COMMISSIONER: All right, thank you. The statement of the deputy commissioner will be exhibit 30 and it will be published in full

ADMITTED AND MARKED: "EXHIBIT 30"

MR COPLEY: Mr Stewart, yesterday we heard evidence that at the present time and for some time now the Queensland Police Service reports all incidents involving domestic violence to the Department of Communities or Child Safety pursuant to the operational procedures manual. We heard evidence not necessarily yesterday but in the past week or so that when Child Safety receives these reports, they

treat them as notifications which must be investigated and we have heard evidence that upwards of 80 per cent of the notifications coming from the Queensland Police Service end up being categorised by Child Safety as being non-substantiated. With that in mind, I would ask you to consider this: an issue that the commissioner raised yesterday with Superintendent Harsley was whether or not there is some way in which Child Safety Services could access the intelligence or the information that the police gather and store on their computer system to see what the police have got there without necessarily having to wait for the police to send it to Child Safety in the form of a notification. Now, Superintendent Harsley said that that was an information technology issue. He thought it may be a broader issue than that but that he would prefer to leave that to you to answer?---Thank you, Mr Copley. Certainly to enable the exchange of information in an efficient way an IT system would be potentially the best way of dealing with that. Bearing in mind that most of our data is now stored on IT systems within our department and in fact I would think in most departments, the exchange of that information through a network system certainly would be the preferred way forward, but that is only part of the equation, as you alluded to.

Yes?---The other parts of that equation are agreement between departments to share and there is a technological solution to part of that as well. The third part of the question is legislation that enables the level of data sharing that would be necessary in this particular case, the very sensitive information that's contained in those various databases.

Presently can Child Safety Service officers access the police computer records to look at the intelligence the police have - - -?---Not to my knowledge, and there are very good reasons for that.

Would you tell us what those reasons are, please?---Well, one would be access to the information. Our system is a closed system. It has very high level security around it and firewalls. Only authorised persons can access it and at this stage that access hasn't been granted, bearing in mind also that we have what we call an integrated data system, so once you get through the door, you actually have access to every room currently in our system. So that's one of the reasons why we're very careful about access to our full system, but there are technological answers to this and quite simple ones.

If the technological difficulties could be overcome, under the present legislative arrangements that exist, would there be any impediment legislatively to you giving access to Child Safety to your intelligence?---Whilst the service has the ability to allow access to specific information by specific people at specific times for specific purposes, the type of system that I would envisage that would overcome the issue that I see here - and that is access not

just by Child Safety to Queensland police records but in fact an amalgam of all the records relating to children at risk and that could come from the Health Department, it could come from the Education Department, it could come from us, it could come from Child Safety as well and probably the simplest way to explain it would be that you'd - you'd set up a system where that information was available in the one place.

You would then have to have software that actually did two things: (1) data matching - because as we all know, John Smith today can be John Fredrickson tomorrow, so you have to have systems that actually do data matching and the third piece that you need on top of that then is the ability, not just to match the data, but to also have potentially automatic triggers that if a record comes in, say, at 2 o'clock in the morning on the log for tomorrow is that this is the fourth time this month that this child has been recognised - and I'm taking this off the top of my head, of course, but it might be the third time this year that a child has come to the notice of authorities. It could be health, education and the Queensland police. That raises a red flag. That child goes into an automatic notification process.

You would envisage that the red flag would come up on the computer system of the other three departments that didn't put that information in at 2.00 in the morning so that they know it's there?---No. They have access to - the red flag would come up on the single system, but the single system should be then interrogated - well, not interrogated. It will spit out information to the relevant agency whenever you need it to spit that information out, so you might - - -

COMMISSIONER: Does each agency have a bucket that it spat information into?---There's a couple of different models, commissioner. You can have what they call a provisioning model. That means we all put the information into the bucket and that bucket could reside anywhere, virtually, but you would have to have an agency responsible for the bucket, of course.

Who would that be?---Well, Child Safety have the legislative responsibility for the protection of children, so my view is that that would be an appropriate place or you could simply say to Queensland police, "Would you please manage this system for us - this service for us and we'll fund that?" and it would sit in an isolated - you would isolate it from your main database and you would then lock it down in terms of controls about who would access it and how they would access it.

You see, because at the moment child protection or Child Safety Services - the chief executive, let's put it that way - the chief executive under the legislation is really strictly only responsible for children in need of protection, not for all children - - - ?---No.

- - - only a limited group. Unfortunately, there's too many in that group. So the information he or she needs at any particular time to perform that function isn't as broad as the information they're currently getting about children?---Okay. I take it that even though that being the case, the complex issue about this is that at 4 o'clock in the morning you may need a child safety officer to access records of a child who has come to notice of one of

those other agencies that has not ever triggered a level of need in terms of their safety under the legislative - - -

Which is why police are honorary child safety officers, virtually?---And certainly they are. They're named in the legislation, I understand that.

That's right?---I suppose what I'm getting at, it's the timing of all of this. You need the information when you need it. It's not about whether they've already gone into that higher level of need category that they've become part of the system where Child Safety have an obligation under the legislation. It's the ability to get to the information quickly, to know that it's accurate and to be able to look at that history and make reasoned decisions and on what action needs to be taken.

Don't they just keep looking in their letterbox?---I'm sorry, in the - - -

Child Safety need the information they need to do their job?---Yes.

They don't need necessarily all the information everyone wants to give them?---What I'm suggesting is that you can set up a system where all of that information resides in the same place.

And it's available to them if they want it?---Exactly.

And when they want it?---Exactly, but you can go a step further by creating criteria within that system that flags things for them.

Yes?---So they don't actually have to go searching through the paperwork, the flag immediately go up and they'll say, "Hey, this is a red for today," or, "This is an orange for today," or, "This is a green for today."

Exactly; the metaphor of the American letterbox where the flag goes up when the letters go in?---Exactly; and so it's that sort of thing. Those sorts of systems are available right today. I don't think that they would happen without legislative support and motivation through a legislative regime because, unfortunately, we're all very, very protective of the sensitive information we have. There's another side to this and that is when you get into the debate between what's information and what's intelligence and that's a whole other debate, but part of that depends on where you site the databases and who has control of the databases.

And whose job it is to use intelligence as opposed to whose job - - - ?---Absolutely.

- - - it is to protect children in need of protection by definition?---You're right, but again having access to all of the records, to me, would be the most fundamental

benefit of having such a system.

To someone - - - ?---Yes. Well, sorry. So it's there if it needs to be there. That's what I'm getting at.

Yes.

MR COPLEY: Intelligence to police could range from direct evidence through to hearsay three times removed or rumour or innuendo, couldn't it?---Basically, that's the argument. Information is something that's absolutely factual and you know it's factual. Intelligence might be simply that this kid was seen on a corner at 2 o'clock in the morning three weeks ago. That's a bit of intelligence, you know, nothing more than that.

Whichever department of government was responsible for the maintenance of and the upkeep of this central system of processing information would probably need extra money to do it, wouldn't it?---Look, this technology is not expensive. Certainly, the software that sits across these, they call it data management systems, major data management or something like that, MDMs, and it's about making sure that the right information is going into the bucket. That's the critical issue and that's not a difficult - that's not a hugely expensive exercise in my - sorry. I always have to defer to the technocrats and certainly my advice is that the type of software we're talking about, the software that we would identify links between people and records and then provide that at the press of a button or automatically is not all that expensive.

So if the barriers to this could be categorised as legislative, cultural - - - ?---Yes.

- - - technological or cost or financial - - - ?---Yes.

- - - the cost barrier you would see would be perhaps at the lower end of that spectrum of difficulty?---I would suggest that, but I can guarantee that once the technologists get hold if it, it will cost you an arm and a leg.

Yes.

COMMISSIONER: Won't go anywhere near it?---It's always an issue but, look, there's so many smart ways you can do this. You can actually have a spoke and hub model where the data stays with the agencies and you have a simple way of going out, sending out the message out on the spokes to the rim and then that information comes back in. So you send a message out to each of the agencies that says, "Do you know Bill Smith, and by the way, Bill Smith could also - you know, it's possible that these are the - information about Bill Smith so you need to do some data minding in your own to see if you've got a Bill Johnson who is actually Bill Smith." So it gets a little bit more complex when you do that. By bringing all the information into one

place, you can run your matching software much more easily and you can do it on a regular basis. There's another really great consequence of having such a system and it's one which does give you efficiencies downstream and that is that if you have all that data about what's happening with those children sitting in a repository, your researchers can get at it and they can start to look at areas and say, "Well, okay, why are we seeing so many children being notified because of" - well, let's say domestic violence in this particular area. Why are we seeing that? You can start to understand the causal factors in that area and maybe they're obvious causal factors, but what it also means is you can actually - then if you're going to treat the causal factors, you can actually put the right services in. At the moment, I think we're not that sophisticated because what we do is we look at an area. We say, "Right. This area - obviously it's got domestic violence. It's got alcohol issues. It's got relationship issues, so we'll plug all of these services in. Oh, by the way there's a sexual assault issue, so we'll plug in our sexual assault service as well." Two years on, you find your sexual assault service is hardly ever used and you knock off programs, you know - got about three people in and you've spent millions of dollars doing that. With this type of facility, one where you can have people looking at the factors impacting on why kids are entering the system, you can actually start to target your services to that area and that has a major - well, you can do it in a more efficient and effective way rather than just a shotgun approach

All right. I have no further questions. Thank you.

COMMISSIONER: Thank you.

So if you were responsible for the health of communities and families, that was your job as opposed to protecting those who were in need of protection under the statutory definition, then you would interrogate the information that the child protection agency had in order to inform your policies of supporting families and communities so that less kids got into the protection system, wouldn't you? ---You've absolutely right. That's exactly what I say.

And again not the other way around?---Yes. See, I think you've got a very, very difficult issue that you're struggling with here in this commission. I mean, if there was an easy answer to this, we wouldn't be here today. It's as simple as that. We would have a better system; you know, we'd be protecting all of our children. That is self-evident, as everyone knows. I think there are ways that you can tweak and improve the processes that we all have to use and I believe - I firmly believe that an intelligent computer or, you know, IT system can help us move forward in terms of our process and can make it more far more efficient and far more effective in the return on investment that we get out of that particular thing, but it's fundamentally attacking the causes of the kids into the funnel in the first place and this is not about police at 2 o'clock in the morning making a decision of whether a child needs to be notified to Child Safety. This is about the weeks and months before that and identifying, "Okay. There's a kid here," for whatever reason. There's a truancy record or something like and your system can actually start to flag those sorts of things and say, "Hey." A little bit of service and a little bit of support at that level might stop that child ever coming to that next stage and unless you have those systems that give you that insight, you're flying blind.

You can't formulate the policies and targets correctly, can you?---Absolutely not, no.

So really what you're saying is that the way you avoid harm which is one of the preconditions to entering the child protection system is by managing risk at the front end, identifying risk, managing and minimising it, to avoid or reduce harm further arm?---The potential for harm, yes.

The potential for harm?---Yes, absolutely. Look, there are still going to be tragedies. There is no system known to man that's going to stop this unless you took draconian action and that's not - we live in a wonderful democracy. That's not going to happen. The bottom line in all of this is it's all right to tweak the process but unless you attack the causal factors, we'll have another one of these inquiries in another eight years.

The object of the exercise then that I'm engaged in must be to work out, if because of our human condition there are always going to be a cohort of children in need of

protection, what that minimum number is and make sure we don't ever exceed it?---It's an interesting concept. I agree with your assumption but there will always be some children who are for whatever reason, for a whole range reasons - and I think the elephant in the room into the future is going to be mental health issues, but it's about protecting those children so they will exist. There will always be that cohort. You're absolutely right that at the moment there is no mechanism that we have to deal more effectively with the 80 per cent of those notifications. Ultimately they just go on file.

So if the exercise was to simply identify the kids at risk who might ultimately end up in the child protection system, then that's a lot different to - the test is: have they or are they at unacceptable risk now of suffering harm and do they not have a viable parent, because they're the two preconditions at the moment, whereas someone further down the track has to say to themselves before you even ask the viable-parent question, "Are these kids at risk?" and how can we manage that risk so we can avoid future harm? ---My supposition though is to say that if you let the notifications come in and you have a methodology that allows a secondary system to provide support mechanisms back at that front end in the very early stages, so early intervention, you actually stop those other notifications coming - - -

That's a good - at the moment the chief executive could do that, strictly speaking. I mean, they treat all your reports as notifications and investigate 100 per cent of them. The question is whether they need to do that or not, but the chief executive can document anything he or she sees fit with the information you provide and that might include giving the information to the community section of the department for the formulation of early intervention and prevention policies?---That would be my preference. The other part of that though is I truly believe that some sort of centralised assessment by professionals certainly will deal with a lot of those notifications where they do just simply file them and they put them into their system as intelligence or they give them to a secondary system that allows that earlier work to be done with the family.

So you don't want it to be information only. You want to do something useful with it?---Absolutely; you know, many of these systems now can - they can save you time because you can tweak your criteria to give you those ones who are plainly in that top echelon that need immediate reaction and some immediate work. Down below that you will have another area that are probably in that yellow area, so an amber area, and use the traffic light system. So your red ones - you've got to do something about them right today. The amber ones - you need to have a really think about that and, you know, maybe do some case management to decide which they will fall.

And keep an eye on them?---Absolutely, and then your green

ones you're probably just going to be able to say - look, other than letting the local support service know that, yes, you've considered it, that one can just go onto the file and that's the reality of it. Our system at the moment is skewed towards the agencies, so I'm talking about police, health and education. People want to do the right thing. They want to put these notifications in when they think that a child is potentially at risk of harm and I've heard - I've been listening to some of the broadcasts on the treatment and a lot of talk about the definitional issues, but at the end of the day people truly out there - those frontline people at 2 o'clock in the morning, whether it's a nurse or a police officer or a teacher at school at 9 o'clock in the morning, they truly want to do the right thing by that child so it will always be a conservative view. Many - they will go at the lower threshold to put the notification in.

Better safe than sorry?---Absolutely right, and it's proven time and time again. We see the skeletons of many careers come out of the court of public opinion, "You didn't obey the rules that were in your manual. You made a decision that was wrong so you're the person to blame for this child being severely beaten or malnourished or even ultimately killed."

Yes, that's the thing, isn't it? I mean, as I said early in this inquiry, it has got to be more than doing the thing right by the book. It has got to also be, as well as that, doing the right thing?---You've absolutely right, and that's why I think it's skewed towards that lower threshold than the higher threshold and that's why we have people putting those notifications in not mindlessly. I actually think they honestly believe they're doing the right thing; not just by the system but by the child.

I suppose that's where the professional comes in. Having got it, how do you assess it? What do you do with it appropriately?---Well, my view of that is that you can have a central panel of people, of extras, and these are the people, the child psychologists and the social workers, whose job it is to look at those reports and look for those little, tiny pieces of information that will give them an idea of, "Are we okay to put this person into the green field or is this person - look, there's a real warning issue here. They're going to go up into red," and we'll manage that more closely. It's a fact of all we won't always get it right and we know that but the system has got to allow for that too, but if we've done - I am concerned and I've listened - as I said, I've listened to some of the evidence already. I am concerned that if you're asking police or other agencies to start triaging out here on the edges before they put this into the mill, that raises a whole range of other issues in terms of training standards and again that culture of conservatism and how you manage that, and I'm happy to talk about any of those issues.

We might get you to do that after lunch, if that's okay, in

respect of that, deputy commissioner?---Pleasure. Thank you. Half past 2 today.

THE COMMISSION ADJOURNED AT 1.22 PM UNTIL 2.34 PM

THE COMMISSION RESUMED AT 2.34 PM

COMMISSIONER: Good afternoon.

MR HANGER: May I - - -

COMMISSIONER: Mr Hanger, good afternoon to you.

MR HANGER: Good afternoon. Another summons served. It's the - these summonses all have the same number even though they're subsequent summonses. This is 1978212.

COMMISSIONER: Hang on, I'll just look. Hang on.

MR HANGER: An extension of time for that because of technology issues. They're set out here, but could I give an extension of time until 31 August?

COMMISSIONER: Mr Copley, or you, Mr Hanger - - -

MR COPLEY: Before I answer that I suppose we would just need to be reminded about what that was a summons for.

MR HANGER: I'll hand you - - -

MR COPLEY: I don't need the book. Yes, that was a summons for what I think would be described as written information, so there, I'd suggest, be no difficulty in giving that extension.

COMMISSIONER: Okay. Mr Hanger, you're lucky Mr Copley is reasonable.

MR HANGER: He's always reasonable. It might be of assistance if these summonses all had different numbers, because I understand that they have the same number - - -

MR COPLEY: Some have - - -

MR HANGER: Some have the same number even though it's a different summons to the same person.

COMMISSIONER: I'm just making sure you noticed - - -

MR HANGER: Thank you, we did.

COMMISSIONER: We'll take that on notice and we will see. That makes perfect sense to me, though. There might be an explanation, I don't know. Maybe it - sometimes they have the same initial digits and then there's a lot after - - -

MR COPLEY: It could be a number that's being put on the document for tracking purposes, your Honour.

COMMISSIONER: Exactly. We may be tracking a document - - -

MR HANGER: I thought that might be the case, but it makes it harder for us to - - -

COMMISSIONER: Yes. No, I understand.

MR HANGER: Anyway, that's till 31 August, if I might.

COMMISSIONER: Yes, of course. We'll check that out. Now, Mr Hanger, do you have any questions?

MR HANGER: Yes, thank you.

Mr Stewart, just a few matters that we would like you to elaborate on. You've discussed this morning, as I understand it, the issue of a centralised hub in respect of intelligence of reports or matters of concern?---Certainly an IT system that would bring together the salient information revolving around children who come to the notice of the various departments that could then be used to - for departments, particularly of child safety, to interrogate and to do data matching and data mining.

Sir, if the commissioner is interested in such a proposal it would be - you would suggest the retention of the services of an IT specialist given the concern that the Queensland government has at the moment with its computerised information systems?---Certainly I understand the government is concerned. There have been some excellent examples of success in this area. The IJIS program (indistinct) justice information system, certainly our very own QPRIME system which brought together about 200-odd indexes, siloed indexes, and we also operate now the public sector network PSET, which is a network operating between a number of key government agencies. So there are people available that could advise the commission, I am sure, quite - in a practical sense.

You yourself in your experience have had a fair bit of work to do with computerised information systems?---I have. I was lucky enough to be given the job of being part of the selection and ultimately the entire QPRIME project in bringing that into the service, which has been a very successful cornerstone of everything that we do in our IT role.

If the commissioner is inclined to pursue the idea of an information retrieval system do you have a person that you would be prepared to recommend as being an expert in the kind of area you think that he would be interested in? ---Certainly I think that there would be available a number of people who would give very practical information to the commission about the type of system that we've been discussing this morning.

Are there a couple of names that you can suggest, or which you would be prepared to suggest at a later point in time? ---I'd prefer, perhaps, to suggest at a later point in time, but Paul Stewart, who is the assistant commissioner

for our ICT area within the Queensland police would be one of the names that I would put forward, and all of the other names would be people who work for him anyway.

Well, doubtless if anyone is interested they will pursue it through that channel?---Thank you.

Could I ask you to turn to the issue of the police's future strategy at the moment as you see it in the area of child protection? Do you want to make some comments on that to the commissioner?---Thank you, Mr Hanger. Certainly I think you would have gathered from my comments this morning that I certainly would like to see a similar role for police that currently exists. I don't believe that providing further roles to the police function would necessarily be advantageous to the overall protection of children in our society. There's a range of reasons for that, primarily, though, particularly in high demand areas where we deal with a lot of child safety matters or children at risk matters, often we have been engaged with those families in a range of other aspects and having the police make decisions, even very considered decisions, is an area that I'm not sure would stand the confidence of communities. I think child safety, one of the points that I didn't bring out this morning and I probably should have, having an agency which is primarily the lead agency that stands aside from these other, how do we say, referring agencies, nor notifying agencies, I think that that actually gives the community some confidence in terms of the decision-making and, you know, at arms-length from those agencies so they are caught up in that initial response activity.

So you're referring there to the fact that the referring agency is police or education or health - - -?---That's right.

- - - and the lead agency, as you use it, is part of the community - - -?---Yes, absolutely.

I suppose you have a concern that police continue to do police work and not family counselling work?---Absolutely. I think that we can't forget in this forum that the work in relation to domestic violence and our interaction with children is only one component of the much larger work that Queensland police does on behalf of the community and the government, of course, but I have to have a caveat here, and my caveat is simply this, government policy is government policy, and what is decided as government policy obviously the police department has to take notice of.

Of course, but you have a concern that the police not become community or social workers or counsellors?---I actually think there's a tension if you start to push police towards a more social worker, welfare view of their work generally, particularly when at the end of the day the role of the police is the enforcement of the laws of the state, it is the protection of the community even to their

own peril, and I just don't see that by moving or pushing that in that direction; in other words, training all of our police, and it would have to be all of our police, particularly (indistinct) police in all aspects that would be necessary to do some sort of triaging or better assessment of the incidents they come across. I'm not sure that there would be a cost benefit to the community.

So is this concern one that is happening now, that is to say, are you presently doing what I'll call broadly social work now, or are you concerned that that may occur in the future?---I'm the first one to say that - I mean, all police are human beings and they have the same feelings when they do their work, so if they see a child in need, I mean, they're not going to turn their back on that child in need, and certainly a child who may potentially be in danger of harm, but there is a process now where the police have a mechanism by which they can report back, and they do, and as I explained this morning, I see police often move into that considerable skewing towards conservative or low-threshold in that reporting process because they are human and because that is the system at the moment.

Thank you. Let me change the subject. Now, school based police officers - - - ?---Yes.

- - - that's been introduced, is it a system that is working? Would you like to see more of it, less of it? What are your proposals in that respect?---At the present time we have 35 school based police officers, I believe, yes, across Queensland. Most of them will have a linkage to the local CPIU, so the child protection units. The government has recently announced that there will be more - in fact, I think the number is 15 - school based or community based police officers. The model is an interesting one and on the return of an investment, I certainly believe that we have more work to do in that space, bearing in mind the ability to demonstrate that whatever roles are people are doing that they are focused on the policing role, but more importantly that the roles that they do are the most efficient possible and that they use the biggest return on our investment.

I suppose going back to our previous discussion, really, the school based police officers are almost doing a social work job rather than actual policing are they?---There's a real continuum in this space.

Yes?---I would agree with you that there are some who, because of their personal traits and their focus and the role statement that they have, I'm certain that they do get involved in that, I wouldn't say social work, but certainly they are concerned for the welfare of children in that school environment. So I would put that at one end of the continuum. At the other end of the continuum, we have school based police officers who are very focused on solving crime; that some of the school students would know about, gathering intelligence and certainly trying to minimise crime within the school environment.

The other heading I wanted you to deal with, to the extent you want to, is the issue of overrepresentation of indigenous young people in the system and I think you also mentioned to me Samoan people in the system?---It's a fact of life that we live in probably one of the most diverse cultural states in Australia and I think I mentioned to you that just recently I heard a fact that the Samoan language is the second language after English spoken in the Logan district, for instance. These are complicating factors bearing in mind the cultural aspects of family life that some of the ethnic groups bring with them, the different cultural groups. They have a different view about what family violence is or about what the treatment of the young people within their own communities and their own families. That brings with it special needs. I believe that the tailoring of services and in fact police services in those areas is very important and we do that through the use of community liaison officers, police liaison officers who are often of those cultural backgrounds to inject ourselves and to try and identify problems before they happen and to consult with the community or broader. Certainly, that's

at that level, in terms of the - whilst the same arrangements occur in indigenous communities, often the isolation of some of those communities bring special challenges to any agency when they're providing support mechanisms to children and families.

In your statement you talk about the police being a frontline 24 hour service. Do you think there is room for the Department of Communities to provide a 24 hour service or a more active 24 hour service?---I suspect that this commission will hear a range of views on this sort of thing. My personal view is that society has changed from - even in the last, well, five minutes, but certainly in the last 10 years. We now have an expectation that Woolworths is going to be open at 9 o'clock at night; that you can go on Saturday - you can go to your bank on Saturday morning; all of those services are available to you. You can go online and you can actually - at any time of the day or night and do your business. I think that generally agencies such as ours which already provide a 24/7 should not been seen as a catch all for jobs that other agencies just don't want to do at 2 o'clock in the morning and my personal view is that I think there is room for reform in terms of a range of agencies that could provide that 24/7 presence, even if it's a central one or a regional presence where access to information, experts are readily available and I'm not talking about a 24 hour phone service where we know that often trying to contact someone on those phones is problematic in the extreme. I'm actually talking about potentially even a call centre that can provide the type of information and feedback that our people need to provide that better service to the community at the time.

Thank you. That's all.

COMMISSIONER: Thank you, Ms Ekanayake?

MS EKANAYAKE: Thank you.

Jennifer Ekanayake of the Aboriginal and Torres Strait Islander Legal Service?---Yes.

Deputy commissioner, at paragraphs 70 and 71 of your statement, you discuss the use of multi-agency coordinated responses. Are you aware of the Child Safety funded Aboriginal and Torres Strait Islander Family Support Services that have been established across the state?---I am certainly aware that there is a range of services available that focus on issues associated with Aboriginal and Torres Strait Islanders. The specific services, I'm not going to sit here and say that I've got great knowledge and for me to talk about those would probably not be of great value to you.

There was some reference to the unique risk assessment framework that the Queensland police have which resulted in a large number of at risk families in the Child Safety region of services intake teams. Given prevention and

early intervention for families at risk, is mainly the responsibility of Child Safety Services and the secondary support services, could you tell us what assistance is provided to general duties officers and CPIU officers to promote diversionary pathways?---Sorry, if I could just clarify your question.

Yes?---You're asking me what assistance these other support agencies provide to our frontline officers or are you asking me about - - -

The Queensland Police Service gives the general duties officers and CPIU officers to promote diversional pathways - given that Child Safety and the NGOs do the support services?---If you're talking about what guidance we provide in our manuals - - -

Yes?--- - - - certainly, access to that information - is that what you're after? We have a large number of manuals within the Queensland Police Service that cover a forum of situations. In the material that was provided to this commission, I understand that extracts from our operation performance - sorry, our operation procedures manuals, our local members were provided - which had specific reference to matters involving Child Safety. In terms of guidance to our officers, this is more than guidance. This is actually direction about what they are required to do. In that way, we provide that. We provide particularly for Aboriginal and Torres Strait Islander and other cultures - right throughout their careers we reinforce multi-cultural awareness and training opportunities for our officers. That starts in recruit training and carries through right throughout their career life. We utilise PLOs quite extensively across the state - police liaison officers - who we choose from; usually from the predominant cultural groups in the particular areas, so it's a case-by-case basis and we utilise them in a way that our interactions with the community are not misinterpreted and certainly where issues arise, particularly cultural issues, that they can give us advice on how best to address those with that particular group. I don't know whether I've answered your question but certainly there is - as I said, if it's about guidance and instruction, certainly our people have that in spades. One of the difficulties we have is just - and I touched on this before. Dealing with children is only part of our role. We have thousands upon thousands of pages of instruction and direction and guidance for our officers in this.

Just continuing from there, what would you say are the current approaches of possible future training for general duties and CPIU officers to strengthen a direct referral pathway for Aboriginal and Torres Strait Islander families and children identified as low risk - I'm talking about low risk where, you know, they might be known to police - to support the reduction of overrepresentation and for more earlier engagement with services?---Certainly, and I'll try to answer your question. It covers, you know, a range of areas. If I could start by just going back one step and just adding some general comments to my previous answer, because what I need perhaps to express is that our strategic plan - our strategic involvement with indigenous communities are subject to separate plans. The service has a range of value statements and guidance to its officers about the professional way they interact with any community, whether it be the entire community or whether it be a particular cultural group within the community and in this case indigenous Queensland, so there's all of those sorts of issues. There is also guidance in the values that they should have and the commissioner's four Ps which include professionalism as a clear value statement to all of our officers is very much reinforced continually. So besides the manuals, if we look at that in a more strategic way, there are a whole range of other documents and guidance given to people. We think our relationship with the indigenous community overall is so important that we actually have an internal indigenous champion within the Queensland Police Service who chairs the indigenous reference police group. That person happens to be me and I chair that group and part of that is because we've recognised that our relationship with indigenous Queensland and in fact indigenous Australia is a very, very important one for the safety not only of the children but of the entire community. So if I just put that in that context, you then said, "What about the areas where there may be low risk?" I hark back to what I said before lunch and that is I think our officers - we look at the ability to refer families in particular or people or in need of support to relevant agencies and in fact we have SupportLink operating within our police service which is a - I say a commercial proposition but that's probably taking it too far. It's certainly a non-government agency or an NGO that operates providing access to officers anywhere in the state to a range of services, domestic violence counselling, sexual assault counselling, financial counselling, a whole range of areas. This has been going for some time and was subsequent to a program called CRYPAR that we had operating in the organisation with child and youth risk-type areas. So when officers saw individual families or groups or young people who were at risk, we'd give them a pathway to make a notification that is not into child safety at all. It's into a different component of the welfare system, so certainly that's available to our officers state-wide. I'm sorry, was there any - - -

Looking at the future, do you envisage any - - -?---Look, there's always room for improvement with what we do.

Training is not necessarily the panacea that a lot of people think it is because at the end of the day you can train, you know, every day of your career but in fact what we need is for our people to be out there doing the job. I think further in - our role in protecting the community will always be paramount to our people. Can I sit here and tell you about specific things that we will do into the future? No, I wouldn't go that far at the moment because we are undertaking a range of reviews about our role, our structure, and these are all as a result of the public-sector review that the government has asked us to do at the moment so there may be changes and there may be improvements, but the philosophy of continuous improvement is one which the Queensland Police Service certainly bases all of its operations.

Thank you. At paragraph 69 of your statement you refer to a rise in QPS call outs to residential care facilities to respond to children in care as both offenders and victims. Given the significant overrepresentation of Aboriginal and Torres Strait Islander children on orders, in your opinion what assistance and joint work needs to be done between QPS, child protection, child safety and residential care services to address this issue?---This mainly falls into the area where children are actually offending rather than as victims so these are children who are already in residential - some sort of residential care but they actually commit offences or commit acts which are so severe that there is no choice but to report it to police. Now, the types of things that I'm talking about are assaults, wilful damage, those types of offences or potentially worse, sexual assaults. Now, these matters are referred to us and we deal with them, as we are required to do in dealing with any complaint or criminal complaint. How can we better deal with this? Again I go right back to my statements this morning. I mean, I would much rather never see the child in this type of custody or in this type of care. My preference would be that we deal with a lot of this case management in the family situation, but again, as the commissioner rightly said, there will always be a group that will end up in care-type facilities. I think we have very good systems of notification. Again it comes down to the type of support that these individuals get in those facilities at that time because they're already in the system. They're way in the system at this stage. Unfortunately there is often that spiral down further into the criminal justice system or youth justice system that eventually is because of this type of behaviour.

ATSILS is aware of the Queensland Police Service's early intervention pilot. Is that the ROBI program?---QEI.

In particular the benefits of a cultural camp?---Sorry?

Is that the ROBI program? I'm not sure whether that's the right name for it, the ROBI program, an early intervention pilot that the service has - - -?---We've had a number of them.

Yes?---"QEI" I think is the title of it which is one of the early intervention programs and there's also been another one that was trialed on the north coast called PRADO. I don't know if they're the ones you're referring to.

We're looking at the - we're interested in, in particular, the benefits of a cultural camp and participation in the Red Dust reading program?---I'm sorry, I'm not in a position to take that any further.

We acknowledge the positive approach to give the access taken within this early-intervention approach and are interested to know how this might benefit children in care, at risk or escalating into the youth justice system.

MR COPLEY: The witness has said that he is not familiar with the matter that the questioner is questioning him about so he can't really comment on the proposition that's just been put to him.

COMMISSIONER: Is Mr Copley right, deputy commissioner? ---Commissioner, no, I don't have knowledge of the particular aspects that counsel is asking me about. However, I could refer back to the CMC report of our involvement with the indigenous community and some of the recommendations that were made there and this involved the notion that police can do more particularly in indigenous communities, not so much the issue of children in care, so if it's the children-in-care aspect, then I can't and perhaps one of my colleagues would be better equipped to do that.

However, if it's thought that a more general concept that police are seen as panacea particularly in isolated indigenous communities to be more involved with children, organising football matches, you know, activities for kids - we have police who organise breakfast programs, a whole range of things at the time. Often those programs are seemingly successful, often unsustainable, and often they rely on the personality of the particular officer and if that officer moves on, the program falls away.

My other question also relates to those pilots, but if I could generally say the early intervention projects that have taken place or pilots, my question then is: if these positive steps that QPS has taken could be utilised as part of a broader commitment by the current government to address, youth offending, given the restorative justice approach, it has taken to addressing offending behaviour - - -

COMMISSIONER: It seems a bit outside the particular - - -?---Yes. I was about to say that all I could say to that is that's probably a bit - - -

MS EKANAYAKE: If I could go back to the SCAN model - - -?---Yes.

- - - I just have a couple of questions on that. Reference that was made to the SCAN model, traditionally consisting of child safety, health and education, you would also be aware of the contribution of the recognised entities dealing with it in the SCAN teams?---Other entities in the SCAN?

The recognised entities - the recognised entities for Aboriginal and Torres Strait Islander children provided for in the legislation?---Yes. Whilst I've certainly been involved with this many years ago, my knowledge - - -

I see?--- - - - I can talk more generally and strategically about the SCAN process. If you are wanting to talk about the working (indistinct) SCAN, again, I would ask politely that that be referred to one of my colleagues.

Thank you, commissioner?---Thank you very much.

No further questions.

COMMISSIONER: Thank you. Ms Wood?

MS WOOD: No questions, commissioner, but in relation to paragraph 67, there's reference made by the deputy commissioner in relation to the other report by the CMC that refers to the service delivery gap that's been mentioned numerous times, counsel assisting might wish to have a copy of the report. It may assist, particularly - - -

COMMISSIONER: The restoring order report?

MS WOOD: Yes. I have a copy here.

COMMISSIONER: Thanks. Do you want to tender that or do you just want to check it out first? May as well tender it, I think.

MR COPLEY: I think given that it's a publication of the Crime and Misconduct Commission, which is already in the public forum - - -

COMMISSIONER: No need?

MR COPLEY: - - - there's nothing to check in that sense, but I think you used that expression, so I'll tender the restoring order report from November 2009.

COMMISSIONER: All right, thank you. That will be exhibit 31.

ADMITTED AND MARKED: "EXHIBIT 31"

COMMISSIONER: Thank you, Ms Wood.

MS WOOD: That's all, commissioner.

COMMISSIONER: Thank you. Mr Capper?

MR CAPPER: Yes. We have no questions. Thank you.

COMMISSIONER: Okay. Thank you. Have you finished, Mr Copley?

MR COPLEY: Yes, I have.

COMMISSIONER: I was just going to ask one question of the deputy commissioner while he's there. I don't want to miss an opportunity.

In paragraph 63 you talk about the new Domestic and Family

Violence Protection Act and about its coverage of unborn children?---Yes.

Do you know whether it's defined in that act; the term "unborn child" is defined in that act, off the top?---Off the top, I couldn't tell you. I'm sorry.

No, fair enough. It also says in the last sentence, "Where the aggrieved is pregnant, the court may name the child in a domestic violence order and protect the child when it is born." Do you know whether that's the extent of it or whether the child can be protected unborn as well? I know that's a little technical but - - - ?---It is.

I can have a look at it. I can read it, surprisingly enough, myself, but I just thought you might know?---No, I don't, personally know. I'm sorry.

MR COPLEY: Well, that would follow, anyway - - -

COMMISSIONER: No, not necessarily.

MR COPLEY: - - - if the child is in utero and there's an order protecting the mother.

COMMISSIONER: It depends who you're protecting the child from.

MR COPLEY: It's got to be the other person in the relationship otherwise it won't be - - -

COMMISSIONER: In this case, yes, yes.

MR COPLEY: - - - domestic violence.

COMMISSIONER: No, that's fine, but I was thinking of it in terms of whether the same definition could be used for section 21A of the Child Protection Act which does the order protecting - it talks about an unborn child being protected, but it doesn't define the term and, of course, the Child Protection Act could cover both the pregnant parent and the non-parent or another parent, but it doesn't matter. I can have a look at it later on and we can work that out without delaying the deputy commissioner any longer. Thank you very much for coming in. I really appreciate it?---Thank you.

MR COPLEY: May the witness be excused?

COMMISSIONER: Yes, he may?---Thank you.

Thanks, Mr Stewart.

WITNESS WITHDREW

MR COPLEY: The next witness will be a Ms McKenzie.

COMMISSIONER: Thanks, Mr Copley. Thank you for your help.

MR HANGER: Mr Commissioner, we've given our friends a statement by Ms McKenzie, but it's actually got a bit of handwriting over it and, of course, there's some amendments she wants to make. If we could use this statement this afternoon, but then I think that six months down the track, you'll forget that there's an amended statement, so I would like to incorporate the amendments in this statement so that we've got a complete and accurate one, if I might do that.

COMMISSIONER: Sure.

MR HANGER: So whilst she can use this one this afternoon, we'll fix it up overnight so that it's a composite statement.

COMMISSIONER: You can uplift it overnight and replace it.

MR HANGER: Thank you.

COMMISSIONER: Now, Mr Simpson - - -

MR HANGER: Have you got a copy?

MR SIMPSON: Yes, commissioner. Do you wish me to formally announce my appearance to the - - -

COMMISSIONER: Yes.

MR SIMPSON: Yes. Yes, my name is Simpson, initials A.P, counsel assisting. I appear with Mr Patrick of counsel. Ms Lyn McKenzie, Mr Commissioner, may she be sworn or affirmed?

COMMISSIONER: Yes.

McKENZIE, LYNNETTE CATHERINE affirmed:

ASSOCIATE: For recording purposes, please state your full name, your occupation and your business address?
---Lynette Catherine McKenzie. I'm deputy director-general of the Department of Education and Training, I am at the moment, and 30 Mary Street - 22nd floor of 30 Mary Street, Brisbane.

COMMISSIONER: Thanks, Ms McKenzie. Thanks for coming. Yes, Mr Simpson?

MR SIMPSON: Yes, thank you, Mr Commissioner.

Ms McKenzie, you are currently the deputy director-general of the Department of Education. You have to answer orally because the recording - - - ?---Yes, that's correct.

You were formally the acting deputy director-general of Education Queensland?---Yes.

Assistant director-general of education programs and services. Is that right?---That's correct.

You've held positions within Brisbane and the Gold Coast in institutes of TAFE?---That's correct.

You've been a teacher, a principal, an executive director of a number of schools?---Correct.

And you've worked in the education system here and overseas?---Correct.

What countries overseas did you - - -?---Japan.

Japan? You hold a masters in education training, a graduate certificate in business, a bachelor of education in science and biochemistry?---That's correct.

And a masters in government administration?---Correct.

Any other degrees?---No, that's all.

Okay. All right. If might take you through some questions in some groups and to give you a focus, I'll call them certain headings. The first heading is what I would describe as mandatory reporting and you start to deal with that at paragraphs 14 and 15 of your statement.

COMMISSIONER: Do you want to tender that statement?

MR SIMPSON: Yes, your Honour. May I tender the statement of Lynette Catherine McKenzie.

COMMISSIONER: I'll tender it because then I have to release it and then I'll give you leave to uplift that. Is there any reason why it can't be published? You don't want it published yet.

MR HANGER: No, it's better to do it properly, I think, really.

COMMISSIONER: Yes.

MR HANGER: There's nothing controversial that's been amended from it, is there? They were just trivial corrections, but I would prefer to get it right.

COMMISSIONER: Yes. No, no, I understand. It's just that with the live streaming and people who are elsewhere but connected electronically, when the statement is tendered and no application is made to suppress, I release it generally so that when paragraph 54 is referred to by counsel here, who already have a hard copy, people know what it is from the electronic copy, but that's something that we can cope with, I guess.

MR HANGER: No, there's nothing in there that is going to embarrass you or anything like that - any corrections you've made, so that's all right.

COMMISSIONER: All right. I'll accept the tender and admit it, and mark it exhibit 32.

MR SIMPSON: That's the statement sworn or affirmed 10 August 2012. Mr Commissioner, the addendum statement, which I wish to also tender which was affirmed 21 August 2012.

COMMISSIONER: All right. The addendum and the principal statement will both be admitted and marked exhibit 32 and released for publication without condition subject to Mr Hanger being able to uplift it overnight and correct it.

MR SIMPSON: Yes, then the new exhibit 32 can replace it tomorrow.

COMMISSIONER: That's right. After it's been tidied up.

The tidied up version will replace the current version as the exhibit?---Yes.

All right.

ADMITTED AND MARKED: "EXHIBIT 32"

MR SIMPSON: I'll take you to look at paragraph 14. You discuss under the heading of Education General Provisions Act 2006 some areas of mandatory reporting. I'll let you refresh your memory about that?---Yes.

Yes?---Yes.

My question goes to this: you speak in those paragraphs about the ideas of school staff being required on a mandatory basis to report what's called Future Sexual Abuse. Now, how does the department define that for its employees to know what they're dealing with?---Yes. In terms of the future sexual abuse, the training materials that are developed cover off how the staff can make those sorts of determinations and it's predominantly focused around grooming behaviours of an adult towards a child that may lead to future sexual abuse. There's information and definitions and examples of the sorts of things that staff members may see that could indicate that there could be a likelihood of future sexual abuse.

The idea of grooming is quite a specific matter and would you agree it's probably properly handled by people at police?---Certainly, our staff don't make judgments as to whether or not the sexual abuse is going to happen. I guess the mandation in the act is that if they have suspicion that there could be sexual abuse in the future based on some of the descriptions of the grooming behaviour then those reports are sent through to the police and to Child Safety and the police to investigate.

So, Ms McKenzie, the training you refer to, does that have a particular title?---Student Protection Training that we provide for all of our staff.

What's the document, do you know off the top of your head, or the policy that has the definition or assistance with respect to future sexual abuse?---The training materials in relation to that are tied up with the student protection. I can get you the name of the document and we can tender that document to the court.

Yes. That would be helpful. I'll then move on to training. You deal with that at paragraphs 43, 44 and onwards. You set out that pre-service teacher training takes place before teachers are placed in a state school? ---Yes.

You describe it as being, "A very brief, general introduction into child protection." Now, is that the teacher training that you've just spoken of?---No. The training I was just talking about is the training that we as the employer provide to our staff, so as part of university courses there's teachers who are undergoing training at university - do have a small component within that. That's in relation to child protection, but once they become employees of the state then we provide an induction program for them and then a refresher course for them throughout their careers.

What is the induction program?---The induction program is part of the student protection training. It's an online program and it takes them through the act as well as the policy and takes them through understanding the sorts of indicators of harm and the things to look for and things that they need to report to their principal.

Is that the program which apparently goes for about one and a half hours online?---That's correct.

So they complete that one and a half online program before they commence teaching in one of your schools. Does that apply also to non-state schools?---Non-state schools have a different policy. You'd need to speak to the non-state schools about what they do within their organisation.

So there's no consistency, is there, then between state schools and non-state schools as to the training that they get before they actually start to teach?---Yes. Certainly, the non-state school sector utilise our training materials, but it's up to each individual governing body to determine the level of training that each of these schools have within the private sector.

All right. As a deputy director of education, though, do you think it maybe would be ideal that there is uniformly across state schools and non-state schools as to this area - an enforced uniformity, that is?---Sure. I guess, I do need to qualify that my responsibility is with the state system only. I don't oversee the non-state system.

Okay?---But in terms of child protection, to have all teachers across the state - whether they're in state or non-state - to have an understanding of the risk factors and the areas of concern with harm I think is a good thing, but again each of the governing bodies have responsibility for determining the types of training, even though we do provide the training to them.

So returning to the state schoolteachers and they're one and a half training presentation that they get before commencing to each, what proof do you have that each of those teachers that teach in the state school sector have completed that training?---Two things: (1) we've got a record on the learning place, which is our IT system, where that training is held. We can actually call the records from there. We also have a requirement that principals keep a record of training at the school and as part of our internal audit program within the department, it is the training under child protection that's required. It is part of our audit regime, so we're able to determine when an audit of a school occurs whether or not that training has taken place.

If a teacher hasn't undertaken that training and ongoing training in child protection, does that affect their registration at all?---That would have to be a question I'll have to take on notice and talk to the Queensland Teachers College. I'm not able to answer that question directly.

Okay. Now, what - - -

COMMISSIONER: Sorry. Sorry, Mr Simpson.

Paragraphs 10 and 11 of your statement, you talk about the current legislative framework and you reproduce the section as amended, effective 9 July 2012, but it doesn't include paragraph 2(a) which says what the principal has got to do with the information once he or she gets it from the first person, that is the teacher?---That's correct. It's not in my statement. I can provide that to you, though.

Yes. No, but just for the record, what it is, is the principal has to tell a police officer if it's reported to him or her. Is that right?---That's correct. The act requires the principal to report directly to the police so if it was a staff member, they report to the principal and the principal is required to report it directly to the police.

So the principal acts as a filter?---No, not in cases of sexual abuse. If a report is given to them, they must provide a report.

This is a new position, as I say, from July this year, isn't it?---The difference previously was that the principal could report to their supervisor, who then could report to the police, but that's been made so that they report directly to the police.

But the teacher doesn't report directly to the police, but only via the principal?---Correct.

All right. But the teacher has an obligation to report to the principal, who then has no choice but to report it to the police?---Correct.

All right. What's the point of that amendment, do you know?---I guess in terms of the principal is the overarching person responsible for the safety and care of students in the school, so we have the reports go through the principal.

Yes. So he or she knows at least what's being reported? ---Correct.

But has no control over whether it is or isn't?---They must pass on that report.

All right. The other thing is the non-state schoolteachers have the same obligation under 366 as state schoolteachers, don't they?---They do.

Is that new or is that existing?---The non-state schools have always had an obligation to report sexual abuse. That's correct.

But, again, now it's through the principal?---Well, again it used to - it was to the principal. The principal could report it to the director of the governing body or - and in this case it's now clear that they report directly to the police.

So while the principal knows what's being reported, the governing body by his teachers or her teachers - the governing body may not necessarily know what's being reported anymore by the principals?---I'll need to think about that for a minute.

Well, if you're taking someone out of the equation and the reason you have the principals in the equation is so they can see what's moving from the school to the police, the person who is no longer in the equation doesn't necessarily, unless the principal tells them - - -?---Yes, look, I take your point. I just need to refer to the act. I'm just not sure whether the act also requires them to pass it on. I don't have a copy of it in front of me. In terms of the non-state schools I just need to check. Thank you.

I think if it's an abuse by an employee of the school then the principal seems to have to report to a supervisor? ---Yes, that's correct. If it is - if they suspect it's the principal then they need to report to the principal's supervisor. I'm just checking the part you're asking in relation to whether the non-state school principal still informs the governing body. Commissioner, unless one of the lawyers in the room can read the act faster than me and find that answer, I don't believe they do have to pass it on to the governing body, but someone may correct that record if that's the case.

All right. Well, we'll - - -

MR SIMPSON: These things are checked off in your accreditation, though. Do you know that?---When - - -

A non-state school has to comply with this. In order to be accredited in Queensland they would need to comply and prove their - - -?---Absolutely. The non-state school accreditation act does require non-state schools to have policies in place for student protection and for the safety of students, and the Non-State School Accreditation Board takes their responsibilities very seriously around that and do follow through any concerns that may be there. They check in terms of their registration that it's there and follow through any concerns that may be raised.

So maybe, Mr Commissioner, it falls then to the governing body to make sure that they're keeping on top of what they're accredited for, perhaps.

COMMISSIONER: Yes.

MR SIMPSON: Can I ask this, though, talking about principals and their onerous position under the act. What extra training do they get over and above what ordinary teachers get in identifying child safety matters?---Sure. In relation to principals, they go through exactly the same training, however they also have direct access to the SCAN officers that are based within our department. So we've got senior guidance officers in every regional office who provide support and take questions, you know, on notice and direct questions from principals whenever they're making decisions around the policy matters about what they need to do in relation to policy or in relation to this legislation. If they are new to the principalship then they have a number to call within the region where they can ask, "What do I do? I've had this report," so that they do follow the act.

So they have an ability to have ready access to someone who can assist them in the comprehension of their obligations, the comprehension of what child safety is all about?---Yes.

What might be a suspicion of harm, or what might be harm, those sorts of things?---Yes.

But teachers don't necessarily have that ability to access those teams?---Yes. The teachers are - not directly to the regional teams, no. It tends to be principals that would contact the regional teams. Teachers usually will go to their guidance officer within the school and ask the guidance officer qualifying questions around that, or whoever provided - whoever within the school is the one that ran the child protection training, because sometimes as well as the online, when they do the refresher it will be a face to face in a staff meeting, those sorts of things. So there will be someone in the school that they can go and ask questions of, or the principal.

Now, you've said in your affidavit that there are refreshers annually and again I'd perhaps ask you to take this question on notice. Is it the case that teachers must perform those things before they can be accredited to teach?---Yes. Can I take that on notice? My - - -

Or continue their teaching, so to speak?---Certainly. I mean, certainly once teachers start with us it is the responsibility of the principal to ensure that the induction happens, but in terms of going back to

registration I'd need to have that clarified for the commission through the Queensland Teachers College.

But there might be circumstances where teachers slip through the gaps and they move from one school to the next and perhaps miss the training?---Given that we've got a policy that you get your - everybody must go through the induction which is online, plus we have annual training every year, you know, of course there's always the occasion, but it's unlikely given the amount of ongoing training that we have.

All right. Now, do you think the system works in terms of this training and in enabling teachers to make those judgments about whether they should report suspected harm? ---I certainly think that the amount of training that teachers have and the officers on the ground that can provide them information, such as guidance officers, principals, deputies, et cetera, and other experienced teachers, that teachers are aware of how to make judgments around harm and risk of harm and are aware of their obligations to provide that information to the principal.

Well, here's a challenge then. In your affidavit you've effectively said that of the matters that are reported 78.7 per cent of them don't even reach the threshold. So balanced against that figure is the system working? ---Again, I believe it is, and I think that part of the point within that is that our reporting is around harm, any significant, detrimental harm, or risk of harm that we perceive, and the threshold that child safety has is when they determine that there is harm and that the parent is not willing or able. So there's a different threshold that we use. We report harm, we don't report - we don't go and investigate whether or not the parent is willing and able to support that child. So I think the fact that we put the reports through, given that we only have one piece of the pie as well - so we might only have knowledge about what we may see or hear from the child, but we don't have what the medical professionals have or what the police may know about that family. So we put in the reports and then those reports are then looked at by child safety and they make the determination as to whether it meets the threshold that the notifications - but we have different criteria by which we determine.

COMMISSIONER: Therein lies the problem, isn't it? That's what the department complains about. It says, "Everybody give us all these reports that go nowhere near our

threshold. It takes us four or five hours to process them and the substantiation rate doesn't change"?---I'm aware of that. It's certainly - - -

What's your response?---No, look, it is a real challenge. I guess we take our responsibility very seriously in terms of upholding the Child Protection Act and ensuring that children are safe and so if we have any information then we believe - and we're clear in our policy to our staff that it's something that they believe would be the significant and detrimental effect on the child and they're at harm or at risk of harm, that they need to provide that information and they're not to make a judgment about whether or not it's going to meet a threshold of whether the parent is willing and able. That's the challenge.

Well, if somebody feels the need to give that information to somebody else better placed than them to make - to keep the child safe, the problem is that's not the department - that's not child protection's job unless the child is in need of protection. So what the department is saying is, "Well, everyone is passing the parcel to us so that if the music stops we're the one who - - -"?---Yes, I understand the argument and it is a challenge, but I think that as has been - over the last couple of days in the commission, that somewhere there needs to be that information gathering, because within schools we only have a small piece of the pie, we don't have the whole information to make a judgment as to whether that child is or isn't safe.

In New South Wales I think everyone reports to a central hotline, without making value judgments, and then the hotline is staffed by people who can make a judgment and the people who staff the hotline decide where it should go to, which is best placed?---Yes.

That relieves everybody of the obligation of - what do you think about that idea?---Again, I certainly believe it needs to go somewhere. Who gets that information - and I understand the arguments put forward by the Department of Communities. Who receives that information is obviously a challenge for the commission to work through, but it does need to go somewhere.

Well, see, there's no point in sending it to the wrong place, is there, and there's no point in sending it on to somebody who is not going to do anything with it because it's not within their statutory remit. So the idea is to identify somewhere where the information is going to get

the treatment that the person supplying the information intends it to get or that it deserves; that is, if it is going to assist in the protection of a child before they get into the tertiary system then somebody needs to be given the responsibility for doing something useful with that information in a preventative sense. Who should that be?---I mean, in terms of who currently exists, at the moment the place it goes to is the Department of Communities, in terms of they're able to look for it. Whether there needs to be another place, whether it be government or a non-government organisation, who can do that filtering, but I agree, it does require somebody to filter it.

Where does it go? Does it go to the Department of Communities, which of course is something more than just the child safety services?---Yes, my apologies, I mixed the language. I can't - we send it to child safety, yes.

Yes. There might be somewhere within communities that might - the chief executive might properly see - - -? ---Yes. I think, you know, in terms of the schooling system, for a principal to send a report through they look - particularly around the harm, not around the mandatory obligation on sexual abuse but around the harm. They look at all the factors. Often the guidance officer has already had a conversation with the parent, if it's, you know, potential - they're concerned about the child being tired when they come to school, those sorts of things. They would have potentially talked to the family. If the parents brought the issue to them, they've already spoken to family and referred them to an alternative agency to get some of that secondary family support. So the ones that we're reporting are actually the ones that the principal, having weighed up everything, they believe is something worth putting on the table.

Yes, I know, but that's a matter of policy, because your only mandatory reporting obligation relates to child sex, doesn't it?---That's correct.

So here's your policy which is commendable because it's child focused clashing with the policy of the tertiary service provider which is also child focused but only when the statutory gates are open. They can't do anything before that except, I think, in section 10 or 11 the chief executive doesn't investigate everything. It can be something else appropriate, but what they're saying at the moment is there's no-one else appropriate, "We're the last

carriage in the train at the moment." Have they asked you to review your policy of report?---There's a trial on at the moment in one our regions to assist our principals in terms of the decision-making tree. We often have conversations as being - through the child safety network we have a number of - our child safety network representative has those conversations around how do we get the, I guess, more refined reporting through. So that decision tree - and you probably heard about the guide that the principals are now using. So the principals are working through that guide to look at whether or not they make a different decision and then refer out to a secondary agency if it's not something that needs to go through to child safety. The challenge with that is that principals already refer out to other agencies if they don't think it's something that needs to be reported to child safety and so although the guide is helpful in giving people a yes, no, where do I go, and particularly helpful for the new principals, perhaps. It's not really changing their decisions about whether to put a report through to child safety.

Well, child safety say you're still getting it wrong 70 per cent of the time.

MR SIMPSON: 78.7 per cent of the time.

COMMISSIONER: Thank you.

MR SIMPSON: Of the 14,286 reportings that you referred to in your affidavit, how is this commission satisfied that there has been a consistency of approach to get to that level. In other words, is there a consistent measure of getting things to the reporting stage or is it just left to the individual teacher or principal to determine?---I understand your question. Certainly it is left to the individual professional judgment of the principal to determine whether a report goes through, however given that we have extensive training and we have the regional support people who they ring and have conversations with and it's not unusual for our principals to also ring the regional intake officers at child safety, then I believe we have quite a consistent measure of what is going through.

I guess, but because it's made by humans and people make errors there's going to be some discrepancy?---Yes, there is.

So have you found there are any regions where one

particular principal reports higher than other principals? ---Certainly over the years that's been the case and because we have - our SCAN representatives have the relationship with the Department of Child Safety through the SCAN process and also the regional intake officers, whenever it occurs, and there have been occasions when there's a new principal and perhaps they need some more training about what is significant detrimental harm, then the risk intake officer will let our SCAN representative know, who will then provide some extra training to that principal. So I think that relationship and ongoing conversation means that we maintain a more consistent approach.

All right. The commissioner was referring to, I think, the area of the child protection guide. That's at paragraphs 53 and I think 64 also of your affidavit?---Yes.

You say there that in the January 12 to June 12 period it's been accessed 97 times. This has been a trial that's been rolled out in the south-east Queensland district or region. Is that right?---Yes.

Now, was that underwhelming or overwhelming or about consistent with what you expected for the access of this guide?---The guide itself wasn't mandated for principals to use during the trial, so experienced principals are less likely to go and have a look at this and to access it online. The feedback I'm getting back is that the inexperienced principals have found that it's been really valuable, but those that have been in the role for a long time and are aware of the sorts of things they need to send through may not have accessed it as much.

COMMISSIONER: Can I just go back to those notification questions? Do you get any feedback from the department about the value of your reports, to use a neutral term? ---Yes, we do. As part of the protocols the child safety intake officers provide feedback to us in relation to the reports and whether they met notification. Twofold, it gives us feedback about that information, but it also allows us to go back and question why it didn't meet notification. So sometimes as through - not in SCAN meetings themselves but through the - I've forgotten the acronym, but the other side meeting which I'll just need to refer to - - -

That's all right?---But, you know, there's the other group that meets as part of SCAN where if it doesn't meet the

notification level and so it's a case that maybe comes to SCAN and we think that maybe it should have met notification, we contact the regional intake officer, have that conversation. In some cases the regional intake officer may change their decisions, in other cases we take it to that multi-agency group to discuss to see if there's anything else that we're concerned about.

When you say it doesn't meet notification, do you mean it was rejected not because there was no viable parent but because it wasn't a significant detriment?---That's my understanding.

Is that the department didn't think that the report involved a significant detriment over the defined time? ---I'd need to check whether a regional intake officer also made a decision around the parent side of it. My understanding is that at that point it's just that they didn't think it met the threshold, but again, keep in mind that we send them in of the view that it's one piece of information.

Yes?---It's not always going to meet the threshold.

Exactly. I mean, you're not trying to meet the threshold, are you?---No.

So it's not surprising that there's a lot don't?---That's correct.

So what's the threshold?---The child safety threshold?

Well, what's the threshold as you - what are you calling the threshold?---Significant and detrimental harm.

Right. That's all?---Mm'hm.

You don't look at the threshold as including an unviable parent?---No, except when it comes - - -

Well, no wonder it doesn't meet the threshold?---Except when it comes to - - -

It's not the same threshold?---Yes, my apologies, except when it comes to self-harm. So if a child was self-harming we'll notify the parent, not necessarily child safety, however if we believe that there is a parent that is not able or willing to protect that child from self-harm then we would send a report through.

Is that common?---Self-harm?

No, reporting someone to the department for self-harming? ---Most parents will be willing and able to provide - take them to a medical practitioner and psychologist, et cetera, provide support, though there are cases where we would report that through. I don't have figures on that. I wouldn't be able to get things on that.

You're mindful of it though being done?---Yes.

What about a situation where you report - sorry, Mr Simpson.

You report a child, child X, and child X has been going to this school for five years. The principal knows that he or she has passed on child X's case to the department five times in a 12-month period. On each occasion it hasn't met the threshold either because it was only a report of harm that, though significant, there was judged to be a viable parent and your feedback from the department says, "Sorry, missed out on the threshold again this time." What do you do about that?---The principal would have a conversation with our SCAN officer in the department and the SCAN officer would then go and have a conversation with the regional intake officer and if they're still not satisfied - if we still believe that it is significant and detrimental harm and should have met threshold, then we'll raise it with the multiagency to see if other agencies have also got information about that parent.

What's happening to the child in the meantime, assuming everyone's at work at the same time?---That's the process that we use if we're believing that there's harm and that it may not have been responded to.

Let's hope it's not self-harm that's involved on this one. There must be a more efficient way of dealing with a dispute as to whether or not a child needs help from someone now?---Keep in mind also at the school level around self-harming we've got guidance officers and we've also got senior guidance officers in the region so we would put that immediate protective service around that child, but at the same time we'd let the Department of Communities know that there may be a long term. We also make direct calls to CYMS which is the child mental health if it's a self-harm case to give them a heads up if there's a concern, but obviously we have privacy issues at hand. If we have the permission of either the parent or the child, we can pass

on the child's name to the medical practitioners, but if the parent refuses us to pass that information on, our only option then is to advise Child Safety.

With self-harm, is more often than not repeated or is it a once off? Which is the more prominent?---It can be either. I mean, there are cases where we - you know, we become aware that a child may be at risk of suicide and we need to get some service to that child or it might be, you know, ongoing self-harming issues that we become aware of that we involve parents as a first point of call and Child Safety if we believe there needs to be further protection.

Okay. Just, finally, on notifications, do you know - I think the reports of suspected abuse from your department is about 15,000 in the last 12 month period?---Yes.

How many of those related to suspected teacher abuse of a child? Do you know?---I could get you those figures. I don't have those figures here, but certainly anywhere where it's an employee, no matter which employee, whether it be teacher or other employee, that information is also referred directly to the CEO's delegate which in our case is our ethical standards unit and those matters are investigated both by police and also internally by our - - -

That's abuse of any kind, including sexual abuse?---Any abuse, any harm, to a child by an employee is reported through to our ethical standards unit, that's correct.

And in the case of sexual abuse it's mandatorily reported to the police as well?---Correct.

Whether it includes an employee, a teacher or anybody else suspected?---That's correct.

And you don't know what the figures are for the last reporting period of sex abuse even, the suspected sex abuse of a child at school by a teacher or employees?---I don't have those figures on me but certainly we would have those figures.

All right, thank you. Would you provide them for me?---I can provide those.

Thank you.

MR SIMPSON: Are there certain regions or particular

schools that have a higher than average reporting? Does the department keep statistics on that?---We don't keep statistics ourselves. We actually have the statistics that come from Child Safety so Child Safety is the one collection point for all of the reports and we get that information back from Child Safety. It comes back to us a whole-of-state figure.

All right. So you don't get from Child Safety a by-school or by-region breakdown?---I don't have that, no.

But do you think Child Safety would have that?---I've never asked them personally that question, but we could potentially see if they do have that.

All right. Now, you address in your statement the early childhood education area. Are you aware that there is what seems to be an inconsistency between the Child Care Act and the requirements under the Education (General Provisions) Act with respect to reporting?---Look, I need to declare that I don't actually oversee the early-childhood area. That information is provided to by the early-childhood area and if there are questions in relation to that, we probably need to get someone from that area to respond.

Okay, but maybe you could answer this question: if you take what I say is a fact, under the Child Care Act a child care worker or carer does not have to report any suspected abuse unless it happens in that child care centre which is sort of what a state schoolteacher would have to face? ---Mm'hm.

Would you say there's a cause for consistency across the various levels of education in Queensland to bring it more into line with what state schoolteachers do?---Sure, I understand your question, and I guess across the - whether it be across the early years' schooling within this state or then when you make comparisons across other states, there are slight variations across, so in terms of that particular act, yes, I suspect - my personal opinion is I'm actually surprised that there isn't the same level of reporting, but I also understand that we've very recently changed out act to have a sexual abuse of any person as opposed to prior to that was only by employees.

This is not just sexual. This is any harm?---Mm'hm.

So if a toddler comes to a child care centre with bruises or some sort of - something to indicate harm to that child,

there's no requirement under the Child Care Act for the carer to notify anybody if it didn't happen at the child care centre?---I wasn't aware of that and that's interesting.

But as a professional in this area, would you agree that there should be consistency?---Certainly it's my view that when you're talking about protection of children and if a child is in a child care centre, they have the same access as we do with school children. It would be a logical thing to expect that they would have a similar responsibility.

There are a lot of child care centres that are almost attached to schools these days, aren't there, in some areas?---Yes, certainly in some cases they are.

It's always the kindergarten running right through to prep and up?---Sure.

Now, if I can change the subject to what we might call behaviour management, do you accept the general proposition that children going through the trauma of abuse and neglect sometimes have complex behavioural issues which teachers then have to manage?---Yes.

Yes, and is it your experience that that might lead to an increased level of, say, suspensions or their exclusions in those particular students?---Certainly where children are demonstrating, you know, challenging behaviours, then they can lead to more suspensions or exclusions. Certainly we have a whole range of procedures in place to try and minimise. Suspension exclusion is a last resort for us. It's not what we go to straightaway, but in terms of protecting other children in the school sometimes we are required to go down that path.

Do you have any information on the number of children in out-of-home care who have been subject to suspensions or exclusions?---There is a report from the Children's Commission that - and I think also from Child Safety that provides that in terms of the suspensions and exclusions and I actually have a summary of that data. Is there a particular question that you're after?

What I guess I wanted to is: what is the targeted mechanism with the department to focus on these children to keep them out of suspension or exclusion because they obviously have - they must have some difficulties to get to that point?---Mm.

So what's the targeted policy that you put into place for these particular students to prevent them from getting that far?---Yes, look, we have a really strong policy around that in terms of the educational support plan and educational support funding that provides support with the educational support plan we look - it's for children in out-of-home care and there's a case-management approach to that to look at what are the needs of those children to ensure that they can get the maximum educational opportunities and one of those, if the child does have challenging behaviours, is in relation to, you know, our consideration of how we can support that child to learn new skills, et cetera. So through those educational support plans the behaviour area is considered and, where necessary, support resources provide it. We also work with Evolve which is funded through - not funded through us but we work in partnership with them to provide - to work with them around strategies for therapeutic support particularly for children with challenging behaviours as well.

Now, there obviously would be some sort of mandatory criteria before you could put a child on an education support plan. What are the mandatory criteria?---Look, can I just read it from the document so I don't confuse everybody. I will just get the support plan document. The requirement around that is for a child who is in out-of-home and are on a custody or guardianship order to the chief executive and enrolled in a state, Catholic or independent school.

And that's it?---That's my understanding.

So there doesn't have to be any particular behaviour displayed before they get to an ESP?---No, actually an ESP is required for all children that meet that criteria. However, obviously the support that's made available to the child is dependent on the needs of each child. So in some cases the child may need minimum support. In others they may require higher levels of support and that's worked out through the education support plan.

Now, as I understand it, $6.3 million was assigned in the 2010-11 financial year to this educational support plan, of which it serviced 4064 students in years P to 12?---Mm'hm.

Could you say whether the focus was more on secondary or primary education in that funding?---I don't have those figures to hand. It would depend on the breakdown of those

children, if they're in primary or secondary. I certainly would be able to provide that to the commission but I don't know.

And of the $6.3 million that was spent on this plan, could you say how much of that actually ended up with the students, so to speak, rather than tied up with an administrator handling it?---Yes, I understand your question. Certainly from Education's point of view we receive the funds in from the Department of Communities. We actually sent it all out to the regional offices and the guidelines are clear that it needs to be going then on a case by case to the students so we maximise the money going to the students as opposed to administration of it. So there would be a small part and I can give you the breakdown of that, but predominantly it's through to the schools to support the children.

If you don't have the information, then perhaps you can provide that in relation to the commission?---Yes, we can provide that.

I also am instructed that with the funding as at 13 July 2010 state schools took up 68.2 per cent of the funding compared with 87.7 per cent of students at Catholic schools and 74.6 per cent of students at independent schools. I guess the question there is: why is the smaller take up of funding in the state schools?---Good question. I'm not aware of that data. I'd have to look into that data.

I'll tell you where it comes from. It comes from the 2009-10 Child Protection Partnerships Report, page 29? ---Okay.

Perhaps you can look at that again and with more notice answer that question?---Yes, thank you, I will.

2009-10 Child Protection Partnerships Report, page 29. Now, I might just return to the idea of behaviour management generally?---Sure.

You spoke before about the alternatives that you would look at before suspension or exclusion. How does the department work with children in out-of-home care to explore those alternatives and what are those alternatives?---So in terms of the process through the educational support plan then all of the stakeholders come together, the foster carers, the child safety officers, the school staff, the students to look at what are their needs.

Now, if one of the needs is that they have challenging behaviours then the school provides in some cases additional teacher aide support to supervise the child in the playground, particularly for the little children, supervise them in the playground while they are, you know, learning. At the same time they will have a skills development program for the child in terms of how to be in the playground and develop their social skills if it's in relation to the way in which they interact with peers. If it's in relation to secondary, we also have alternative education sites where it may be that their schooling is done in a smaller environment rather than in a larger school, so we look at what suits the individual child and look at a solution for that child, whether it be skills training or whether it be an alternative education setting that meets their needs.

Is a lot of that dependent upon what the other stakeholders use or do in the process, like the foster carers?---Yes.

Does it depend a lot upon their attitude to it?---I mean, certainly whether it be children in out-of-home care or children in home care, the partnership between parents and family and the child for managing a child within a school setting is crucial. So obviously we do need to work with the foster families in terms of what support they can provide and we also then work with other agencies, such as the Evolve program and students being referred to those if they are needing the higher level of therapeutic support.

All right. In your affidavit you talk about how a principal might assess certain things about a particular child before he or she suspends or excludes that child, such as where they're going to be if they're excluded or suspended. Where does a principal find those tools to assess whether they should exclude or suspend a child who perhaps might be walking the street because a parent is unable to care for them yet the child is not in the child protection system as such?---Before a child reaches suspension, there would have been meetings with parents and conversations with parents about the sort of expectations that the school has around the behaviour of that child, the support programs that the school is going to provide for that child, the expectations the school has for parents for supporting the school in ensuring that the child understands the acceptable level of behaviour, et cetera. So during those lead up meetings and any other interactions they're having with the child, the principal would have been made aware of the circumstances of the child and makes judgments around those sorts of things. The suspension just doesn't happen because they decide to suspend someone. It's a process of trying many things before we reach the suspension and exclusion.

But if you've got parents who are just not being cooperative and the child is being disruptive and you may suspect there's harm or some problem with the family, what is a principal meant to do when they're confronted with a

situation where if they suspend the child or exclude the child, the parent isn't going to care for them, on their assessment, but they have no other choice for the good harmony of the school? Where do they go to?---Well, if they believe that by suspending the child, the child could be at risk of harm because the parents aren't willing or able to care for that child then there would potentially be a report through to Child Safety, but you're right, the principal has a responsibility for the good order and management of the school and a safe and supportive environment for all children in the school. So that's one of those professional challenges they face every day about managing children and young people within that environment and deciding whether or not their behaviour is such that it is disrupting good order and management or the safety of other children in the school.

COMMISSIONER: What about the situation where - I notice in that notification provision 365 - the reporter, if you like, reports anybody who is suspected of sexually abusing a student under 18? That could cover the situation of a 17-year-old student sexually abusing a 13-year-old at the school and you would have to report that?---Certainly in the case where there's a significant age difference like that, that would be something that would need to be reported.

Why would the significance be age determined -the reportability of it?---One of the challenges that we have is around young children who may be involved in activities together which is not a power relationship, all those sorts of things. We would alert the families, but we would also alert Child Safety. So the harm associated with that - usually with sexual abuse you don't alert families. It's straight through to report, but with younger children, you would often involve the family as well.

Like if they were experimenting or something like - - - ?---Yes.

- - - that as opposed to someone exploiting a power differential - - - ?---That's right.

- - - and an older boy and a younger girl or vice versa?---That's right. That's right.

The mandatory obligation doesn't draw a distinction between the age disparity, does it?---No.

And the only distinction you draw is that you might tell a parent if they're both 13 or 12 or something - - - ?---That's right.

- - - but not necessarily if they're older?---No, that's right.

But why wouldn't you tell the parents in the case of the older children?---In the case of the older children, one of

the challenges that we face is that we have under 426, the confidentiality clause, so we need to - with the older children, we need to make judgments about whether or not the child is able to say to us, "I don't want you telling my parent," and we make a judgment whether or not they're able to ask us to do that under that 426 and if they say, "I don't want you telling my parent," then in some cases we refer to Child Safety, but we may not necessarily directly tell the parent. What we usually do in all cases, we talk to the children about, "You need to make sure that your parents are aware," you know, "Do you want us to - what words are you going to use and do you want us to be there?" those sorts of things and work that through for the young person.

Is that a bit like telling the child they've got to do their homework?---A bit like that.

What is the privacy right of a student who's aged 16?---We follow the same line as the health follows in terms of making a judgment. We lean on the side of parents always being informed, but where there's a concern that there may be further harm. We may not always tell the parent if the child is saying, "If you tell my parents this will happen," we'll report it to Child Safety and let them work that through.

Do you put a qualitative or a value element on the word "abuse" in 365?---What do you mean by that?

The obligation is to report sexual abuse of a person under 18 at a state school. What's abuse at a state school?---So I guess if we've got two 17-year-olds consenting and we become aware of that through conversations of a child talking about what they did on the weekend, it may not be something that we refer through to Child Safety if they're both 17.

Or their parents?---Well, we would again advise the young person that they need to discuss that with their parents. If they ask us not to, then we don't always tell the parents, f it becomes something that a guidance officer is advised by, for instance, but in the main we work with children to tell their parents anything that we believe they need to discuss with their parents.

That's what I meant, on the basis that the two 17-year-olds consenting are in the same - assuming the same power, assuming one of them is not - - - ?---Not being coercive or bribery - - -

- - - with a disability at the same school?---Yes. That's correct.

Then you wouldn't regard that as abuse, reportable abuse, would you? If one was a 17-year-old and the other was a 17-year-old with a disability, would that be abuse?---Yes, we would report that. As part of our act in relation to

students with disabilities, then we do report that.

If they both had a disability or the same sort?---Yes, if they both have a disability, it would be likely we would, but it would be a judgment call depending on the situation.

If neither had a disability and they were the same age as the two that did?---Again it would be a judgment call, but I think I'm taking your point that if they both have a disability engaging, it's probably less likely that we'd refer that to Child Safety as opposed to talk to them about - to their parents.

Because neither situation is abusive?---Yes.

Is that right?---I understand what you're saying.

No, is that right? Is that why you wouldn't?---Say, there were two 17-year-olds and whether they had a disability or not - - -

It's irrelevant, yes?---If one of them came to us and said, "Hey, look, this happened and I really didn't want to," and those sorts of things and there was suspicion that it may have been not consensual, then we would report it.

So would you look at the power, whether they're on even terms, I mean, and what, the legality of the act?---Mm'hm.

Is that what you look at to work out if it's abusive? ---Yes, certainly we look at the power relationship and the legality of it.

Is it defined "abuse", "sexual abuse", in your act?---In our training we give examples of it but the word "abuse" - I will need to check whether that's defined. I'll have to take that question on notice.

It might be helpful if it was so that everyone knew what "abuse" was given the notifications problem that we're encountering. All right. We will just leave that alone for the moment. Say, you have got a 16-year-old and a 15-year-old, neither of whom have a disability - what do you do then - and it was consensual - well, it wasn't coerced, put it that way?---I understand your question. In terms of the 15-year-old, there would be a legal situation.

There would. Would it be abusive?---It would be something that we would - because of the legal situation, it would be something that we are likely to report. Our principals would be expected to - - -

For fear that you had failed your mandatory reporting obligation?---Because of the fact that it's actually a child under the age of consent.

And a fear that that might be abuse which you should have reported?---Mm.

All right. You don't want to find yourself in that

position of uncertainty, do you? You would want to clarify it if it's not already?---Mm.

Now, going to the management, that's really what got me onto this. How does a principal manage a situation we had of the two 16-year-olds or the 15 and the 16-year-old who may or may not be involved in a sexually abusive episode? ---I don't understand your question in terms of how do they manage it.

Yes, they are both still in the same class or still in the same school. One has been reported to the department for sexually abusing the other. How do you manage that?---We have cases where students are in the same school where there has been a range of different matters that may have happened where it's difficult for them to be in the same school. In some cases parents choose to move them between schools.

Only if they know?---Yes, that's correct. In other cases the school puts in processes where students are in - you know, have changed their classes or they'll arrange it so that they don't need to be spending time together if that's what they want to do.

One might be a witness in a criminal case against the other?---Yes, and that happens in a range of different things, whether it be, you know, what children are doing during weekends and they may have issues with the police where we've got those sorts of things and the police work that through with us if there's a need to have them separated.

My question, I suppose, really is: is it left to the good judgment and commonsense of a particular principal or is it set down in a policy document somewhere?---Yes, those sorts of things are left to the judgment of the principal under the policy. Obviously with the policy there's going to be a number of judgments that the professionals need to make about is this harm and is it detrimental and what they do.

And does the principal have a decision tree to help?---The principal has the - there's not a yes-no. We don't have a yes-no. We do have scenarios in the training to say, "Well, here's a scenario," and those sorts of scenarios build up some of their judgment.

Are there scenarios that I just mentioned in there?---I'd have to check whether those exact ones are in there.

They don't have to be exact, similar?---Similar, yes.

Because they're all conundrums and you've got a new piece of legislation that has serious obligations and penalties for default so certainly it would seem to be the order of the day. I might call it quits for the day, but I do want to pose some questions before I do, though. I want to give you guys some homework tonight. Mr Hanger, you first. Who is the chief executive, because there's no definition in the act.

MR HANGER: It's the director-general, I'm told.

COMMISSIONER: By what - how? The act assumes that there's such a person and it gives this person all these responsibilities and obligations and authorities.

MR HANGER: And we don't know who it is.

COMMISSIONER: And I can't identify who that person is by law.

MR HANGER: Yes.

COMMISSIONER: Who that legal entity is who gets into trouble for not doing what they're supposed to do or who exceeds authority for something or who brings - who instigates litigation on behalf of a department without authority.

MR HANGER: I'll bring him in handcuffs.

MS .....: It's a her.

MR HANGER: It's a her.

COMMISSIONER: Yes.

MR HANGER: Mrs Martin tells me it would be in the administrative arrangements, but we'll find out.

COMMISSIONER: Yes.

MR HANGER: Yes, that's the first bit of homework.

COMMISSIONER: As long as the person purporting to be the chief executive is actually the chief executive under this piece of legislation, because the chief executive of fostering is defined but not otherwise. I also would like some submissions on at this early stage why section 14 is structured the way it is and why it's necessary - and if the provisions of section 18 bear upon that question, because you will see that in section 14 if the chief executive, it says, becomes aware - I presume gets to know; that's what that means, whether because of notification, which is a term not defined in the act, given to the chief executive or otherwise, so getting to know somehow, of alleged harm or alleged risk of harm.

Harm is defined. Alleged is not defined, but we know what

that is. It doesn't include suspected harm. It only refers to alleged harm, and then it goes on to talk about a new term "or alleged risk of harm". The only risk of harm we know about in the act is an unacceptable risk of harm in the definition of "child in need of protection". We don't know about a risk of harm of a lesser degree and I don't know why risks as well as harms are something that the chief executive would become aware of except by reporting from mandatory reporters, because section 14 then goes on to say "and reasonably suspects". So you might become aware of this but it doesn't matter unless as well - - -

MR HANGER: There's something else as well.

COMMISSIONER: - - - you also reasonably suspect the child is in need of protection.

MR HANGER: Yes.

COMMISSIONER: Which includes as one of the preconditions harm, so why do you need to - - -

MR HANGER: Sorry, I - - -

COMMISSIONER: Yes, because if he does - if both of those things are satisfied then he's got to do something immediately. He's got to do an investigation immediately, or he can take some other unspecified appropriate action. The reason why section 18 might be relevant is because he seems - an authorised officer; this is other than the chief executive, or a police officer, who reasonably believes a child is at risk of harm - again, not a degree of risk - and as well as being at risk of harm, and is likely to suffer harm, so that means "probable harm", presumably, then they can immediately take the child into custody for protection. So may be at harm and risk of harm of lesser degrees other than unacceptability are somehow relevant to immediate safe custody. I don't know, but it seems to be the only way it might have any relevance, because otherwise, as I said before, the chief executive, whoever that person is, really only needs to know whether there's a risk of significant detriment from abuse or neglect without a viable parent, because all these risks of harm and these harms, unless they come from abuse or neglect or sexual exploitation they don't seem to be relevant to the chief executive for the purpose of exercising his or her functions.

MR HANGER: Yes.

COMMISSIONER: They're very relevant, of course, in terms of protecting children generally, but protecting children under the statute they don't seem to me to be very relevant.

MR HANGER: All right. Well, we'll take that onboard.

COMMISSIONER: Thank you.

MR SIMPSON: Mr Commissioner, might we give some indication to Ms McKenzie as to how much longer she might be required?

COMMISSIONER: How much longer?

MR SIMPSON: I'd be 15 to 20 minutes.

COMMISSIONER: 15 to 20 minutes.

MR SIMPSON: I've two areas to cover off on.

COMMISSIONER: All right. Mr Hanger, how long do you think you will be with Ms McKenzie?

MR HANGER: 20 minutes.

COMMISSIONER: Sorry?

MR HANGER: 20 minutes.

COMMISSIONER: 20 minutes. Ms Ekanayake?

MS EKANAYAKE: Not very long.

COMMISSIONER: Not long.

MS WOOD: I have no questions at this stage, commissioner.

MR CAPPER: 20 minutes or so.

COMMISSIONER: Okay, that's the indication?---Thank you.

Mind you, they're all from lawyers. Okay, we'll adjourn until tomorrow at 10.00.

WITNESS WITHDREW

THE COMMISSION ADJOURNED AT 4.20 PM
UNTIL THURSDAY, 23 AUGUST 2012