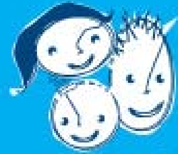

commission for children and young people and child guardian

Summary Report

An investigation into the adequacy of the actions of certain government agencies in relation to service provision to a subject child

March 2011

Explanatory Note

This is a summary and edited report of an investigation conducted by the Commission for Children and Young People and Child Guardian about the adequacy of the actions of the Department of Communities (Child Safety Services) and Queensland Health in relation to service provision to a subject child.

This summary report highlights the main points made in the full report which was provided to the Directors-General of both agencies and their relevant Ministers in October 2010.

I have not made the full report concerning this matter publically available. In this summary report I have also edited details regarding the subject child's period in the child safety system. This is to protect the confidentiality of the subject child pursuant to section 189 of the *Child Protection Act 1999* as well as to protect the privacy of the subject child's family and officers from the Department of Communities (Child Safety Services) and Queensland Health who had contact with the subject child and family.

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Abbreviations and Dictionary

Acute Care Team or ACT
The Acute Care Team is a multi-disciplinary team of mental health professionals within each health service district whose primary roles include:
- initial contact triage and assessment of people presenting, or referred to the mental health service
- the development of the initial management plan and/or referral to other government and non-government agencies
- provision of psychiatric response to each health service district, and
- limited intensive follow-up of clients of the service.

Case note
A record of case-related information.

CCYPCG or the Commission
The Commission for Children and Young People and Child Guardian.

CCYPCG Act
The *Commission for Children and Young People and Child Guardian Act 2000* (Qld).

Child Concern Report or CCR
A child concern report is a record of child protection information received by the Department of Communities that has been 'screened out' and does not meet the threshold for a Child Protection Notification.[1]

Child Guardian
Part of the Commission for Children and Young People and Child Guardian. An external accountability mechanism in relation to the provision of services to, and decisions made in respect of, children and young people in the child safety system.

Child Protection Notification or CPN
A matter constitutes a Child Protection Notification when information is received about a child who may be at harm or risk of harm which requires an investigation and assessment response. A notification is also recorded on an unborn child when there is reasonable suspicion that they will be at risk of harm after they are born.

Child Safety Practice Manual or CSPM
The Child Safety Practice Manual is a practice guide which contains procedures and guidelines informing the delivery of child protection services in Queensland. At the time of this report, Stage 9 of the Practice Manual has been implemented.

Child safety system
The child safety system includes the services collectively delivered by the former Department of Child Safety (as lead agency) and relevant government and non-government service providers to children of whom the Department becomes aware because of allegations of harm or risk of harm, regardless of whether they enter out-of-home care.

Child Safety Service Centre or CSSC
Service delivery officers of the Department of Communities (Child Safety Services).

[1] Child Safety Practice Manual (CSPM) (July 2010 updates), Glossary of Terms.

Children and young people or children
Persons aged 0 to 17 years.

Child Protection Act 1999 or CPA
Child Protection Act 1999 (Qld).

Department of Communities (Child Safety Services) or the Department
Formerly the Department of Child Safety. Lead agency with responsibility for child protection in Queensland.

Departmental officer
An officer or employee of the Department of Communities (Child Safety Services).

Director-General
The chief executive officer of the Department of Communities (Child Safety Services).

Harm
Harm to a child under section 9 of the *Child Protection Act 1999* is defined as any detrimental effect of a significant nature on the child's psychological or emotional wellbeing. Harm can be caused by neglect, sexual exploitation or physical, psychological or emotional abuse.

Intake
Intake is the first phase of the child protection continuum and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child, or when a request for departmental assistance is made.[2]

Investigation and Assessment or I&A
Investigation and assessment is the second phase of the child protection continuum. It is the Department's response to all Child Protection Notifications, to determine the safety and protective needs of a child where there are allegations of harm or risk of harm.

Mandatory Notifiers
Under legislation there are groups of people and professionals required to report child protection concerns. These include:[3]

- medical practitioners
- family court personnel and counsellors
- employees of licensed residential facilities
- staff of the Commission for Children and Young People and Child Guardian, and
- authorised officers or employees of the Department of Communities with respect to harm involving children in residential care.

My officers
Officers of the Commission's Investigations Team within the Child Guardian Group.

[2] CSPM (July 2010 updates), Glossary of Terms.
[3] CSPM (July 2010 updates), Glossary of Terms.

Notifier

A notifier is a person who informs the Department about alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, irrespective of how the information is recorded or responded to by the Department.[4]

Queensland Health or QH

Lead agency with responsibility for health and health services in Queensland.

Recognised Entity

An entity (an individual or organisation) with whom the Department of Communities (Child Safety Services) must consult about issues relating to the protection and care of Aboriginal and Torres Strait Islander children.

Risk of harm

The likelihood of a child suffering physical, psychological or emotional harm in the future.

Structured Decision Making or SDM

Structured Decision Making is an assessment and decision making model to assist departmental officers in making critical decisions about the safety of children. Structured Decision Making was developed by the Children's Research Centre, and aims to:

- reduce subsequent harm to children; and
- reduce the time for permanency arrangements for children in out-of-home care.[5]

Systemic issues

Includes issues relating to children in the child safety system which have affected, or will potentially affect, more than one child in a way detrimental to their rights, interests and wellbeing.

[4] CSPM (July 2010 updates), Glossary of Terms.
[5] CSPM (July 2010 updates), Glossary of Terms.

Summary of my investigation

1.1 Background

This is a summary report on the outcome of an investigation by the Commission for Children and Young People and Child Guardian (CCYPCG) in relation to the quality of decision making and service delivery provided to an indigenous child (the subject child) by the Department of Communities (Child Safety Services) (the Department) and Queensland Health (QH). The subject child was allegedly murdered by the mother.

My investigation has reviewed the quality of decision making and service delivery provided to the subject child while a child in the child safety system. The subject child was in the child safety system for only a short period of time during the assessment of child protection concerns. The child protection concerns were referred by QH while the mother was in hospital following the subject child's birth.

The referral from QH alleged:
- incorrect handling and feeding of the subject child by the mother which left the subject child at risk of physical harm
- neglect of the subject child by the mother as she was not attending to the subject child in a timely manner, and
- lack of bonding and affection by the mother to the subject child.

The child protection concerns were initially assessed by the Department as a Child Protection Notification (CPN) with a 10 day response timeframe. Following the mother's discharge from hospital, QH followed up with a number of home visits in order to provide support for the mother in caring for the subject child. QH advised the Department following these home visits that the mother was engaging with QH support services and that QH had no concerns regarding her care of the subject child.

Subsequent to receipt of this information, the Department made the decision to downgrade the CPN to a Child Concern Report (CCR) and finalise the matter without an Investigation and Assessment (I&A). The Department did not have any further involvement with the subject child prior to the subject child's death. Accordingly, there was a considerable lapse of time between the limited involvement with the subject child and family by the Department and QH and the subject child's death.

I have determined that the quality of decision making and service delivery by the Department and QH was generally appropriate based on the quality of information available to each agency. However, I have identified a number of issues regarding the quality of consultation and information sharing between both the Department and QH relating to their service provision to the subject child and family. It is my opinion that the quality of decision making and service provision to the subject child would have been more comprehensive had there been more effective collaboration and information sharing between the Department and QH regarding this matter.

To this end, my investigation report on this matter addressed my views regarding possible strategies to improve the quality of information sharing between the Department and QH in instances where both agencies are providing services to children in the child safety system. This summary report provides an edited and summarised version of these outcomes.

It is my assessment there is no evidence that any action or inaction by the Department or QH contributed directly or indirectly to the death of the subject child. However, as discussed above, I have identified some potential gaps in service delivery which I believe had an impact on the quality of services provided to the subject child.

1.2 Terms of Reference

The Terms of Reference for my investigation were as follows:

1. Evaluate the quality of decision making and service delivery provided to, or required to be provided to the subject child and family by the relevant service providers while the subject child was in the child safety system.

2. Evaluate the adequacy of the policies and procedures utilised by the relevant service providers with regard to services provided to the subject child.

3. Identify any potential gaps in the service delivery and/or systemic issues that may have impacted on the quality of service delivery by the relevant service providers to the subject child and family.

4. Make any necessary opinions and recommendations.

1.3 Jurisdiction

My investigation was conducted pursuant to my investigative powers contained in Chapter 4 of the CCYPCG Act. Section 64 of the CCYPCG Act provides that I may investigate a matter relating to a service provided, or required to be provided, to a child in the child safety system if I believe:

- the rights, interests or wellbeing of a child or children may be seriously affected if the investigation is not conducted, or
- the matter raises issues of public interest, or
- the matter raises a significant issue about a law, policy or practice underlying the service, or about the need for a law, policy or practice to underlie the service.

I formed the opinion that this matter raised issues of public interest pursuant to section 64(1)(b) of the CCYPCG Act.

Section 64 of the CCYPCG Act also limited my investigation to a service provided, or required to be provided, to the subject child while the subject child was in the child safety system.

The CCYPCG Act provides clarification regarding when a child is in the child safety system:[6]

> **13 When is a child *in the child safety system***
> (1) A child starts being ***in the child safety system*** if the chief executive (child safety) becomes aware (whether because of receiving a notification or otherwise) of alleged harm or alleged risk of harm to the child
> (2) A child stops being ***in the child safety system*** if –
> (a) the chief executive (child safety) decides there is no ground for forming a reasonable suspicion that the child is in need of protection, or
> (b) otherwise –

[6] CCYPCG Act, section 13.

(i) the child is not the subject of an order under the *Child Protection Act 1999*, and
(ii) the chief executive (child safety) decides not to take action, or further action, relating to the child.

I determined that the subject child was in the child safety system for a period of 29 days during the Department's assessment of the child protection concerns.

However, my investigation determined that some specific issues relevant to service delivery to the subject child, including the actions of certain government agencies, continued for a short period after the subject child exited the child safety system. While these actions did not occur while the subject child was in the child safety system, they are related to issues which arose and were relevant to the assessment of the child protection concerns. I determined that it was appropriate to review these actions to ensure that my investigation provides a holistic and comprehensive assessment of the quality of services provided to the subject child while in the child safety system.

1.4 Reporting procedures, recommendations and natural justice

Section 80(2) of the CCYPCG Act provides that as soon as practicable after completing an investigation other than an investigation of a complaint, I must prepare a written report and give a copy to:
- the chief executive (child safety)
- if the report relates to the delivery of services to children by a service provider other than the child safety department – the service provider, and
- if I consider it appropriate, the Minister responsible for the subject matter of the investigation.

Pursuant to section 80(3) of the CCYPCG Act, my report may include recommendations that a service provider take stated action within a stated time that is reasonable in the circumstances.

Section 80(4) of the CCYPCG Act states that if my report makes a recommendation and I am not satisfied that the service provider has taken the stated action within the stated time, I may give a copy of the report and my comments to the Minister responsible for the service provider.

Section 85(1) of the CCYPCG Act states that I must not include in a report any comments adverse to an entity identifiable from the report, unless the entity has been given a copy of the comments and given a reasonable opportunity to respond to them. Pursuant to section 36 of the *Acts Interpretation Act 1954* an entity includes a person and an unincorporated body.

In this report I have made comments that may be regarded as being adverse to the Department and QH. I have not made any adverse comment specifically directed towards any individual officer.

Accordingly, my provisional report was provided to the Department and QH in provisional form on 28 September 2010 for both agencies' comment and response, pursuant to my statutory obligations.

QH provided its response to my provisional report on 11 October 2010 and the Department provided its response on 18 October 2010. I carefully considered all relevant information, arguments and submissions put forward by both agencies and

where required, made amendments or additions to my report. Submissions have been incorporated into my report at various points where appropriate.[7]

Finally, I have ensured that I conducted this reporting process in accordance with my paramount statutory obligation to act independently and in a way that promotes and protects the rights, interests and wellbeing of children.[8]

[7] In its response to my provisional report, QH stated that there were no comments identified in the report that may be deemed adverse to QH. According, no submissions from QH have been included in the body of my report.
[8] CCYPCG Act, section 22.

Evaluation of the actions of the Department of Communities (Child Safety Services)

2.1 Assessment of the decision to record a 10 day response priority

Commentary regarding Opinion 1

Opinion 1:
The child protection concerns referred by Queensland Health included a number of high risk factors for the subject child which were not reflected in the Structured Decision Making *Response Priority Assessment* tool. The Department should have considered whether a discretionary override to a 24 hour response timeframe was appropriate.

The Child Safety Practice Manual (CSPM) provides the following guidance with regard to the use of a discretionary override of the Structured Decision Making (SDM) *Response Priority* tool:[9]

> A discretionary override is optional and is only to be used in unique circumstances, which are not already captured within the response priority questions and definitions. For example, if there are concerns that physical evidence may be lost if a response is delayed or when the child is known to be in a safe environment (out of the home).

The information in the *Report of Reasonable Suspicion of Child Abuse and Neglect* form which the Department received from QH suggested that over a four day period following the subject child's birth and until the referral of the child protection concerns, there was a continuing pattern of behaviour from the mother which left the subject child at risk of physical harm in her care. The QH referral also indicated that the mother had not developed any level of attachment to the subject child and there were concerns regarding her leaving the subject child unsupervised. The mother had also demonstrated unexplained high levels of anxiety about the birth and had previously suffered from depression.

In addition to these risk factors, the mother was to be discharged from hospital on the day the referral was received by the Department. It was not clear what level of support the mother would receive once she left the hospital and concerns had been raised that the mother was not able to complete a domestic violence questionnaire while in hospital. Finally, the information provided to the Department at that stage was that the mother had refused all support services offered by the hospital.[10]

I am also mindful that the mother had not shown any capacity while in hospital to understand or implement appropriate care strategies for the subject child when demonstrated to her by nursing staff and while she was in a controlled and supportive environment. This suggested that the subject child may have been at a higher risk of harm when the mother was no longer in hospital.

During interview, relevant departmental officers stated that the 10 day response timeframe was considered appropriate at the time because the subject child was not at immediate risk of harm given that:[11]

- the subject child was still in hospital and the mother was being monitored by the nursing staff, and

[9] CSPM (July 2009 updates), chapter 1, section 2.3.
[10] The mother later accepted support services by QH.
[11] Interview with departmental officers, 13 August 2010.

- QH officers did not indicate during discussions prior to, or after making the referral that the subject child was at immediate risk of harm and that the Department should respond to the concerns immediately.

With regard to these points, while the subject child and the mother were still in hospital when the referral was provided to the Department, the *Report of Reasonable Suspicion of Child Abuse and Neglect* form clearly states that they were to be discharged on that day. Accordingly, that protective factor was no longer in place.

It was also suggested that QH officers did not indicate during discussions prior to, or after making the referral that the subject child was at immediate risk of harm and that the Department should respond to the concerns immediately. In this regard, it was suggested that in cases where QH is of the opinion that there is immediate risk of harm to a child, QH advises the Department that it should commence the I&A immediately and then follows up to enquire about the progress of the investigation.[12] It appears QH did not indicate any level of immediate risk in this instance.

While it is important that there is a level of cooperation between the Department and QH regarding assessing and responding to child protection concerns and risk of harm, the Department is the lead agency tasked under legislation to determine the appropriateness and priority of intervention. Accordingly, it was the responsibility of departmental officers to make an assessment, based on the risk factors, about the response priority for the CPN and determine whether a discretionary override was appropriate.

I understand that departmental policy requires that a discretionary override only be used in 'unique circumstances.' Based on my discussion above, I am of the opinion that the *Response Priority* tool did not capture all the appropriate risk factors in this instance. Consequently, this case includes 'unique circumstances' where a discretionary override may have been appropriate.

In response to my provisional report, the Department provided the following information to further inform my opinion on this matter:[13]

> *"The Department could have considered a discretionary override to a 24 hour timeframe. However, in reviewing the information that was to hand at intake, many of the concerns could have been interpreted in a number of ways. For example [the mother's] reluctance to not provide information or fill in forms could be considered as social inadequacy and/or illiteracy, rather than an indication of secrecy or denial. In hindsight a more protective view has been taken."*

It should be noted that during interview, the departmental officers responsible for the assessment reviewed the risk factors for the subject child and acknowledged that a discretionary override to a more urgent response timeframe may have been appropriate.

[12] Interview with departmental officers, 13 August 2010.
[13] The Department's response to my provisional report, dated 18 October 2010.

2.2 Appropriateness of involvement with the Recognised Entity

Commentary regarding Opinion 2

Opinion 2:
The Department correctly consulted with the Recognised Entity prior to making a decision about its response to the child protection concerns referred by Queensland Health.

Section 6 of the *Child Protection Act 1999* (CPA) requires that:

- when making a significant decision about an Aboriginal or Torres Strait Islander child, the Department must give an opportunity to a Recognised Entity for the child to participate in the decision making process,[14] and
- when making a decision, other than a significant decision, about an Aboriginal or Torres Strait Islander child, the Department must consult with a Recognised Entity for the child before making the decision.[15]

The CSPM requires that when information is received about an Aboriginal or Torres Strait Islander child, the Department must contact a Recognised Entity prior to the decision being made about the response.[16] In this matter, the Department correctly contacted the Recognised Entity, before a decision was made about the Department's response, to request its advice on the child protection concerns. The Recognised Entity recommended a CPN with a 10 day response timeframe which is the response which was eventually recorded following completion of the SDM tools.

In response to my provisional report, the Department indicated that it agreed with Opinion 2.[17]

Commentary regarding Opinion 3

Opinion 3:
The recording of a Child Protection Notification is a 'significant decision' under the *Child Protection Act 1999*. The Department did not involve the Recognised Entity in the decision making process regarding the process of screening in the child protection concerns as a Child Protection Notification.

The CSPM provides that the recording of a CPN is a 'significant decision' under section 6(1) of the CPA.[18] When a CPN is the likely response to child protection concerns, the Department must:[19]

- provide the Recognised Entity with an opportunity to participate in the decision making process, and
- record the information about the involvement and views of the Recognised Entity in the *Recognised Entity Participation* form in ICMS.

The CPA makes a specific distinction between a 'significant decision' and a decision other than a 'significant decision' in determining the level of involvement by the Recognised Entity. A 'significant decision' is defined under the CPA as a decision about an Aboriginal or Torres Strait Islander child which is likely to have a significant impact on the child's life.[20]

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[14] Child Protection Act 1999, section 6(1).
[15] *Child Protection Act 1999*, section 6(1).
[16] CSPM (July 2009 updates), chapter 1, section 2.1.
[17] The Department's response to my provisional report, dated 18 October 2010.
[18] CSPM (July 2009 updates), chapter 1, section 2.1 and chapter 10, section 10.1.
[19] CSPM (July 2009 updates), chapter 1, section 2.1.
[20] CPA, section 6(6).

In the case of a 'significant decision' the Recognised Entity must be given the opportunity to participate in the decision making process while the Recognised Entity must be consulted about decisions other than a 'significant decision'. This is a significant distinction in the involvement of the Recognised Entity and in the Department's obligations to involve and collaborate with the Recognised Entity in the decision making process.

Based on the risk factors for the subject child and the advice provided by the Recognised Entity, the child protection concerns were likely to have been screened in as a CPN. Accordingly, the Department was required to involve the Recognised Entity in the decision making process when completing and determining the screening criteria and response priority.

Part of involving the Recognised Entity in the decision making process should have involved consulting the Recognised Entity about the specific cultural considerations incorporated within the screening criteria definitions.[21] The CSPM also provides that the Recognised Entity should be consulted regarding the different child rearing practices of Aboriginal and Torres Strait Islander families, which include:[22]

- earlier independence of children
- children taking responsibility at an earlier age
- cultural authority within kinship and/or clan groups, and
- cultural responsibility among the extended family and community (passing on of knowledge or skills).

However, after the initial contact, no further advice was provided to the Recognised Entity about the outcome of the screening process. The Recognised Entity was not advised about whether the child protection concerns had been screened in as a CPN or the recommended response priority.[23]

The Recognised Entity was also not involved in the decision making process regarding the 'significant decisions' which were part of recording the CPN. For example, the Recognised Entity was not involved in decision making steps such as:

- completing the SDM *Screening Criteria* tool, and
- competing the SDM *Response Priority Assessment* tool including whether to use a discretionary override.

There is no indication that any specific cultural considerations were taken into account by the Department with regard to the use of these SDM tools or in the decision making process generally. This would appear to be contrary to the requirement of section 6(1) of the CPA and the CSPM.

In response to my provisional report, the Department provided the following submission with respect to Opinion 3:[24]

> *"The completion of the screening criteria and response priority tools are not distinct significant decisions in their own right. These two tools are completed as part of the broader process that contributes to the significant decision about whether a notification should be recorded in relation to alleged child protection concerns. While the recognised entity was not consulted during the completion of each individual tool, it was given the opportunity to participate in the final decision about recording a notification with a 10 day response time (as noted in Provisional*

[21] CSPM (July 2009 updates), chapter 1, section 2.1.
[22] CSPM (July 2009 updates), chapter 1, section 2.1.
[23] Interview with officers from the Recognised Entity, 12 August 2010.
[24] The Department's response to my provisional report, dated 18 October 2010.

> *Opinion 2). Any discussion about the completion of these tools should form part of the discussion in relation to Provisional Opinion 2."*

I note the Department's submission with regard to this issue. However, my discussion regarding Opinion 2 was with respect to the Department's compliance with the following requirement of the CSPM:[25]

> When information is received about an Aboriginal or Torres Strait Islander child, contact with a recognised entity should occur prior to the decision being made about the response, and is to occur in keeping with any established local protocols. Where there is no local recognised entity available, contact another recognised entity in the region.

As indicated in Opinion 2, I am of the opinion that the Department correctly consulted with the Recognised Entity prior to the decision being made about whether the child protection concerns should be 'screened in' as a CPN.

However, Opinion 3 is with regard to the legislative requirement pursuant to section 6(1) of the CPA which states that:

> When making a significant decision about an Aboriginal or Torres Strait Islander child, the chief executive or an authorised officer must give an opportunity to a recognised entity for the child to participate in the decision-making process.

This requirement is clarified in the CSPM where it states that the recording of a CPN is a 'significant decision' under the CPA.[26] Accordingly, the Department was required to provide the Recognised Entity with an opportunity to participate in the decision making process about recording the CPN.

As I indicated in my discussion above, there is no indication that an opportunity to participate in the decision making process was provided to the Recognised Entity. It should be clarified that this requirement is distinct from the requirement that the Department contact the Recognised Entity about the response to child protection concerns.

I am of the opinion that completing the SDM *Screening Criteria* tool and the SDM *Response Priority Assessment* tool are important steps in the 'significant decision' to record a CPN. However, I accept the Department's submission that the completion of the *Screening Criteria* and *Response Priority Assessment* tools are not distinct significant decisions in their own right. I also accept the Department's submission that these two tools are completed as part of the broader process that contributes to the significant decision about whether a CPN should be recorded in relation to child protection concerns.

However, the broad issue which I have addressed in Opinion 3 is that the Department did not involve the Recognised Entity in the decision making process regarding 'screening in' the child protection concerns as a CPN. I refer to my discussion above regarding why I consider this issue distinct from the matters discussed in Opinion 2.

[25] CSPM (July 2009 updates), chapter 1, section 2.1.
[26] CSPM (July 2009 updates), chapter 1, section 2.1 and chapter 10, section 10.1.

Commentary regarding Opinion 4

Opinion 4:
The Department did not involve the Recognised Entity in the decision making process regarding downgrading the Child Protection Notification to a Child Concern Report. The Department also did not advise the Recognised Entity that the Child Protection Notification had been downgraded to a Child Concern Report.

Before the I&A was commenced, the Department made the decision to downgrade the CPN to a Child Concern Report (CCR) following additional information provided by QH. The decision to downgrade the CPN was approved, but there is no evidence that the Recognised Entity was involved in the decision making process regarding this decision.[27] The Recognised Entity was also not advised by the Department that the CPN had been downgraded to a CCR.

The decision to downgrade an approved CPN is clearly a 'significant decision' and the Department was required, pursuant to section 6(1) of the CPA, to provide the Recognised Entity with the opportunity to participate in this decision.

It should be noted that during interview, the relevant departmental officers acknowledged that the Recognised Entity was not involved in decision making regarding downgrading the CPN and that on reflection, this was an error.

In response to my provisional report, the Department indicated that it agreed with Opinion 4.[28]

2.3 Requesting information from interstate jurisdictions

Commentary regarding Opinion 5

Opinion 5:
The Department did not request information from interstate child protection jurisdictions before making the decision to downgrade the Child Protection Notification, despite receiving information that the mother may have had an interstate child protection history.

In the *Report of Reasonable Suspicion of Child Abuse and Neglect* referred from QH, there was an indication that the mother may have had an interstate child protection history.

The departmental officers responsible for the intake stated that information was not requested from interstate jurisdictions in this instance because the subject child was the mother's first child. Also, due to the mother's young age and because there was no indication she had cared for a child previously, it was viewed as unlikely that she would have an interstate child protection history.[29]

I am of the opinion that the Department should have requested the interstate child protection history during the assessment of the child protection concerns, if not before the initial response was determined, certainly before the decision was made to downgrade the CPN to a CCR. The interstate child protection history may have highlighted issues which would have informed the Department's decision to downgrade the CPN.

[27] Interview with officers from the Recognised Entity, 12 August 2010.
[28] The Department's response to my provisional report, dated 18 October 2010.
[29] Interview with departmental officers, 13 August 2010.

As part of the information gathering stage for my investigation, I received the mother's interstate child protection history. While the interstate child protection history is not particularly significant, it may have provided an insight into the mother's parenting experience and how her childhood experiences may have impacted on her own parenting style and the quality of her attachment with the subject child. The child protection history may have also highlighted the poor relationship between the mother and her family and the resulting lack of maternal familial support.

This may have presented an opportunity for the Department to consider options for referring the mother to an appropriate community or other service to assist in developing her parenting skills and improving her quality of attachment with the subject child.

In response to my provisional report, the Department provided the following information to further inform my opinion on this matter:[30]

> *"In relation to this matter, the completion of interstate child protection history checks should have been completed as part of the officer's information gathering during the investigation and assessment…"*

2.4 The decision to downgrade the Child Protection Notification

Commentary regarding Opinions 6 and 7

Opinion 6:
The Department did not commence the Child Protection Notification within the required 10 day timeframe.

In response to my provisional report, the Department indicated that it agreed with Opinion 6.[31]

Opinion 7:
The additional information provided to the Department by Queensland Health following the visits by Queensland Health officers was limited and did not address or mitigate the child protection concerns. The additional information does not support the decision to downgrade the Child Protection Notification.

The CSPM provides that the decision to downgrade an approved CPN should be a rare occurrence and may occur only in the following circumstances:[32]

- following the decision by a receiving Child Safety Service Centre (CSSC) that an approved CPN that has been transferred from another CSSC does not meet the threshold for a CPN and should be recorded as a CCR, in accordance with current policies and procedures
- following a review, quality assurance process or audit of work undertaken by another team leader, senior practitioner, manager or other senior staff, and
- following specific policy and procedural directives that have been endorsed by the Director-General and implemented, resulting in changes in practice and a need to review existing work.

[30] The Department's response to my provisional report, dated 18 October 2010.
[31] The Department's response to my provisional report, dated 18 October 2010.
[32] CSPM (July 2009 updates), chapter 10.12, section 1.1.

During interview, departmental officers stated that the decision to downgrade the CPN was based solely on information provided by QH, following two home visits made to the mother by QH officers.[33] The information from QH indicated that:[34]

- QH had *"no concerns"* regarding the mother's care of the subject child
- the mother was receiving support from QH and was engaging with appropriate support programs
- the mother would receive frequent visits and support from QH officers for up to a 12 month period, and
- the mother was supported by the father who was present at the second home visit.

Based on this information, the Department determined that the child protection concerns had been mitigated now that the mother was engaging appropriately with support services. Consequently, it was assessed that the subject child was no longer at risk of harm in her care.[35]

Based on this additional information, the Department formed the opinion that the original decision to record a CPN was incorrect and that the child protection concerns did not meet the threshold to record a CPN.[36]

However, I have serious reservations about the Department relying solely on the additional information provided by QH to downgrade the CPN, for the following reasons:

- the additional information was limited in detail
- the additional information was received second hand by departmental officers and these officers did not discuss the additional information with the relevant QH officers
- QH was providing support to the mother in caring for the subject child and was not visiting her for the purpose of making observations or assessments about child protection issues, and
- the additional information did not address or mitigate all the child protection concerns which had been raised.

Of particular concern is the limited nature of the information on which the Department made the decision to downgrade and the fact that the additional information did not address all the child protection concerns.

The additional information which was provided to the Department by QH focused on:

- the mother's engagement with support services
- the mother's good rapport with QH officers who were supporting her
- the mother had been "*tentative*" with the subject child on the first visit but on the second visit she was "*more relaxed and more involved with her baby*"
- the father was present at the second visit, and
- QH had no concerns after the second visit.

There was no information provided by QH which addressed:

- the attachment between the mother and the subject child and how the mother's attachment had improved since she had been discharged from hospital

[33] Interview with departmental officers, 13 August 2010.
[34] Information provided in telephone calls and emails from QH officers.
[35] Interview with departmental officers, 13 August 2010.
[36] Interview with departmental officers, 13 August 2010.

- how the mother addressed the concerns about attending to the subject child's needs in a timely manner, and
- how the mother had demonstrated proper care strategies including appropriate handling of the subject child beyond being "*more relaxed and more involved with her baby*".

The information provided by QH indicated that the mother had made progress addressing the child protection concerns which had been raised. However, the information was limited and did not provide adequate information to negate the significant risk factors for the subject child which had been recorded on the CPN. I am of the opinion that the additional information did not justify or support downgrading the CPN.

In response to my provisional report, the Department indicated that it agreed with Opinion 7.[37]

Commentary regarding Opinion 8

Opinion 8:
The Department did not comply with proper process pursuant to Chapter 10.12 of the Child Safety Practice Manual in downgrading the Child Protection Notification to a Child Concern Report. The downgrade was approved without:
- consultation with the Senior Practitioner about whether the downgrade met the requirements of current policy and procedure
- advising the Child Safety Service Centre Manager of the proposed downgrade and the rationale for the downgrade, and
- seeking the approval of the Child Safety Service Centre Manager to downgrade the Child Protection Notification.

The CSPM provides that the decision to downgrade an approved CPN should be a rare occurrence and should only occur following a review, quality assurance process or audit of work undertaken by another Team Leader, Senior Practitioner, Manager or other senior staff. The downgrade policy is not to be used in response to the inability of a CSSC to commence an I&A within the recorded timeframe.[38]

To ensure the integrity of the process, the CSPM provides a clear procedure which must be followed to downgrade an approved CPN. The downgrade may only occur in accordance with this process.[39] The process includes the following steps:[40]
- the CSO will raise the request with the appropriate Team Leader and discuss the recorded child protection concerns and rationale for the request
- the Team Leader must ensure the request meets the requirements of current policy and procedures and must consult with the Senior Practitioner
- if the Team Leader endorses the request, forward an email outlining the request and the rationale for the decision to the CSSC Manager for review
- the CSSC Manager will review the request and the rationale, and, if in keeping with current policy and procedures, approve the request and advise the Team Leader and CSO by return email, and
- if the request is not approved by the CSSC Manager, the I&A must be commenced within the response timeframe, or as soon as possible.

[37] The Department's response to my provisional report, dated 18 October 2010.
[38] CSPM (July 2009 updates), chapter 10.12, section 1.1.
[39] CSPM (July 2009 updates), chapter 10.12, section 1.2.
[40] CSPM (July 2009 updates), chapter 10.12, section 2.

This process was not followed in this matter. Interviews with departmental officers confirmed that the decision to downgrade the CPN was made at officer level without consultation with the Senior Practitioner and without approval by the CSSC Manager.[41]

In response to my provisional report, the Department indicated that it agreed with Opinion 8.[42]

Commentary regarding Opinion 9

Opinion 9:
The Department should have consulted with Queensland Health prior to the decision to downgrade the Child Protection Notification with a view to clarifying and seeking further information from Queensland Health regarding the home visits and discussing these matters in the context of no further departmental involvement.

There is no evidence that the Department consulted with QH about the decision to downgrade the CPN. The decision to downgrade was made based on two telephone conversations and one email from QH.[43] No further follow up or consultation with QH about the decision or about the rationale for the decision was conducted prior to the downgrade and subsequent approval of the CCR.

There is no policy requirement for the Department to consult with an external agency prior to making a decision to downgrade a CPN. The decision is rightly a departmental decision to be made based on current policy and after an assessment of the child protection concerns. However, the CSPM does require that the Department provide notifiers from other government or non-government agencies with information about the response to child protection concerns referred by that agency.[44]

There are a number of factors in this case which should have obliged the Department to consult with QH before making the decision to downgrade the CPN. These factors include:

- the Department had already provided advice to QH that the child protection concerns had been screened in as a CPN with a 10 day response timeframe
- departmental officers had informed QH officers that an I&A would be conducted
- the Department relied solely on information from QH about the risk of harm to the subject child in the care of the mother to downgrade the CPN, and
- the information provided by QH was limited and while it indicated that the mother was making good progress, it did not address all the child protection concerns.

In addition, while QH's information about the outcome of its home visits was positive with regard to the mother's care of the subject child, this information was based on the belief that the Department was conducting an I&A with regard to the child protection concerns. At no stage was any officer from QH of the understanding that the Department was considering downgrading the CPN based on their observations and opinions about the safety of the subject child and the appropriateness of the mother's standard of care.[45]

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41 Interview with departmental officers, 13 August 2010.
42 The Department's response to my provisional report, dated 18 October 2010.
43 Interview with departmental officers, 13 August 2010.
44 CSPM (July 2009 updates), chapter 1, section 4.1.
45 Interview with QH officers, 12 August 2010.

I have previously stated that the information from QH that the Department relied on to downgrade the CPN was limited in detail, was provided second hand and did not address or mitigate all the child protection concerns. In this regard, it was not appropriate for the Department to make what was a significant decision to downgrade the CPN, based on such limited information, without first contacting QH to clarify the information provided and advise of its decision that an I&A would not be undertaken.

By consulting QH about its decision to downgrade the CPN, the Department would at least have made QH aware of the reliance it had placed on the information gathered by QH during the home visits and the continuing quality of support to be provided to the mother by relevant support services.

This last point is of importance as one of the major reasons provided for downgrading the CPN was that the mother was receiving appropriate support by QH. Given that QH was providing support which was assessed as a major protective factor for the subject child, the Department had an obligation to consult with QH about its decision to downgrade the CPN and advise that QH would be the major support for the mother in the absence of departmental intervention.

As it happened, QH was not aware of the decision to downgrade the CPN or that the Department was relying on QH support services as the major support and protective factor for the subject child.

For these reasons, I am of the opinion that the Department should have contacted QH to advise that it was considering downgrading the CPN based on the information which had been provided about the home visits. This would have led to a process of information sharing which would have greatly informed the Department's decision making.

In response to my provisional report, the Department indicated that it agreed with Opinion 9.[46]

Commentary regarding Opinion 10

Opinion 10:
The Department did not record a response to the Child Concern Report. A response of 'information and advice' to Queensland Health should have been recorded and information and advice about the Child Concern Report should have been provided to Queensland Health.

When a CCR is recorded, there are three responses which may be taken by the Department:[47]

- information and advice
- referral to another agency, and
- information provision to the police or another state authority.

On the CCR which was approved following the downgrade of the CPN, none of these options were selected. Accordingly, there was no response provided to the CCR and the matter was simply closed to the Department.

In this case, it would have been appropriate for the Department to provide information and advice to QH (as the notifier) about its response to the child

[46] The Department's response to my provisional report, dated 18 October 2010.
[47] CSPM (July 2009 updates), chapter 1, section 2.6.

protection concerns and about the positive role of QH in supporting the family and minimising the risk of harm to the subject child through home visits.

Information and advice is an appropriate response to a CCR:[48]

- when there is provision of general service information and advice to the notifier to assist with the needs of the child and family
- when sending the notifier information regarding local services or brochures such as 'parenting information sheets'
- discussion with the notifier about the concerns raised and strategies to deal with the situation or talking to the family, and
- there is provision of information and advice to the child or family where they subsequently contact the Department.

It should be noted that during interview, the departmental officers who were responsible for assessing the child protection concerns acknowledged that advice should have been provided to QH regarding the decision to downgrade the CPN. These officers stated that it was unusual that information was not provided in this instance as there is a good relationship between the two agencies and child protection matters were discussed regularly.

In response to my provisional report, the Department provided the following information to further inform my opinion on this matter:[49]

> *"…It is agreed that departmental officers should have included a response to the Child Concern Report and that this would have been 'information and advice' to Queensland Health…"*

[48] Practice Resource: Child Concern Report Responses and Referrals.
[49] The Department's response to my provisional report, dated 18 October 2010.

Evaluation of the actions of Queensland Health

3.1 Initial collaboration between the Department and Queensland Health

Commentary regarding Opinion 11

Opinion 11:
Queensland Health correctly completed a *Report of Reasonable Suspicion of Child Abuse and Neglect* following the identification of child protection concerns when the subject child and the mother were in hospital. Both the Department and Queensland Health engaged in appropriate consultation and information sharing around the referral of the child protection concerns.

The evidence suggests that initial collaboration and information sharing between the Department and QH with regard to the child protection concerns was appropriate. My investigation established:

- a *Report of Reasonable Suspicion of Child Abuse and Neglect* was correctly referred by QH to the Department after child protection concerns were identified
- there was appropriate collaboration and information sharing between the Department and QH at the time the child protection concerns were referred
- the Department advised QH that the child protection concerns had been screened in as a CPN with a 10 day response timeframe, and
- QH provided additional information to the Department regarding its observations and opinions following home visits by QH officers to the mother and the subject child.

The degree of information sharing between the two agencies during the early stage of the assessment of the child protection concerns appears to have been both frequent and appropriate.

In response to my provisional report, QH did not provide any comment with regard to Opinion 11.[50]

3.2 Assessment and actions taken regarding receipt of the mental health concerns

Commentary regarding Opinion 12

Opinion 12:
Queensland Health did not refer concerns raised about the mother's mental health, including suicidal ideation and thoughts of self harm to the Department. Having regard to the child protection concerns already referred, the mental health concerns suggested an enhanced risk of harm to the subject child and should have been referred to the Department as child protection concerns.

As previously discussed, following contact between the Department and QH regarding the mothers' progress during the home visits, the Department decided to downgrade the CPN to a CCR. This decision was based on the positive information provided by QH about the mother's care of the subject child and her engagement with QH support services during home visits. The Department did not advise or consult with QH about its decision to downgrade the CPN.

[50] QH's response to my provisional report, dated 11 October 2010.

Prior to the Department's decision to downgrade the CPN, the mother attended an appointment with her GP where she disclosed symptoms of postnatal depression and expressed suicidal ideations and thoughts about self harm. She provided no disclosures which indicated that the subject child was at risk of harm. The GP referred the mother to the QH Acute Care Team (ACT) for assessment.

The ACT made contact with the mother following the referral. The outcome of the ACT's assessment was that no further action would be taken based on the mother's statement that she was no longer suicidal and she did not wish to engage with a mental health service.

There is no evidence that QH advised the Department that mental health concerns had been raised about the mother. I have confirmed through interviews with relevant departmental officers that the Department was not advised that the mother had disclosed mental health concerns, expressed suicidal ideation or thoughts of self harm.[51] Relevant QH officers also confirmed that the information was not referred to the Department.[52]

The *Public Health Act 2005* makes it mandatory for health professionals[53] to immediately notify the Department of all reasonable suspicions of child abuse and neglect and/or likely child abuse and neglect.[54] It is an offence for health professionals not to report reasonable suspicions of child abuse and neglect cases to the Department.[55]

I acknowledge that there is a degree of ambiguity about whether the mental health concerns raised about the mother indicate a reasonable suspicion of child abuse and neglect and/or likely child abuse and neglect with regard to the subject child. The mother did not at any stage disclose specific threats or indicate risk of harm towards the subject child. The referral from the GP stated that the mother had "*serious suicidal ideations*" and "*thoughts about plans to kill*" but specifically "*nil neglect of baby*" and "*nil problems of baby bonding*."[56] The mother also specifically denied thoughts about harming the subject child during her assessment by the ACT.[57]

QH officers indicated during interview they had no concerns for the safety or welfare of the subject child in the mother's care. This was based on the following factors:[58]

- the mother was considered a low suicide risk and a low aggression risk based on the outcome of the ACT assessment
- the mother was well supported at home by the father
- the father was an experienced parent who was able to ensure the subject child's safety and welfare, and
- the mother was receiving support in the way of regular home visits by QH.

However, there are a number of factors in QH's assessment of the mother's mental health which I believe highlighted an enhanced level of risk for the subject child. In particular, I note that during the assessment:[59]

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[51] Interview with departmental officers, 13 August 2010.
[52] Interview with QH officers, 12 August 2010 and QH officer on 27 August 2010.
[53] Health Professional is defined in the *Public Health Act 2005* as a doctor or registered nurse.
[54] *Public Health Act 2005*, section 191.
[55] *Public Health Act 2005*, section 193.
[56] Letter from GP to QH.
[57] QH Adult Mental Health Services Consumer Intake, QH Acute Care Team Log and Interview with QH officer, 27 August 2010.
[58] Interview with QH officer, 27 August 2010.

- the mother was described as a "*difficult historian*"
- the mother denied suicidal thoughts and symptoms of depression and "*would not elaborate further*"
- the mother "*appeared vague and perplexed*," and
- the mother appeared to be "*possibly minimising symptoms*."

While these factors do not categorically establish that the subject child was at risk of harm in the mother's care, they do raise questions about the reliability of the mother's disclosures about her mental state. In my opinion, this includes her statement that she had no thoughts about harming the subject child.

During interview, my officers asked QH officers why the Department was not advised of the mental health concerns which had been raised.

QH officers advised that the concerns about the mother's mental health and associated potential risks of harm to the subject child, were not referred because QH was of the understanding that the Department was involved at that time with the mother as part of the assessment of the I&A.[60]

Consequently, at the time they received the information about the mother's mental health concerns, relevant QH officers were of the mistaken belief that the Department was involved with an I&A regarding the risk of harm to the subject child. In this regard, QH officers appear to have assumed that matters pertaining to the mother's mental health would be taken into account and addressed as part of the assessment of the child protection concerns which QH had already referred.

I acknowledge that QH officers were not provided with information by the Department regarding its assessment and response to the child protection concerns QH had referred. However, it is my opinion that the mental health concerns should have been referred as additional child protection concerns irrespective of whether there was an open I&A. There are a number of reasons why I hold this opinion, including:

- the mother had expressed feelings of suicidal ideation and self harm and she was the primary carer for the subject child
- child protection concerns about possible risk of physical and emotional harm to the subject child by the mother had already been identified and referred by QH
- while QH had been advised that an I&A would be commenced, it was not clear when the Department would visit the mother and sight the subject child
- the mental health concerns provided an enhanced and immediate risk for the subject child in the care of the mother and a risk that was not addressed in the original child protection concerns, and
- issues regarding the mother's mental health, particularly her suicidal ideation and self harm, may not have been disclosed and assessed as part of the I&A.

For these reasons, I do not think it was appropriate for QH officers to assume that the mental health concerns would be addressed as part of the I&A. I am of the opinion the mental health concerns, assessed in conjunction with the original child protection concerns, presented an identifiable risk of harm to the subject child. Accordingly, the mental health concerns should have been referred to the Department as additional child protection concerns.

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[59] QH Acute Care Team Log.
[60] Interview with QH officers, 12 August 2010.

In response to my provisional report, QH did not provide any comment with regard to Opinion 12.[61]

3.3 Further involvement by Queensland Health with the subject child and family

Commentary regarding Opinion 13

Opinion 13:
Queensland Health did not inform the Department that the mother made the decision to no longer engage with Queensland Health support services.

Two weeks after mental health concerns were raised regarding the mother, the mother advised QH that she no longer wished to engage with support services. As a consequence, there would be no further home visits to the mother and the subject child by QH.

As discussed earlier, one of the primary reasons the Department downgraded the CPN to a CCR was that the mother was receiving support through QH. The mother's engagement with these support services was assessed as a significant protective factor as it included home visits of varying intervals for up to one year. When the mother chose to no longer engage with support services, this protective factor was no longer in place.

There is no evidence that information regarding the mother's disengagement with QH support services were provided to the Department. There appears to have been two reasons the information was not provided:

- QH officers were still of the understanding that the Department was involved with the family as part of the I&A,[62] and
- QH officers did not have any ongoing concerns about the mother's care of the subject child.[63]

I have discussed issues regarding the first point elsewhere in this summary report. With regard to the second point, I agree that the information gathered during the home visits suggested that the mother was acting appropriately with the subject child and had developed suitable care strategies. QH officers stated during interview that when the mother made the decision to no longer engage with support services, they did not have any concerns about the mother's care of the subject child or about the safety of the subject child in the mother's care.[64]

I acknowledge that the evidence suggests that the mother had developed appropriate care strategies and a good attachment with the subject child at the time she decided to disengage from support. However, I have concerns regarding the actions of QH following the mother's decision to disengage, considering significant concerns had been raised regarding her mental state, suicidal ideation, risk of self harm and signs of possible postnatal depression. It is my opinion that with these concerns having been raised, there was a risk of leaving the mother with no support services to assist her.

Accordingly, QH officers were asked during interview whether the mental health concerns had any impact on their assessment of the appropriateness of the

[61] QH's response to my provisional report, dated 11 October 2010.
[62] Interview with QH officers, 12 August 2010.
[63] QH Primary and Community Health Aboriginal & Islander Health Service Progress Notes.
[64] Interview with QH officers, 12 August 2010.

mother's care of the subject child and the subject child's safety and wellbeing in her care. QH officers stated that the advice provided by the ACT was that the mother had denied any suicidal ideation, thoughts of self harm or harm to the subject child and that she did not want to engage with a mental health service. QH officers stated that they relied on this advice and there was no indication during their contact with the mother that she was suffering from mental health issues or that the subject child was at risk of harm in her care.[65]

It was appropriate for QH officers to rely on specialist advice regarding the mother's mental health. However, it does not appear that QH officers were aware that the mother's engagement with QH support services was regarded as a significant strategy for minimising the risk of harm to the subject child by the Department.

Irrespective of this last point, I believe it would have been appropriate for QH to have informed the Department that the mother was no longer engaging with any QH support service and that there would be no further home visits or monitoring of the family.

In response to my provisional report, the Department provided the following information to further inform my opinion on this matter:[66]

> *"Agreed. This provisional finding is accurate, though understandable as Queensland Health professionals…did not have any concerns regarding [the mother's] care of [the subject child]."*

In response to my provisional report, QH did not provide any comment with regard to Opinion 13.[67]

Commentary regarding Opinion 14

Opinion 14:
Queensland Health did not inform the Department that it lost contact with the father and the mother after they vacated their home. Queensland Health did not advise the Department it would have no further contact or provide no further support to the family following their disappearance.

After the mother advised QH she no longer wished to engage with support services, it appears that the family vacated their home and as a result, had no further contact with QH. QH officers made a considerable effort to contact the mother and father without success.

However, no action was taken with regard to the disappearance of the family because QH had "*no concerns with bub being looked after*."[68] QH officers advised during interview that the Department was not advised of the loss of contact with the family because QH had no concerns about the safety of the subject child in the care of the mother.[69]

Following the disappearance of the family, QH had no further contact with the subject child either through home visits or telephone contact. I am of the opinion that this is relevant information in contrast to previous advice provided to the Department. Accordingly, it would have been appropriate for QH to advise the

[65] Interview with QH officers, 12 August 2010.
[66] The Department's response to my provisional report, dated 18 October 2010.
[67] QH's response to my provisional report, dated 11 October 2010.
[68] QH Primary and Community Health Aboriginal & Islander Health Service Progress Notes.
[69] Interview with QH officers, 12 August 2010.

Department that it had lost contact with the family and no further support services would be provided.

In response to my provisional report, the Department provided the following information to further inform my opinion on this matter:[70]

> *"Agreed. This provisional finding is accurate, though understandable as Queensland Health professionals…did not have any concerns regarding [the mother's] care of [the subject child]."*

In response to my provisional report, QH did not provide any comment with regard to Opinion 14.[71]

[70] The Department's response to my provisional report, dated 18 October 2010.
[71] QH's response to my provisional report, dated 11 October 2010.

Quality of information sharing and provision between agencies

Commentary regarding Opinion 15

Opinion 15:
The quality of information sharing and provision between the Department and Queensland Health regarding intervention and services provided to the subject child and family was not comprehensive or adequate to ensure quality of service provision and decision making by either agency.

Based on the evidence assessed during my investigation, there is no indication that any action or inaction by the Department or QH contributed directly or indirectly to the death of the subject child. I am satisfied that both the Department and QH made decisions about appropriate involvement and service delivery to the subject child and family on the basis of the quality of information which was available to them.

However, the most significant aspect which has arisen from my investigation is that the quality of information which was available to both agencies was not the best information available. Both the Department and QH made decisions about the quality and appropriateness of their service delivery based on assumptions about services the other agency was providing and were both frequently unaware the other agency was not providing services or had ceased providing services.

This situation occurred because of a lack of appropriate information provision on the part of both the Department and QH at vital moments during their involvement with the family.

I am of the opinion that there were substantial omissions in information provision on the part of both agencies. Had the Department engaged with QH regarding its decision to downgrade the CPN, it is more likely the information regarding the mother's mental health disclosures, withdrawal from QH support services and subsequence disappearance from her home would have been reported to the Department.

Similarly, had QH engaged with the Department regarding the mother's mental health concerns and the enhanced risk they presented to the subject child and then advised of her withdrawal from support services, it is likely that the Department's response to the child protection concerns would have been different.

In response to my provisional report, the Department indicated that it agreed with Opinion 15.[72]

In response to my provisional report, QH did not provide any comment with regard to Opinion 15.[73]

[72] The Department's response to my provisional report, dated 18 October 2010.
[73] QH's response to my provisional report, dated 11 October 2010.

Recommendations

I have made the following recommendations for action by the Department and QH pursuant to section 80(2) of the CCYPCG Act:

Recommendation 1:
The Department amend the Child Safety Practice Manual to clarify that the decision to downgrade or delete an approved notification is a 'significant decision' pursuant to section 6(1) of the *Child Protection Act 1999*.

Recommendation 2:
The Department review the quality of training which is provided to Child Safety Officers regarding working with Aboriginal and Torres Strait Islander children, incorporating cultural considerations in decision making and involving the Recognised Entity in 'significant' decision making. In particular, as part of this review, the Department must determine whether current training clarifies when the Recognised Entity must be involved in decision making rather than merely consulted.

Recommendation 3:
The Department amend the Child Safety Practice Manual to clarify that the downgrade policy is not to be used to downgrade or delete an approved Child Protection Notification in response to a reassessment of child protection concerns following the receipt of additional mitigating information about the child protection concerns in isolation to the approved decision making process.

Recommendation 4:
The Department amend the Child Safety Practice Manual to ensure that notifiers from government or non-government agencies are provided with information when the Department's response to child protection concerns they provide is downgraded or deleted.

Recommendation 5:
The Department and Queensland Health jointly review current state-wide processes for information sharing at the local Child Safety Service Centre and health service district level to determine the adequacy of current processes. Part of the review should examine whether there is scope and/or need to implement a process of monthly meetings between Child Safety Service Centres and local Child Protection Liaison Officers to discuss and share relevant information about matters:

- referred by either agency for service provision by the other agency, and
- where both agencies are involved with service provision to a child or their family.

Recommendation 6:
The Department and Queensland Health disseminate the outcomes, opinions and recommendations from this report to the relevant offices and staff who were involved with this matter to facilitate practice improvements and learnings.

Both the Department and QH have advised that they accept my recommendations.

The above recommendations require timely action in order to reduce the likelihood of future service delivery to children in the child safety system and their families being impacted by the issues which I have discussed in this summary report.

Accordingly, I have requested that the agencies immediately action the recommendations and provide an interim and final report to me, with information to satisfy me that the recommendations have been implemented. I request that these reports are provided to me within the following timeframes:

- an interim report at three months from the date of release of my report, and
- a final report no later than six months from the date of release of my report.

Following receipt of the final implementation report from each agency, I will provide advice to the Directors-General of the Department and QH and the respective Ministers, regarding the satisfactory implementation of my recommendations.