



Chapter 5

Systemic issues

Key messages

- In 2006–07 the CDCRC considered a number of cases that provide insight into the effectiveness of the completed reform process.
- Significant progress has been made to implement the reform agenda in key areas of departmental practice, but there is clear evidence that some historical service delivery issues continue to impact on outcomes for children and young people.
- Recurring issues in service delivery noted by the CDCRC in the case reviews completed during the year, include:
 - approaches to risk assessments that adversely affect their quality
 - scope for greater interagency collaboration
 - inadequate responses to unborn child notifications
 - the extent to which the individual needs of children and young people with disabilities are met
 - risks created by inadequate record-keeping, and
 - contextual issues impacting on service delivery within particular Child Safety Service Centres.

System-level reporting

The CDCRC's review criteria require it to determine, among other things, whether the department's internal review findings and recommendations "*identified any evidence of broader systemic issues for the Department of Child Safety's consideration*". This is arguably the most important of the review criteria, as it requires an assessment of the impact of case-specific findings on the broader service delivery environment.

Within the context of child death reviews, a systemic issue is considered by the CDCRC to be one that has been identified in one or more reviews of systems, policies or practices, and that is either currently affecting, or has the potential to affect, more than one child in a way which is detrimental to their rights, interests or wellbeing.

In 2006–07 the CDCRC commenced a project to capture system-level data in relation to child protection practice issues identified in child death reviews. Through the compilation and analysis of review data, it is the CDCRC’s intention to draw together concerns about a number of individual threads of the service delivery system upon which it has commented in its reports to the department. This should position and support the department in responding to multiple individual recommendations as themes in service delivery.

This approach will, ideally, form the logical next phase of operation of the CDCRC. It represents the application of system-level data, gathered and analysed throughout the three years of CDCRC operation to date, to create a focused agenda to positively influence change. The CDCRC is working towards adopting the Child Guardian Key Outcome Indicators³³ to structure the capture and reporting of the system-level data in future reports.

Potential systemic issues identified in 2006–07

In the CDCRC’s previous two annual reports, the majority of cases discussed involved service delivery to children and young people before or during the early stages of an extensive period of reform of Queensland’s child protection system. The CDCRC acknowledges that widespread efforts have been made to address many of the issues identified in child death case reviews, including significant changes to the department’s service delivery framework. The pace of reform has remained high, with the result that even the six-month statutory time frame during which the reviews are completed is often sufficient for relevant changes to policy and practice to have taken effect. Where possible, the CDCRC has attempted to link its recommendations to the wider reform agenda and to acknowledge this in its own recommendations and its responses to those of the department.

In 2006–07 the CDCRC considered a number of cases that provide insight into the effectiveness of the completed reform process. This early glimpse indicates that, on the one hand, significant progress has been made to implement the reform agenda in key areas of departmental practice, but, on the other hand, there is clear evidence that some of the historical service delivery issues continue to detract from the quality of the department’s services.

The CDCRC has made the further observation that, although key policies and procedures have been amended to produce enhanced service delivery, the implementation of these reforms into frontline practice has, in some instances, not yet gained traction, with the result that non-compliance issues continue to feature in the findings of the reviews.

³³ The Child Guardian Key Outcome Indicators are the eight outcomes-based measures used by the Child Guardian to gather, assess and report information about the effectiveness of the child safety system. The Child Guardian developed the indicators in 2006 after extensive research and consultation with relevant entities, including the CDCRC. For further information, see the *Child Guardian Report 2006* available at <http://www.ccyipc.qld.gov.au/about/publications>

Potential systemic issues arising from the CDCRC's consideration of reviews in 2006–07 are discussed below under the following headings:

- Risk assessment
- Unborn child notifications
- Interagency collaboration
- Children and young people with disabilities
- Record-keeping, and
- Contextual issues affecting service delivery.

Although the above issues have been separated into discrete topics of discussion for the purposes of this report, the CDCRC wishes to emphasise from the outset that, by their very nature, none of these issues are mutually exclusive when considered in terms of their impact on overall service delivery; nor indeed can any thorough analysis be undertaken without due regard to the complex and interdependent nature of the whole range of factors which affect the operation of the child protection system.

A key consideration, both for the department in its ongoing commitment to reform and enhanced service delivery, and for the CDCRC in its commitment to capacity building in this regard, must therefore be the unprecedented need for a sustained and coordinated approach to systemic change and a shared vision based on the welfare and best interests of Queensland's children, particularly those who are most vulnerable.

Risk assessment

Effective risk assessment is fundamental in determining the ongoing protective needs of children and young people. This requires that all relevant information, including details about past history and present circumstances, is integrated and assessed to determine the overall level of risk to the child or young person. Inadequate risk assessment has been a common theme in many of the cases reviewed by the CDCRC over the past three years.

Features of ineffective risk assessment noted by the CDCRC include:

- not taking into account previous child protection history
- not obtaining information from other agencies, where appropriate
- failing to engage collaboratively with other agencies to assess the level of risk and inform subsequent case planning
- failing to reassess the level of risk and revise previous assessments when presented with new information
- failing to accurately interpret and analyse information concerning risk and protective factors
- inadequate record-keeping

- inexperienced staff
- inadequate supervision and training, and
- contextual issues impacting on service delivery.

In particular, the CDCRC has identified a number of concerns regarding the risk assessment considerations relevant to the Intake and Investigation and Assessment (IA) processes. The IA phase, as implied by its name, requires that the analytical skills of investigation and assessment are applied to the circumstances, resulting in the child's actual level of risk and relative safety being determined. The process therefore requires not only searching and gathering of information, but a critical approach to this information for the purposes of testing its validity, assessing its consistency with other relevant information, and making an ultimate determination as to whether the allegations are substantiated and how the needs of the child can best be met. The tendency for relevant information to be accepted at face value, interpreted in a non-critical manner and integrated with other information in a superficial way is a subtle yet concerning feature of many examples of service delivery examined through the review process.

The CDCRC holds the view that the appropriate skills, attitudes and professional dispositions relevant to the investigation process should form a vital component of the department's training and professional development of staff, in order to maximise their effect on outcomes for children and young people. The CDCRC welcomes the opportunity to provide further feedback, support and guidance to the department in this challenging area of practice.

Structured Decision-Making

The department implemented the Structured Decision-Making (SDM) tools on 31 October 2005, after the delivery of statewide training to staff. SDM is designed to be applied at critical decision points from the Intake process to case closure, and to provide consistency and accuracy in decision-making through a comprehensive assessment model based on defined thresholds.

Of particular relevance are the prompts that the SDM tools give to departmental staff to reinforce the need to conduct external checks. These checks encourage interagency information sharing and can also validate information already received. The SDM process essentially streamlines the entry of cases into categories for departmental intervention, thereby determining required response time frames, levels of intervention and viable alternatives for children at various points within the system. The aim of SDM is therefore to assess and reduce current and future risk of harm to children and young people and to expedite permanency for children in out-of-home care within specific time frames.

The use of SDM puts the onus on the department's Intake process to gather sufficient information to fully inform the decision about an appropriate departmental response. This process focuses in particular on whether the information received is to be 'screened in' as a Child Protection Notification (CPN) requiring a subsequent IA, or 'screened out' as a Child Concern Report (CCR), for which the department will take no further direct action. However, even with the use of SDM, the Intake officer must use their professional judgement to correctly weigh up the key factors relevant to the child or young person's safety, and a discretionary override feature is available to departmental staff for use in instances in which extraordinary circumstances or unusual factors result in a judgement that the relevant SDM outcome is not compatible with the needs of the child.

It is therefore evident that the quality of assessments undertaken using SDM is only as good as the level of professional expertise and knowledge of the individual departmental officer using the tool. This obviously places an onus on the department to demonstrate a concerted and ongoing commitment to training, support and critical evaluation of the effectiveness of SDM.

The SDM tools had been applied in 46 of the 62³⁴ cases of individual children and young people considered in the 2006–07 reporting period. In 57.0% of these cases the CDCRC identified concerns of varying degrees about the department's use and/or application of SDM. These concerns included:

- the SDM tools were not used at all to assess information
- relevant information required to accurately assess risk using SDM was not sought and/or not interpreted in a manner which was compatible with SDM
- the discretionary override option was not considered and/or used, even when professional judgement ought to have raised doubts about the sufficiency of the SDM outcome
- there was evidence that the SDM tools were not always completed correctly and/or contemporaneously
- all harm types had not been included in the screening tools
- the SDM response priority tool had not been selected appropriately, resulting in a 10-day response time frame rather than a 24-hour time frame
- there were delays in the electronic recording of the completed SDM tools
- the *Safety Assessment* was not documented within 72 hours of the decision being made, as required by the Child Safety Practice Manual, or it was not completed at all
- the *Family Risk Evaluation* either was not completed or was completed prematurely, and in some cases was not completed until after the child had died, and

³⁴ The figure of 62 has been used where appropriate throughout this report, as this was the distinct number of children and young people, as opposed to 61, which was the number of reviews considered (two children were the subject of a joint review).

- the *Child Strengths and Needs Assessment* was not approved and/or did not address particular risk factors.

The CDCRC acknowledges that the introduction of SDM has been a significant shift in the department's approach to assessing risk, and has necessitated the customisation of the tools and the statewide training of frontline staff. Accordingly, there is some margin of practice error that may reasonably be expected during the early stages of the tool being applied. Nonetheless, the potential significance of each decision through the identification of these issues highlights the importance of the departmental commitment to the monitoring and evaluation of the ongoing application of the tool.

Information gathering

One key aspect of the department's risk assessment that has consistently been identified as an issue of concern by the CDCRC is information gathering. This continues to be a feature of many of the reviews where SDM has been applied, which is an early sign that more needs to be done to improve the department's performance in relation to this aspect of risk assessment. While providing a consistent framework for decision-making, the outcomes determined by the SDM tools are only as good as the information used to inform them.

Specifically, in 2006–07 a number of cases evidenced that poor or insufficient information was gathered during the Intake process, in terms of both the depth of information gathered and the accuracy of the information recorded. The failure to conduct a pre-notification check³⁵ was also identified as a significant problem in this context, with the department's decision not to record a notification being open to challenge in six of the cases considered. In essence, the CDCRC observed that the department's decision in those cases was flawed, as insufficient information was gathered and applied to inform the SDM tool, thus reducing the likelihood that the threshold for recording a notification would be reached.

The following case study illustrates the CDCRC's concern.

Case study³⁶

A CCR was recorded four weeks before the SC's birth. The CCR alleged that there were severe domestic violence incidents between the parents, and that one of the parents had a history of domestic violence and drug use. The departmental officers involved in this case applied the screening criteria within 24 hours. However, one of the officers wrote on a handwritten note that

³⁵ A pre-notification check is made when information is received from a notifier which indicates that a notification may need to be recorded, but additional information is needed to complete the screening criteria assessment tool and determine the appropriate departmental response (Department of Child Safety Child Safety Practice Manual, Stage 5, May 2006).

³⁶ Case Review 18/2007.

there was “no information to indicate an increase in severity or frequency of the domestic violence”. The screening tool was completed without the QPS being contacted to obtain the details of the parents’ domestic violence and criminal history.

The department’s review appropriately concluded that an accurate application of the information using the SDM screening tool should have prompted departmental staff to form the opinion that the matter reached the CPN threshold. The review also appropriately concluded that the department did not engage with the family and missed an opportunity for involvement in what was potentially a high-risk situation for the SC.

In addition, the CDCRC noted that the failure to conduct a pre-notification check with the QPS also affected the department’s overall assessment of risk in this case. As a result, the information was incorrectly ‘screened out’ as a CCR and no further action was taken by the department.

The following case study further evidences the CDCRC’s concern about the impact of poor information gathering on the assessment of risk.

Case study³⁷

An unborn child notification with a 10-day response time frame was raised in relation to SC’s unborn sibling after a domestic violence incident involving excessive alcohol use by both parents. The referral was made directly to the SCAN Team by the QPS and identified previous criminal involvement of the father and a number of previous domestic violence calls for service.

In conducting the IA, the department failed to request relevant information from the QPS that would have revealed the type and extent of the history of violence and substance abuse. Nor was information sought from Queensland Health – its staff were engaging with the family and held information concerning SC (then aged six months) and the welfare of SC’s older sibling.

The review accurately identified that the department’s failure to seek relevant information concerning risk to all of the children, and concerning the broader family history and context, led to an ineffective assessment of risk to SC and a lack of appropriate intervention to ensure SC’s safety and that of his older sibling.

The CDCRC further identified a lack of willingness on the part of each of the agencies concerned to share relevant information, both within the SCAN Team context and as part of pre-notification information gathering. Together with evident confusion about the referral practices and intervention thresholds of the department, this case clearly illustrated the negative and far-reaching impact of a lack of holistic information gathering on the IA process and outcomes.

³⁷ Case Review 31/2006.

Finally, a recent child death case review illustrates the CDCRC's concern in relation to the department's response to risk factors relevant to a young person who was placed in the care of their extended family.

Case study³⁸

The SC was subject to an unapproved CCR at the time of their death (the CCR was upgraded by the department to a CPN after the child's death). The CDCRC identified that a previous CPN was recorded at the time when the child and their siblings were placed by their mother in the care of a member of their extended family. After a limited IA in response to the first CPN, the department determined that the placement with the extended family member was suitable.

The subsequent CCR alleged that:

- the members of the extended family were drinking heavily
- the members of the extended family were providing the child with inappropriate medication
- the house was unhygienic, and
- the child and their siblings were being hit by an extended family member.

However, the children remained in the extended family's care and there was no further departmental involvement until after the child's death.

The CDCRC considered that the department should have applied for statutory guardianship orders for the child and siblings to ensure that they received appropriate care and protection. Had this occurred, the department would have been required to conduct a thorough assessment of whether the extended family member was an appropriate long-term foster carer, to reassess the child and their siblings' placement with the extended family member in light of the concerns raised in the CCR, and to provide appropriate case planning and financial support as required. The CDCRC noted that this did not occur and the SC and their siblings remained in the extended family member's care without adequate support from the department, in an environment which did not meet their needs and exposed them to further risk of significant harm.

Unborn child notifications

As identified in its 2005–06 Annual Report,³⁹ an ongoing priority of the CDCRC remains departmental practice when advice is received about an unborn child who it is reasonably suspected will be at risk of harm after he or she is born. In 2005–06 the department reported that it received 874 notifications in relation to unborn children.

³⁸ Case Review 7/2007.

³⁹ *Child Death Case Review Committee Annual Report 2005–06*, pages 25–26.

Current departmental policy requires the recording of a notification, with the purpose of the IA before the birth being based on the principles of prevention and early intervention, subject to the mother's willingness to engage with the department to reduce the risk of harm to the child after birth. The CDCRC acknowledges that this is a challenging area of child protection practice, particularly if, before the birth, the prospective mother is unwilling to engage and receive support services.⁴⁰

Once again, key systemic themes of effective risk assessment, interagency collaboration and timely case management are evident in relation to unborn child notifications, with each of these factors being of greater significance in effective case management by the department, owing to a number of unique factors and considerations. These include the obvious difficulty of assessing risk and protective factors for a child who is not yet born and may be weeks or months away from birth, establishing the circumstances and contextual considerations of the mother and child during and immediately after birth, and determining the related intervention thresholds for other support services concerning engagement with the mother and her unborn child prior to birth.

Since its commencement,⁴¹ the CDCRC has considered 19 cases that specifically involved an unborn child. Of the 19 cases, 5 children died at birth and 14 died some time (from one month to one year) after birth.

The CDCRC identified the following concerns with departmental practice involving unborn children and their families:

- failure to record the SC as an unborn child on a CPN
- failure to gather sufficient information and/or adequately assess the risk of harm to the unborn child
- inconsistent departmental practice in relation to the time frames for recording an unborn child notification
- failure to forward an Unborn Child High Risk Alert to relevant hospitals and/or failure to liaise with the relevant hospital after the birth of SC
- failure to refer the case to the SCAN Team when this was clearly warranted and met the SCAN referral criteria
- inappropriateness of existing departmental policies and practices in circumstances involving significant risk of harm to unborn children resulting from domestic violence

⁴⁰ The Child Safety Practice Manual, Stage 5, May 2006 provides that, when the current actions or environment of the pregnant woman indicate future risk for the child, the department will intervene to alert the woman to the risks and available support services. The screening criteria will screen in as a notification received about an unborn child who is reasonably suspected to be at risk of harm after he or she is born, because of the current behaviour or circumstances of the parent. The purpose of an Investigation and Assessment before the birth of a child is to offer help and support to reduce the likelihood of departmental involvement after the birth of a child, and an IA can only occur with the consent of the pregnant woman.

⁴¹ From its establishment in August 2004 up until 30 June 2007, the CDCRC has considered a total of 111 child death case reviews in relation to 113 distinct children. The CDCRC has identified that 19 of those cases specifically involved an unborn child notification.

- the need for a higher priority rating to be available for unborn child notifications in certain circumstances where the risk of harm to a child after birth requires a more immediate response, and
- the need for departmental staff to understand that relevant information can still be sought from prescribed entities and service providers, even when a mother does not consent or is unable to consent to an IA being conducted.

Within the current service delivery environment, the CDCRC has identified very young and unborn children as a particularly vulnerable subset of the at-risk child population, as supported by the scope and range of the practice concerns identified above.

The CDCRC has concerns about some aspects of departmental practice regarding unborn children, particularly about the relative priority of these cases in relation to other types of cases notified to the department. Specifically in instances in which case backlogs, staff shortages and other workload and/or resource constraints are seen to impact on the delivery of child protection services by a particular Child Safety Service Centre (CSSC), a trend has been identified whereby the required IA process for unborn child notifications may be de-prioritised and assigned a lower response priority, whether formally through the process of screening and assessment or informally through discretionary workload management by individual staff. The result is that the required IAs either are not completed or are subject to delayed commencement.

One recent child death case review illustrates the CDCRC's concern in this regard.

Case study⁴²

The SC died aged 3 months from causes yet to be determined. The child was subject to an outstanding IA at the time of his death. The CDCRC identified that an unborn CCR was initially recorded four weeks before the child's birth, involving severe parental domestic violence. The CCR was not created until the commencement of a backlog clean-up two months after the information was received by the department. No further action was taken by the department in relation to the child concerns until a CPN, again involving domestic violence issues, was recorded by the department one day after the child was born. The CPN was given a 10-day response priority rating. However, on the date of the child's death, the CPN was unallocated and an IA had not commenced.

The department made the following finding in its internal review report:

Despite the CPN having a 10-day priority rating, the IA remained unallocated and un-actioned. The child had not been sighted by departmental officers

⁴² Case Review 18/2007.

and no assessment had been made of the concerns about the subject child's safety. This delay in actioning the CPN was inadequate and inappropriate as the department was obliged under section 14(1) of the *Child Protection Act 1999* to investigate whether the subject child and sibling were in need of protection. The review found that the reason for inaction was the excessive workload and backlog, requiring IA staff to concentrate on higher-priority CPNs. The Manager of the CSSC has provided information that confirms that the department is addressing the workload issues.

The CDCRC formed the view that the department's finding in the above case study was appropriate. However, it was concerned that the workload problem at this CSSC must be addressed promptly as the review suggested that there were 637 outstanding cases for IAs and that the backlog team was assessing outstanding cases that were 18 months old. The CDCRC was particularly concerned about the following statement in the department's internal review: *"it is disturbing, although not surprising, that the CPN relating to the child was not actioned"*.⁴³

The above case and the myriad of underlying practice and systemic issues which the CDCRC identifies are a sobering reminder of the work still to be done in refining and strengthening the policy and practice frameworks which should dictate the approach to frontline service delivery. The CDCRC will pay further attention to the department's treatment of unborn child notifications throughout the coming reporting period and it is hoped that ongoing work by the department to improve its practice in this area will be reflected in the findings of the department's reviews in the year ahead.

Interagency collaboration

Crucial to the effective functioning of the child protection system is the acceptance that no single agency or entity is able to provide the full range of services, supports and possible interventions required to ensure the safety and wellbeing of children. Although the department retains lead agency responsibility for child protection in Queensland, the core business and statutory responsibilities of a number of other key government agencies encompass broad aspects of child protection.

The CMC inquiry into abuse of children in foster care highlighted limited interagency collaboration, service coordination and information sharing as key impediments to the effective functioning of the former system, and accordingly targeted these factors as vital areas requiring improvement.

As a result, the majority of key recommendations implemented as part of the reform phase have involved, either directly or indirectly, attempts to enhance

⁴³ Child Death Case Review, dated 14 February 2007, para 6.48.

and better facilitate interagency collaboration across the child protection continuum of prevention, early intervention, statutory and other support services.

Enhancements to effective information sharing since 2004 primarily have a legislative basis, through the addition of specific provisions within the *Child Protection Act 1999*. These provisions, set out in section 159 of the Act, prescribe a broad range of circumstances in which relevant agencies may request and provide certain information concerning children in need of protection. These provisions are designed on the premise that the safety and wellbeing of children should, as far as possible, take precedence over all else and are thus intended to eliminate many of the former barriers to information sharing.

A key component of the reforms involved legislating the SCAN Team system, in recognition of its value and significance to multi-agency, multidisciplinary case management. The Act now prescribes the existence, core functions and membership of the SCAN Team system and provides the legal basis and legislative protection from liability for its operation.

The CMC also recommended the establishment of dedicated Child Safety Director (CSD) positions within government agencies with child protection responsibilities. The purpose of these positions was to coordinate and oversee the operation of child protection activities within the home agency, including both the reform of existing policies, procedures and other structures, and the subsequent monitoring and evaluation of their effectiveness. A further key role of CSDs is to ensure consistent representation within the whole-of-government context through the CSD Network and other relevant forums, to provide the coordination and cooperation upon which a more collaborative service delivery culture is based.

In its June 2007 report *Reforming Child Protection in Queensland: A review of the implementation of the recommendations contained in the CMC's Protecting Children Report*, the CMC noted that some child safety reforms are yet to be fully realised with regard to the establishment of a coordinated child protection service delivery model. The CMC further noted that the government has made encouraging progress in implementing the recommendations. The department has developed a draft *Queensland Child Protection Strategy 2007–10* to give a broad direction in child protection for government and non-government agencies over the next three years, and a Child Protection State-wide Partnership Taskforce has also been established.⁴⁴

Ensuring a consistent standard of coordination remains one of the greatest challenges facing the child protection system as a whole and the Department of Child Safety as its lead agency.

⁴⁴ Crime and Misconduct Commission, *Reforming Child Protection in Queensland: A review of the implementation of recommendations contained in the CMC's Protecting Children Report*, June 2007, pages 29–31.

During the reporting period, the CDCRC was pleased to identify some cases of effective interagency collaboration and service delivery. The following case study highlights such practice.

Case study⁴⁵

The SC was the subject of two CPNs which were received within a period of five days. The department's response in relation to the second CPN, which was recorded with a priority 1 (24-hour) rating, was clearly appropriate and complied with the department's policies and procedures.

The concerns raised in the CPN were that the child and the child's siblings were neglected and that the family was homeless. Within 24 hours, an IA was commenced and the department immediately collaborated with the QPS in relation to ascertaining the family's whereabouts.

Within 48 hours, the QPS located the family. The QPS officers sighted the child on two occasions prior to departmental officers doing so. Within two business days, the child was sighted by departmental officers and one parent was interviewed. Departmental officers identified medical concerns for the child and a medical assessment was immediately arranged, which resulted in the child being hospitalised.

After the completion of an IA, which included interviewing the children, they were placed in the care of an approved foster carer, with the parents' consent. The CPN outcomes for all children were recorded as substantiated neglect and risk of physical and emotional harm.

42

Similarly, the following case study highlights a review that identified appropriate collaboration between the department, the QPS, Queensland Health (QH) and the SCAN Team.

Case study⁴⁶

A child was admitted to hospital as a result of injuries that appeared to be non-accidental. The incident was notified to the department and to the QPS because the medical opinion was that the explanation for the cause of injury was not consistent with the injury. Once intensive medical intervention measures were removed from the child, his condition deteriorated and he died in hospital.

After the child's admission to hospital a CPN was recorded with a 24-hour time frame. Numerous meetings between the QPS, QH and the family were clearly documented in the IA. The department also appropriately included

⁴⁵ Case Review 7/2007.

⁴⁶ Case Review 26/2007.

community and cultural supports to assist in its communication with the family.

Because of the serious nature of the injuries to the child and the medical opinion that these injuries were not caused in the manner alleged by the family, QPS staff conducted their own investigation of the matter, as well as assisting the departmental investigation.

The department's internal review found that departmental staff had regular contact with medical personnel for updates on the child's condition. Departmental staff also made numerous visits to the hospital to meet with the family and facilitate supervised contact.

As well, the matter was appropriately referred to the SCAN Team by health professionals and the department also made a supplementary referral.

The CDCRC acknowledged that the department sufficiently involved the QPS and QH in undertaking child protection assessments and provided coordinated service delivery to the child and the child's family.

Therefore, the CDCRC formed the opinion that interactions had taken place between all of the various agencies to coordinate the appropriate service delivery to the child and his family. The CDCRC noted that this coordinated approach served to minimise any misunderstandings between agencies' personnel and highlighted the vital role that coordinated case management can play in addressing the full spectrum of child protection needs in complex cases.

However, problems of limited coordination and collaboration between services continue to be a common feature in the cases considered by the CDCRC.

Queensland Police Service

The following case study is an example of poor collaboration with the QPS.

Case study⁴⁷

A notification was received by the Child Safety After Hours Service Centre (CSAHSC) including allegations that SC, in the care of a relative, was being routinely administered valium in order to sedate SC through periods of heavy alcohol use by the relative.

The CSAHSC raised a five-day response notification in relation to these allegations and referred the case to CSSC for an IA to be conducted. The CSAHSC failed to notify the QPS of the allegations, in spite of the department's statutory obligation to notify the QPS, pursuant to section

⁴⁷ Case Review 7/2007.

14(2) of the *Child Protection Act 1999*, when information received by the department includes a reasonable suspicion that a criminal offence has been committed involving a child. No consultation between CSAHSC and CSSC occurred concerning the appropriateness of such a referral or whose responsibility it should be to notify QPS, thus evidencing a lack of internal communication regarding the transfer of the case from CSAHSC to CSSC.

CSSC subsequently failed to notify the QPS pursuant to section 14(2), and failed to make any general inquiries with the QPS regarding the issue of the illicit drug administered to SC.

As a result, no police involvement took place, nor was there any further action by the department until the matter was downgraded to a CCR approximately nine months later on the basis that no evidence to support the allegations had come to light.

The department's internal review accurately identified that this failure to notify the QPS was a significant deficiency of the department's involvement with SC and was evidence of poor information-sharing practices between the two agencies. The review further correctly stated that, at the very least, consultation with the QPS concerning the possible criminal implications of drug administration should have taken place as a matter of course, even if CSSC staff were unclear as to whether or not a criminal offence had actually been committed.

SCAN Team

The SCAN Team system is a whole-of-government response to vulnerable children and young people who have been abused or are at risk of harm and who would benefit from a coordinated, multidisciplinary response. The benefits of the SCAN Team system are that all core member agencies are able to make referrals for children to a wide range of services, and collaboratively plan to meet the protection needs of children and ensure their safety through recommendations aimed at coordinated case management.

The CDCRC has identified concerns in relation to the department's recurring failure to make a referral to the relevant SCAN Team when this is clearly warranted – that is, when the case meets the documented referral criteria and would clearly benefit from this unique form of multidisciplinary approach. Other identified concerns about the operation of SCAN Teams include:

- inappropriate reliance by all core member agencies on the SCAN Team as the only means by which relevant information is exchanged, thus delaying and hindering overall case management
- interpersonal conflict among core members, resulting in an unwillingness to collaborate in accordance with the role and purpose of the SCAN Team system

- incomplete or inconsistent provision of additional or updated information to the SCAN Team, thus limiting its ability to add value to the child’s case management, and
- inefficient use of SCAN Teams, including non-compliant referral practices and unnecessary referral of cases for which interagency involvement is not required.

The following case study highlights the CDCRC’s concerns.

Case study⁴⁸

A departmental internal child death case review involved a child and its family who first became known to the department when an unborn CPN was recorded in relation to the child. The harm category was recorded as ‘emotional harm’ for the child, with concerns raised in relation to one parent’s substance abuse, domestic violence and criminal history. The CPN was assigned a 10-day response time frame because of the number of weeks gestation of the unborn child.

A further CPN was received approximately 3.5 months later in relation to the child. The concerns raised related to the parent’s hospital admission and the parent’s subsequent discharge from the hospital against medical advice. An IA was commenced the day before the child’s birth and finalised on the day when the child was born. The IA recorded an outcome of ‘substantiated at risk: emotional harm’.

The CDCRC determined that the circumstances met the SCAN Team referral criteria. The review highlighted the importance of collaboration between various agencies to ensure a coordinated delivery of services, with the absence of a referral to the SCAN Team highlighted as a key deficiency of departmental and interagency involvement with the SC in this case. The CDCRC was of the opinion that, once the unborn CPN was recorded, the case should have been referred to the SCAN Team for meaningful multi-agency discussions and recommendations, particularly involving QH to discuss the necessary support services available to the family, and the QPS to further explore the relevance and impact of the criminal and domestic violence history.

The CDCRC will continue to consider the appropriateness of SCAN Team involvement to manage complex cases or those that clearly require a multi-agency response.

Collaboration in cases involving adolescents

As noted in the 2005–06 annual report, the CDCRC has continued to pay attention to specific cases involving adolescents who engage in risk-taking behaviours or lifestyles. To strengthen the CDCRC’s recommendation made

⁴⁸ Case Review 24/2007.

during the 2005–06 reporting period, that the department develop specific practice guidelines to help officers in assessing and intervening with adolescents, the CDCRC made a further recommendation in the current reporting period relating to the need for a multi-agency response in these cases.

Case study⁴⁹

The case in question involved an adolescent SC whose ongoing conduct featured an escalating pattern of high-risk behaviours, transient and unstable self-placement decisions and a pervasive resistance towards any form of engagement with the department or other support services. In spite of the best efforts of the individual departmental personnel with primary case management responsibilities for SC, together with a concerted effort to establish a network of other supporting agencies and individuals, the department was confronted by an increasingly grave situation in which it was unable to determine an appropriate means by which to engage with SC on a consistent basis and make her safe. This inability resulted from a lack of departmental policy and guidelines concerning the management of this form of behaviour, a lack of clarity concerning the department's responsibilities to SC, and the ever-present inconsistency in the quality and type of collaborative measures undertaken by the department in relation to other relevant agencies.

After the suicide of the SC and consideration of the complex systemic issues illustrated by this case, the CDCRC concluded that there is a need for a specific interagency response mechanism to provide expert and intensive support to young people with high-level/complex needs who engage in risk-taking behaviours and are unwilling to engage with the department. Therefore, the CDCRC recommended that the department refer this matter to the Child Safety Directors' Network (CSDN) for consideration of how individual agencies could have improved and/or coordinated their service delivery to this young person.

The CDCRC identifies this as an area of need requiring considerable and targeted attention by the department and its partners, because of the unique and complex needs of this client group and the diverse case management skills and strategies that are needed. The CDCRC will continue to monitor this issue in future child death case reviews and will look to further develop the department's capacity to respond effectively. The CDCRC intends to increase its participation with other stakeholder agencies, through relevant forums such as the Child Safety Directors' Network, in order to more fully promote its holistic approach to enhanced service delivery to vulnerable children.

⁴⁹ Case Review 19/2007.

Children and young people with disabilities

In 2006–07, 18 of the 62 children whose cases were considered by the CDCRC were identified as having complex medical needs and/or disabilities. In many of these cases, the review revealed a profound lack of departmental understanding of the extent and implications of the child’s medical needs while they were alive, including the nature of the disability/illness, related implications for care and support needs, and the availability and necessity for appropriate support services to provide specialised care to the child and their carer/family.

The CDCRC recognises and respects that each and every child is unique and, as such, is entitled to individual consideration to the maximum possible extent. However, those children with complex and chronic medical needs and/or disabilities require an additional level of consideration and careful case planning, with each child having differing requirements which have to be recognised and addressed to ensure their wellbeing.

The criteria used to assess the care and protection needs of the general population of children known to the department do not always seem to neatly fit in the case of children with complex needs and can result in adverse or counterproductive decisions being made which are not in the child’s best interests.

To illustrate this point, the CDCRC identified, in several cases, concerns about the appropriateness of the placement options for a child or young person with a disability. Relevant factors included the level of knowledge of the carer concerning the nature and support needs of the child’s disability, access to required medical and other support services, and the type and extent of ongoing departmental contact required to achieve the goals of the child’s case plan.

Case study⁵⁰

In one child death case review involving an Aboriginal child with complex medical needs, the major theme was that, although the selected placement was acknowledged from the outset as being less than ideal, it was considered by departmental staff to be the best available option which allowed the child to remain in his community after the death of his primary caregiver.

The department’s review identified that the placement decision complied with the Indigenous Child Placement Principle in terms of its cultural appropriateness, but the placement was not age appropriate and developmentally appropriate, given the medical and care needs of the child. The department’s review further identified that no documentation existed to indicate that any assessment of the suitability of the placement had ever occurred. The department’s review concluded by noting that the nature of the child’s medical condition required the involvement of a number of services on

⁵⁰ Case Review 47/2006.

an ongoing basis to ensure his physical and emotional health and wellbeing, and that there had been a failure by the department to take this need into account when determining the placement.

As a result, there was a lack of consistent and proactive coordination and case management on the part of the department and a resulting lack of vital service provision to the child, which was contrary to his best interests.

The review appropriately recommended that the process be revisited and best-practice guidelines for proactive case management be established for children with special needs, particularly where multiple factors require consideration – for example, when the child is an Aboriginal or Torres Strait Islander and has special needs because of a medical condition or other disability.

The lack of standardised practice is, however, not only limited to placement decisions and issues involving children in out-of-home care. It is also acknowledged that the risk and protection factors relevant to the child's ongoing safety and wellbeing are frequently more complex than those with which departmental officers may be readily familiar, thus increasing the likelihood that the relevant IA may lack sufficient depth and insight to meet the child's true needs.

A further difficulty faced by departmental officers appears to involve effective risk assessment and case planning for children with complex medical needs. This was particularly evident in cases where the child had an uncertain or poor prognosis, or those cases in which the long-term support needs of the child could not be accurately determined at the time of assessment and case planning.

Case study⁵¹

Important assessment and care planning tasks were deferred for a period of three months, based on the department's reasoning that the child was "*in the care of the hospital and therefore not at immediate risk of harm*". The department's review appropriately identified that the child remained in the hospital for a period of three weeks under no care agreement. Therefore, the child was neither in the care of the parents, who were unwilling/unable to care for the child, nor in the care of the department.

The department's review concluded that this represented poor practice to the extent that no-one was making day-to-day decisions for the child and no long-term or sustainable measures were being put into place to support the child beyond the immediate short-term future. The hospital was therefore left with

⁵¹ Case Review 14/2007.

this responsibility by virtue of the child's in-patient status, when in fact it was the department's legislative responsibility to have taken action.

In addition, the review identified that the department subsequently placed the child in an unapproved placement without following any of the required processes, providing any financial support to the carers or offering any other form of support or contact for a three-month period.

Of concern to the CDCRC was the fact that this did not appear to be an isolated event, as demonstrated in this further case study.

Case study⁵²

It was identified that QH had significant involvement with the child, as the child remained hospitalised from the time of the child's birth to the time of the child's death. The department was advised of child protection concerns in relation to the child's premature birth and the mother's alleged drug use. Concerns about the parents' lack of engagement with the child were also expressed to the department. However, the department did not act upon the concerns until about five months later.

The department's internal review found that its involvement and communication with QH were insufficient in this case to deliver effective services to the child and the child's family in that:

- the department did not sufficiently engage with QH to explore the depth of information this agency held about the child protection concerns
- limited feedback was provided by the department to QH regarding how and when intervention would occur with the family
- there was a distinct lack of collaboration by the department and QH during the five-month period, and
- there was a failure to respond to repeated requests by QH staff for departmental advice on its intentions for the child and to engage with the child's family.

The department's internal review concluded that the insufficient involvement with QH related to the failure by the relevant CSSC to assume responsibility for the assessment of the child protection concerns and to progress the IA in a timely manner. The CDCRC considered that the department's original review should have made an additional finding in this case, that its service delivery to the child and the child's family during the period of review was inadequate and failed to meet their protection needs.

⁵² Case Review 40/2006.

The CDCRC identified a number of key learnings for the department arising from the series of events highlighted in the above case study. First, it is vital to ensure that short-term, non-approved care arrangements – most notably non-placement services being provided by other facilities such as hospitals – are not left with the responsibility for ensuring the child’s ongoing safety and protection in the absence of any departmental action to do so. Such an occurrence may not only have significant implications for the appropriate risk management of the child, but may also compromise the core business functions of other entities and place an undue burden on the personnel of the other agency – whose statutory obligations to the child primarily involved, in this case, the provision of medical, rather than child protection, services.

It is incumbent on the department to ensure that its statutory obligations to provide appropriate placement and support options to all children are consistently met, thus requiring the establishment of dedicated policy and practice guidelines for staff in order to ensure quality service delivery to children whose needs may pose additional challenges to departmental staff.

This case also highlighted the importance of collaborative case management and effective information sharing, which is, as highlighted throughout this report, a cornerstone of effective service delivery. These cases highlight the need for the department to identify, access and consult with other agencies and entities with specific expertise in and knowledge of the care needs of the child.

A sobering reflection of the progress still to be made in this regard is the fact that, during the reporting period, 14 of the 18 cases involving children with complex medical needs revealed a lack of collaborative case management with key agencies including Disabilities Services Queensland, Queensland Health and the Department of Education, Training and the Arts.

The department has given an undertaking to progress negotiations with the above agencies, along with other relevant services, to consider and establish an appropriate collaborative service delivery model for children with complex disabilities, with the intention of developing relevant policies and protocols to guide and standardise key aspects of service delivery. Key factors still requiring clarification include, but are not limited to, the responsibility for funding and provision of specialist equipment and resources, and the timing and thresholds for intervention of various agencies.

The CDCRC will continue to seek updates from the department on the status of these protocols and will further support and advise on this body of work as necessary in order to ensure that the continuum of service delivery to children with complex medical needs or disabilities is addressed.

Record-keeping

Poor record-keeping practices and non-adherence to policies and procedures by departmental staff have been identified as consistent themes in the majority of child death case reviews since the commencement of the CDCRC in 2004. The

CDCRC has made nine recommendations in relation to this in order to support the focus and effectiveness of the reform process.

It is acknowledged that a number of historical issues concerning records management, rapidly evolving technical infrastructure within the department, and difficulties in the training, retention and supervision of staff, have posed considerable challenges to the department in developing and maintaining an effective standard of record-keeping.

The steps taken by the department to deal with this issue, most notably the recent implementation of the Integrated Client Management System, are encouraging. Accordingly, the CDCRC has an expectation that a reduction will occur in the number and extent of record-keeping problems highlighted in case reviews.

However, the expected reduction in record-keeping issues was not apparent in 2006–07.

The CDCRC again identified concerns with the department's performance in this area. In particular, the CDCRC is concerned that important child protection information is being recorded in notebooks and not entered into the department's electronic systems for significant periods of time, with some information only being recorded after the child or young person's death.⁵³

A separate but related concern is the recurring failure by departmental staff to complete and submit relevant case reports and material for supervisory endorsement. This vital procedural requirement serves a number of functions related to both effective case management and the development of key competencies in staff.

The CDCRC is of the opinion that it is important to remedy this ongoing systemic failure and ensure that all relevant information is electronically available in a timely manner. This is of utmost importance, given the nature of the risks to children and young people, which can rapidly escalate and which often take on their full significance only when considered along with all previous history of harm and risk of harm.

In addition, the CDCRC has noted that there are significant implications if the child is not recorded on the system at the time of death, and hence when the QPS conduct their child protection history search and enliven their investigative process. The existence of child protection information is also highly relevant to QPS, post-mortem and coronial investigations, again highlighting the interdependence of all agencies in ensuring that all children are afforded their right to due process and a high standard of service delivery, both while they are alive and in the event of their death.

Record-keeping and its underlying issues of transparency and accountability remain critical areas of practice, with potentially far-reaching impacts on

⁵³ For example; Case Reviews 5/2007 and 9/2007.

individual children and young people. This is therefore an area that the CDCRC will continue to monitor closely, with the expectation that improvements will become evident throughout the forthcoming reporting period.

Contextual issues affecting service delivery

The inability of CSSCs to adequately respond to child protection concerns in a timely manner because of understaffing and other contextual problems is a recurring theme in the department's child death reviews.

Throughout the past year, the CDCRC has observed an increasing trend towards discussion of such issues within child death case reviews. Examples of contextual factors frequently cited as detracting from the department's ability to provide adequate standards of service are:

- staffing issues, including high staff turnover, excessive vacancies within specific CSSCs and lack of staff expertise in the key service delivery areas of Intake and IA
- excessive workloads and case backlogs
- poor staff morale
- lack of supervisory structures and inconsistent supervisory practices
- lack of timely training and professional development
- lack of support services, particularly in rural and remote areas
- poor service delivery to Indigenous communities, including lack of departmental presence in the community, poor understanding of cultural considerations and a lack of available Recognised Entity services, and
- poor relationships with other agencies in the catchment area.

The connectedness of these contextual factors to outcomes for children and young people is obvious. However, the safety and wellbeing of children and young people should in no way be compromised by them. Accordingly, the CDCRC encourages the department to use the review process as an opportunity to identify and deal with contextual problems. It also places an emphasis on the predictive ability of the department's resourcing and reporting models to generate alerts in relation to thresholds for when contextual issues may impair outcomes for children and young people.

In response to this issue, the department provided the following advice:⁵⁴

- *To address areas of workload pressure the department has appointed teams of locum staff to assist the permanent staff with throughput. Initial funding of \$2 million was released for the creation of temporary positions which enabled the establishment of ten specialised Investigation and Assessment Teams in 12 locations across Queensland.*

54 Correspondence dated 21 September 2007.

In February 2007 a further \$3 million was made available from Treasury. These funds are targeting the 23 CSSC's with a backlog in excess of 100 Investigations and Assessments.

- *The department has completed a review of workloads. The purpose of the review was to:*
 - *develop a fair and accountable system for measuring the workloads of Child Safety Officers and Child Safety Support Officers*
 - *identify child safety service centre workload indicators for Child Safety Officers and Child Safety Support Officers, and identify processes for management of workloads for these officers.*
- *Several CSSCs are trialling the tools identified in the review for managing workloads. One of the tools being trialled is predictive planning. It is a workload management process that promotes structured planning of a worker's caseload over a 6 - 8 week cycle. Child Safety Officers develop a detailed plan to respond to the tasks and activities required for their cases according to urgency of particular tasks and complexity of carers. They are closely supervised by their Team Leaders to ensure that complexity of cases match the experiences and skills of the workers.*

To the extent that contextual factors are currently hindering effective service delivery, it is imperative that departmental staff also understand their obligation to formally raise concerns with their managers or zonal directors. In other words, all departmental staff have an obligation to be proactive in dealing with factors, be they internal or external, which are known to be detracting, or have the potential to detract, from the department's ability to perform its core business of ensuring the safety and wellbeing of children and young people.

In 2006–07 the CDCRC made the following recommendation.

CDCRC recommendation

The CDCRC recommends that the department provides further information to the Committee as to the current reporting systems in place within the department to enable problematic contextual issues to be brought to the attention of the appropriate level within the department, so that they may be addressed before they negatively affect the department's ability to appropriately respond to children at risk of harm.

The CDCRC will continue to monitor and report on this issue, so long as the impact of contextual factors continues to be highlighted in departmental reviews.