

## 2 Effective assessment

**“[The Department of Child Safety] could have moved me into care faster and listened to me more about what it was like living with Mum.”<sup>12</sup>**

### Chapter 2 key messages:

- The number of outstanding Investigation and Assessments by the Department of Child Safety is high but has decreased from March 2006 to December 2006.
- There are marked differences in the number of outstanding Investigation and Assessments across Queensland. Further investigation is needed to determine the reasons for these differences and what action is needed to achieve systemic improvement.

Effective assessment plays a pivotal role in determining the ongoing protective needs of children and young people and the services children and young people receive once a Notification is recorded by the Department of Child Safety. In 2006 the Child Guardian focused on monitoring the Department of Child Safety’s process for conducting Investigation and Assessments.

The process used by officers of the Department of Child Safety when they receive information about allegations of harm or risk of harm to a child or young person is called Intake. The Department of Child Safety must make a decision about the appropriate way to respond to the information, which can be either:<sup>13</sup>

- recording a Notification (this response occurs where there are allegations of harm or risk of harm<sup>14</sup> to a child, and a reasonable suspicion that the child or young person is in need of protection<sup>15</sup>), or
- recording a Child Concern Report (this response occurs when the information received does not meet the threshold for recording a Notification).

If the information is recorded as a Notification, the Department of Child Safety will investigate the concerns and assess the protective needs of the subject child(ren) further through a process called an Investigation and Assessment.<sup>16</sup> The Department of Child Safety’s Child Safety Practice Manual explains that this involves:

- reviewing the child protection history of the child and family, determining who will be involved in the Investigation and Assessment process and planning for interviews
- sighting and interviewing each subject child, interviewing the parents and obtaining information about the child and family from other agencies and relevant individuals

12 Young person’s view as quoted at page 95 of *Child Guardian Views of Children and Young People in Care, Queensland, 2006*.

13 Departmental officers use a suite of tools under the Structured Decision-Making model to guide them when making this decision.

14 Harm, as defined in section 9(1)(3) of the *Child Protection Act 1999*, is any detrimental effect of a significant nature on the child’s physical, psychological or emotional wellbeing.

15 Section 14 of the *Child Protection Act 1999*.

16 Previously known as ‘Initial Assessments’.

- assessing each child’s safety and whether there has been harm to a child or if there is risk of future harm, and
- deciding the outcome of the Investigation and Assessment and what intervention will occur to meet the ongoing protection and care needs of the child.

This chapter outlines the information that the Child Guardian currently has about Intake, Notifications, and Investigation and Assessments at both the system level and the level of the individual child or young person.

## 2.1 Investigation and Assessments at the system level

### 2.1.1 Statewide data

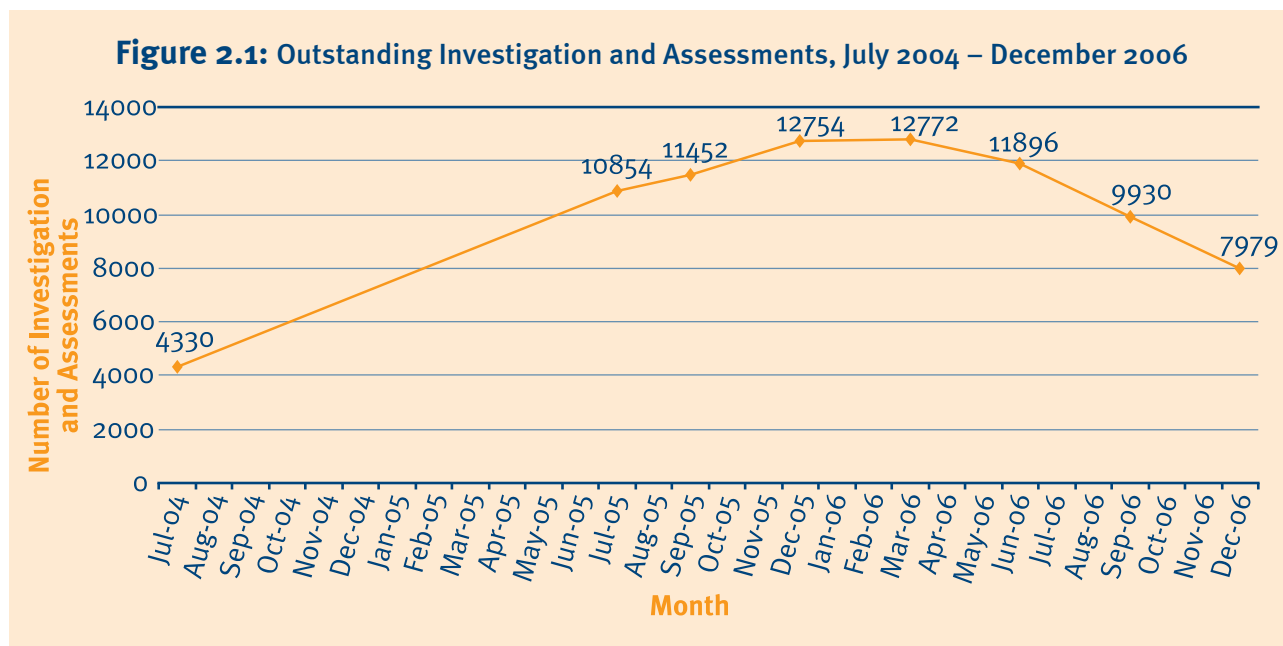
In early 2005 the Child Guardian identified that the safety of children and young people might be compromised because the Department of Child Safety had a large number of outstanding Investigation and Assessments. An Investigation and Assessment is considered to be ‘outstanding’

by the Child Guardian either if it is waiting to be allocated to a Child Safety Officer or if it has been started but not completed.

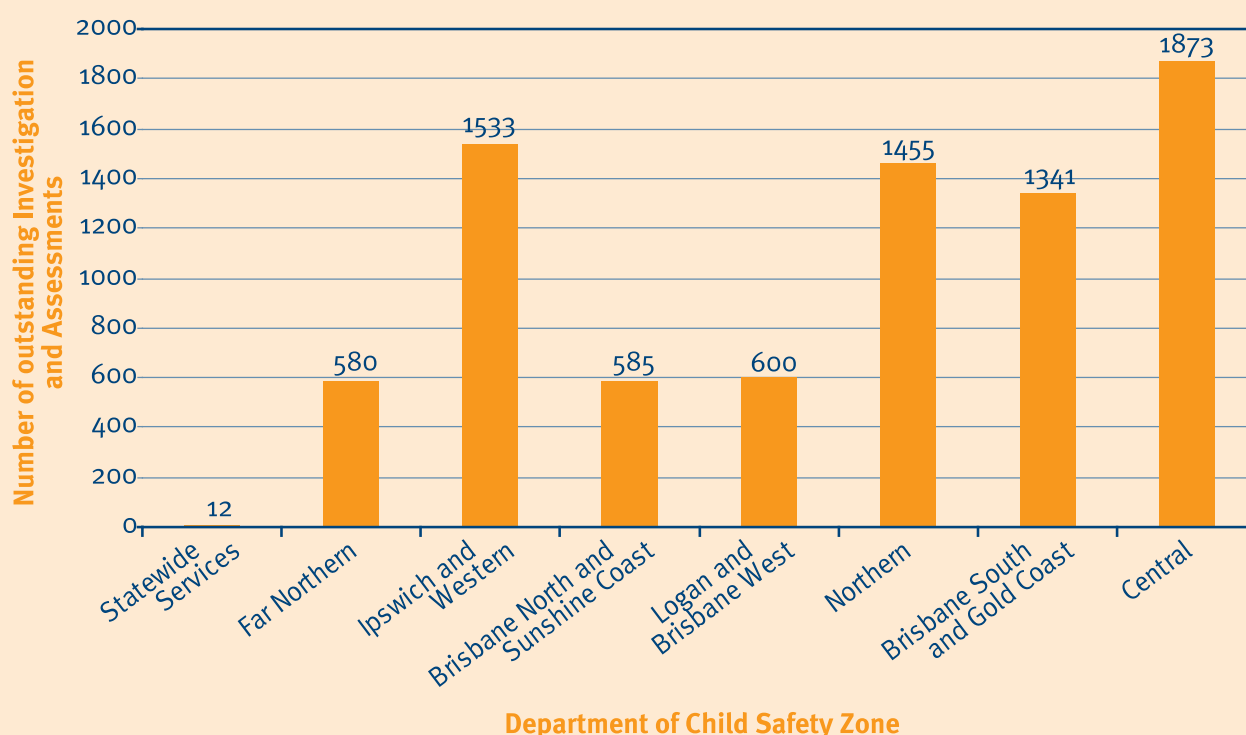
As a result of information received, the Child Guardian began a long-term review to determine if there are any systemic issues relating to processing and/or completing Investigation and Assessments within individual Child Safety Service Centres. The information obtained as a result of this two-year review is outlined in Figures 2.1 and 2.2.

Key features of Figure 2.1 are:

- from July 2004 to December 2006, the statewide total of outstanding Investigation and Assessments increased from 4330 to 7979
- the largest number of outstanding Investigation and Assessments was recorded in March 2006 with a total of 12,772, and
- the largest part of the overall increase was recorded between July 2004 and July 2005, when there was an increase of 151%.



**Figure 2.2: Total number of outstanding Investigation and Assessments by Department of Child Safety Zones, December 2006**



The number of outstanding Investigation and Assessments is an important measure of the potential risk to children and young people.

Further contextual information is needed for an assessment to be made about the appropriateness or otherwise of the data in Figure 2.2. Other information which would need to be considered is:

- the length of time that the Investigation and Assessments have been outstanding
- the workforce capacity and competing work priorities of individual Child Safety Service Centres within each Zone, and
- the total numbers of Investigation and Assessments for individual Child Safety Service Centres within each Zone.

The Department of Child Safety has advised<sup>17</sup> that it considers the number of outstanding

Investigation and Assessments, as a proportion of Notifications received in a given period, represents a “better picture” of the level of uncompleted work.

The Child Guardian has not to date gathered or considered the above information because of the Department of Child Safety’s recent acknowledgement that further effort and resources (including the allocation of \$5 million) are required to continue to deal with outstanding Investigation and Assessments.<sup>18</sup>

The Child Guardian is also pleased that the decrease in the numbers of Outstanding Investigation and Assessments shown in Figure 2.1 (see previous page) supports the Department of Child Safety’s advice to the media in February 2007 that the backlog of Investigation and Assessments was decreasing.

<sup>17</sup> By way of letter dated 19 March 2007.

<sup>18</sup> According to a media statement titled ‘Queensland Child Protection gets \$5M boost’ by the Premier and the Child Safety Minister on 4 February 2007.



The Department of Child Safety's public acknowledgement of the problems associated with outstanding Investigation and Assessments and its continued commitment to funding solutions to these problems represent a commitment to achieving better outcomes for children and young people who may have been harmed and may be at risk of harm.

To address the differences in numbers of outstanding Investigation and Assessments across Queensland, the Child Guardian is currently considering requiring the Department of Child Safety to undertake a detailed review of specific Child Safety Service Centres to identify the underlying causes of high levels of outstanding Investigation and Assessments. The results of such a review should improve the Department of Child Safety's ability to monitor and address high numbers of outstanding Investigation and Assessments in the future.

### **2.1.2 Interviews within the Investigation and Assessment process**

As outlined above, conducting interviews with all subject children, parents and other relevant adults and agencies is an important way to gather information within the Investigation and Assessment process.

Because of this, the Child Guardian conducted a review<sup>19</sup> of 72 Investigation and Assessments completed by the Department of Child Safety in April 2005. The focus of this work was to establish some early comparative benchmarks by which to assess performance of the reform process begun in 2004 by the Queensland Government on whether all relevant people were interviewed during the Investigation and Assessment process. When a decision was made by the Department of Child Safety not to interview a relevant person, the adequacy of

that decision was also assessed by the Child Guardian.

The following issues were identified from the review of 72 Investigation and Assessments:

- 22% of the subject children in the review were not interviewed<sup>20</sup>
- in 30% of the Investigation and Assessments, not all care providers were interviewed, and
- in 42% of the Investigation and Assessments which identified relevant agencies, not all relevant agencies were interviewed.

The Child Guardian will review a further sample of current Department of Child Safety Investigation and Assessments in order to compare the results with the above results of the 2005 review. This will allow the Child Guardian to inform the Department of Child Safety about the effectiveness of the following reform initiatives in improving the conduct of interviews since 2005:

- the detailed guidelines contained in the revised Department of Child Safety Practice Manual, and
- additional training that has been provided to Child Safety Officers.

### **2.2 Investigation and Assessments for individual children and young people**

The Child Guardian has undertaken a number of reviews of work done in relation to individual children and young people. These are usually investigated as a result of concerns identified through the Child Guardian's Community Visitors, complaints received or child death review work. The Child Guardian completed 14 detailed reviews of service delivery to children and young people during the 2006 calendar year.

The implementation of the many recommendations made by the Child Guardian will be monitored to assess whether better outcomes for children and young people were achieved. Examples of these reviews are provided over the page.

19 The review was a 'desk-top' review of the Department of Child Safety's records of the Investigation and Assessments and was therefore based only on the information contained in those documents.

20 For the purposes of this review, it is considered that 'sighting' a child is equivalent to 'interviewing' a child when it appears from the Investigation and Assessment text that the child was unable to be interviewed (because of age and/or ability to participate). Therefore the results reflect the number of children either appropriately sighted or interviewed as recorded in the Investigation and Assessment documents.

### **2.2.1 A review by the Department of Child Safety in relation to an adult, 'Ted'**

Complaints about the safety and wellbeing of a number of children in the care of their father/stepfather ('Ted') were received by the Child Guardian in 2005. In particular, the information received raised concerns about the quality of previous Investigation and Assessments about children and young people in the care of Ted.

The Child Guardian required the Department of Child Safety to conduct a review of this matter.<sup>21</sup> The Department of Child Safety responded appropriately to this request by appointing an experienced person external to the relevant Child Safety Service Centre to conduct a full review of the electronic records and hard-copy files and assess the actions and decisions of departmental officers. In addition, the review also considered whether Department of Child Safety policies and procedures were complied with.

The Department of Child Safety's review identified serious practice issues in relation to the Department's assessment of the safety and wellbeing of children in the care of Ted. Significantly, the Department of Child Safety confirmed that previous Investigation and Assessments of alleged harm by Ted had not been conducted thoroughly, and additional children came to the attention of the Department of Child Safety as potentially being in need of protection from harm as a result of the review.

The Department of Child Safety's review report recommended that:

- a Notification be created and an Investigation and Assessment undertaken to ensure the safety of the children currently in the care of Ted, and
- a case meeting be convened, comprising the Department of Child Safety and external agencies involved with the coordination of services to the family, to discuss and plan future interventions with the family.

The Department of Child Safety's review report also made a number of systemic recommendations, including:

- that all field staff in the relevant Child Safety Service Centre undertake professional development in relation to holistic assessment

- that the results of the review be used to inform the planned development of a policy on the review of multiple Notifications, and
- that the results of the review be used to identify significant gaps in past practice and to ensure that current training and the current practice manual reflect and reinforce best practice.

The Child Guardian supports these recommendations and is satisfied that they adequately addressed the Child Guardian's concerns about this case at both an individual and a systemic level.

The Department of Child Safety conducted an Investigation and Assessment subsequent to the review report and identified a number of recurrent risks to the safety and wellbeing of the children who have contact with Ted. The Department of Child Safety decided to commence an Intervention with Parental Agreement with Ted to allow monitoring of the safety and wellbeing of the children and young people in his care through regular departmental contact. The Child Guardian is satisfied with this approach.

### **2.2.2 A Child Guardian investigation into service delivery to a child, 'Billy'**

Allegations that a subject child ('Billy') may have been at risk of harm at home were received by the Child Guardian in 2004. In particular, it was alleged that Billy's mother was involved in the manufacture, supply and use of illegal substances.

The Child Guardian's first step was to communicate with the Department of Child Safety about the concerns and this resulted in Billy's immediate safety being addressed by the Department of Child Safety.

After this, the Child Guardian reviewed all of the Department of Child Safety's records in relation to its service delivery to Billy over a defined period of time to ascertain the quality and effectiveness of any Investigation and Assessment processes that were conducted by the Department of Child Safety in relation to Billy.

As a result of the investigation, the Child Guardian formed the opinion that the Department of Child Safety:

- had not recorded and assessed all allegations received

<sup>21</sup> By way of formal notice under section 31G of the *Commission for Children and Young People and Child Guardian Act 2000*.

- had not conducted holistic assessments in response to allegations regarding Billy’s safety and wellbeing
- had not interviewed all relevant witnesses
- had not identified all relevant risk factors
- placed an unreasonable amount of reliance on the advice of other agencies in assessing the risk of harm to the child, and
- had not recorded all relevant information in the Investigation and Assessments.

The Child Guardian also formed the opinion that the Department of Child Safety’s Practice Manual (at the time) required revision and additional guidelines in relation to the recording of Notifications and the possible reassessment of time frames in responding to a Notification.

As a result of the above, the Child Guardian recommended that the Department of Child Safety:

- make amendments to the Practice Manual in relation to the recording of Notifications and the possible reassessment of time frames in responding to a Notification
- review Billy’s current placement, having regard to the findings in the Child Guardian’s provisional report, and
- inform future service delivery, by advising all of the officers who are currently or who have been involved in this case of the contents of the Child Guardian’s report.

### **2.2.3 A review of service delivery to a group of children, ‘Sibling Group Z’**

Allegations were received in 2005 that a group of siblings (‘Sibling Group Z’) were being harmed and were at risk of future harm while in the care of their parents, and that information had been provided to the Department of Child Safety about this harm.

The Child Guardian required the Department of Child Safety to conduct a review<sup>22</sup> of its service delivery to Sibling Group Z and its review report identified the following areas of service delivery which required improvement:

- Investigation and Assessment of Notifications, and
- record-keeping.

The Child Guardian considered this review and made additional case-specific and systemic recommendations.<sup>23</sup> These included that:

- the individual case plans for each sibling be reviewed and further developed
- the relevant Child Safety Service Centre develop and implement strategies to maximise the opportunity for the parents to re-engage with the Department of Child Safety
- the Manager of the Child Safety Service Centre share findings of the review with the Zonal Management Team and facilitate practice discussion on system development and training needs of staff at a Zonal level
- feedback be provided to the Training and Special Support Unit for the training of Child Safety Officers in relation to conducting Investigation and Assessments and how child protection histories should be considered during the Intake process, and
- the relevant Child Safety Service Centre consider the findings of the review and develop an action plan in relation to Intake systems, training needs, systems development and human resource development.

### **2.3 Future Child Guardian work on effective assessments**

In compiling this Report the Department of Child Safety was invited to submit advice about its key initiatives for 2006. In relation to effective assessments, it advised of the following:

- After an injection of \$2 million (funded by carryovers into 2006-07), an additional 37 temporary staff were employed in Investigation and Assessment clean up teams in a number of Zonal and Child Safety Service Centre locations, commencing May 2006. At their peak, this included 8 team leaders, 24 Child Safety Officers and 5.5 systems or administrative support positions. For part of 2006, several zones had reduced staff due to recruitment difficulties.

As at end January 2007, the Department of Child Safety has achieved a 37% reduction in outstanding Investigation and Assessments, with 7,861 Investigation and Assessments outstanding.

22 Under section 31G of the *Commission for Children and Young People and Child Guardian Act 2000*.

23 Under section 31H of the *Commission for Children and Young People and Child Guardian Act 2000*.

- Amendments to the Department of Child Safety Practice Manual will include foundational theoretical frameworks for child protection practice, short summaries of theories and their application to practice, along with an introduction to the United Nations Convention on the Rights of the Child. This stage is due for release in June 2007.
- Development of practice papers, '*Parental substance misuse and child protection: Overview, indicators, impacts, risk and protective factors*' and '*Parental substance misuse and children protection: intervention strategies*' to provide Department of Child Safety officers with information about:
  - the incidence of substance misuse
  - different types of substances, associated symptoms and impacts on the user
  - the connections between parental substance misuse and child abuse/neglect
  - abstinence versus moderation
  - possible harm to the child
  - risk and protective factors
  - responding to notifications alleging parental substance misuse
  - inter-agency collaboration
  - drug and alcohol interventions
  - implications for Department of Child Safety case planning, including strategies to independently screen and monitor parents who have misused substances when reunification is being considered
  - worker safety
  - key resources, and
  - development of procedures on drug testing.

The Child Guardian (and the Child Death Case Review Committee) will continue to conduct quality assurance work around Investigation

and Assessments, as they are a key mechanism for the Department of Child Safety to perform its statutory function of identifying which children and young people need to remain at home with their parents (with or without early intervention and prevention services) and which children and young people need to enter out-of-home care.

Future work by the Child Guardian will also consider the Intake process and the way that government service providers refer information to the Department of Child Safety about harm or suspected harm to children and young people.

This is currently being done through a review of the systems, policies and practices of some government agencies<sup>24</sup> for referring information regarding harm or suspicions of harm about children and young people to the Department of Child Safety.

The review will consider whether other government agencies have adequate systems to capture and report on data relating to referrals of harm. At the conclusion of the review, the Child Guardian will provide specific feedback and findings and recommendations (if necessary) to each agency. The results of the review will be reported in the *Child Guardian Report 2007*.

Also, in 2007 data will be gathered about the Child Guardian Key Outcome Indicators in relation to effective assessments as follows:

- the number and proportion of children and young people who are the subject of an outstanding Investigation and Assessment and the average time that these have been outstanding, and
- the number and proportion of distinct children and young people who are the subject of recommendations by the Suspected Child Abuse and Neglect (SCAN) Team where those recommendations are subsequently the subject of Exception Reports<sup>25</sup> and Exception Resource Reports.<sup>26</sup>

24 Including the Department of Communities, the Queensland Police Service, Queensland Health, the Department of Education, Training and the Arts, Disability Services Queensland, the Department of Housing, the Department of Corrective Services and the Department of Justice and Attorney-General.

25 When a core member agency agrees to a recommendation during the course of a SCAN Team meeting and subsequently departs or is considering departing from the recommendation as agreed, an Exception Report is required to be prepared.

26 When an officer is aware that they are unable to action an agreed SCAN Team recommendation because of a lack of resources or an inability by the responsible agency to meet the time frame for action proposed, an Exception Resource Report is required to be prepared.