Torres and Cape Hospital and Health Service submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee; Child Protection Reform Bill 2017

Torres and Cape Hospital and Health Service

The Torres and Cape Hospital and Health Service (TCHHS) is an independent statutory body governed by a skills based Board, and manage primary and acute care services across the region from hubs in Weipa, Cairns and Thursday Island. It is the most northerly of Queensland's Hospital and Health Services and covers over 158,000km^2 across 13 local government areas.

The TCHHS is one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples. TCHHS provides health care to a resident population of more than 25,000 people of which 63.7% identify as Aboriginal and/or Torres Strait Islander. TCHHS makes this submission in respect of the safe care in connection of Aboriginal and Torres Strait Islander children.

Executive Summary

Torres and Cape Hospital and Health Service (TCHHS) is one of the largest providers of health care to Indigenous communities in Australia and it's staff experience child safety related matters routinely. TCHHS has undertaken a Root Cause Analysis (RCA) as a consequence of harm to an infant, on a background of mandatory reporting concerns. The infant had previously been transferred and investigated for non-accidental injuries, yet a reportable suspicion about the infant had not been made to the Department of Communities, Child Safety and Disabilities (the Department). We believe the outcome of that analysis requires urgent and serious reconsideration of parts of the Child Protection Act 2009.

On 1 July 2013, the Queensland Child Protection Commission of Inquiry (2013) released its final report - *Taking Responsibility: A Roadmap for Queensland Child Protection*. The report made 121 recommendations 'aimed at addressing the risk of systemic failure and making Queensland the safest place to raise children'[i]. The recommendations resulted in the *Child Protection Reform Amendment Bill 2014.*

In particular, amendments were made to include a new part 1AA that included sections 13A-13J-reporting suspicions about harm or risk of harm. The new part sought to provide:

- 'clear direction for any person to report concerns when they reasonably suspect a child is in need of protection.
- a consolidated provision for all existing mandatory reporting obligations contained in legislation or government policy.
- a single 'standard' to govern reporting obligations and determine what is a reportable suspicion; and guidance to help professionals consider if any concerns they hold about a child are a reportable suspicion, and how and when to make reports'[ii].

We contend that, the new part has not achieved clarity for mandatory reporting and has negatively affected reporting behavior; evidenced through reporting volumes and in this case a tragic outcome.

The introduction into the mandatory reporting requirements of the reporter to make the dual consideration as to whether there is harm and *a parent is able and willing to protect the child from harm* has transferred the intake assessment role of the Department with respect to making a notification decision, to the role of the mandatory reporter at the point of making a reasonable reportable suspicion report. Such decisions cannot be effectively made at the reporter level, are not being made and intake reports to the department are subsequently declining. The assessment that *a parent is able and willing to protect the child from harm* is a decision that should be made at the investigation level by the Department.

This submission highlights the concerns with amendments made to the Child Protection Reform Amendment Bill 2014 and proposes how sections 13E and 13H may be remedied to improve Aboriginal and Torres Strait Islander child safety and child safety reporting more broadly across the State.

The Queensland Child Protection Commission of Inquiry 2013.

The Queensland Child Protection Commission of Inquiry (The Commission) noted the case for reform arising from the stress the child protection system was under. The Commission heard that in recent years prior to the Inquiry, child protection intakes had tripled; out of home care children had doubled (in mainstream communities) and had tripled in Aboriginal and Torres Strait Islander communities. Children in care were staying longer in care.[iii]

The Commission was also mindful of the 1998–99 Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry) and the 2003–04 Crime and Misconduct Commission Inquiry into the Abuse of Children in Foster Care (CMC Inquiry), both of which raised public awareness of risks related to children in protection.[iv]

Not surprisingly, The Commission sought solutions to reduce the demand on the statutory system.

Unsustainable demand

Information provided to the Commission indicated the unsustainable demand on the Queensland statutory system was the result of:

1. the high number of intakes to child safety (reporting stage)
2. too many investigations being conducted by child safety (Notification Stage)[v]

It is important at this point to clarify the differences between Mandatory Reporting, Child Concern Reports and Child Safety Notifications.

Mandatory reporting is required under Section 13E of the Child Protection Act 2009 (the Act) by relevant persons through consequence of their professional roles and encounter with children.

A Child Concern Report arises following an intake assessment arising from a report to the Department of Communities, Child Safety and Disabilities (the Department) 'when the information received does not suggest the child is in need of protection. No further departmental action is required in response to a child concern report, but Child Safety may provide information to the reporter, the police, or another state authority and may make a referral to another agency'.[vi]

A Child Safety Notification is recorded following an intake assessment arising from a report to the Department of Communities, Child Safety and Disabilities (the Department) 'when the department reasonably suspects the child is in need of protection'. That is; the child meets the threshold for notification.[vii]

Prior to the *Child Protection Amendment Act (2014)*, section 10 of the Act clearly stated the threshold for notification as:

> *'A child in need of protection is a child who—*
> *(a) has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; and*
> *(b) does not have a parent able and willing to protect the child from the harm'.*[viii]

The Commission was provided information that 'if an intake is assessed as raising a reasonable suspicion that a child is in need of protection — that is, the child has suffered or is likely to suffer harm and no parent is able and willing to protect the child — it has met the threshold for notification and is recorded as such'[ix].

In addition, The Commission was informed that 'of the 114,503 intakes in 2011–12, 24,823 met the threshold for notification, with these relating to 21,909 distinct children, a rate of 20.5 children notified per 1,000 population aged 0 to 17 years. Some children have repeat notifications. From the 19,353 children with notifications in 2010–11, 22 per cent (4,210) were re-notified within 12 months'[x].

The Commission noted however, that 'most reports to Child Safety are assessed as child concern reports because the issues raised do not reach the threshold for a notification — that is, a reasonable suspicion that a child has suffered harm, is suffering harm or is at unacceptable risk of suffering harm and where the child has no parent able and willing to provide protection'[xi].

The Commission also noted that 'in contrast to the trend in child concern reports, the number of intakes recorded as notifications had generally decreased since 2004–05 (apart from a 15 per cent increase from 2010–11 to 2011–12). In 2011–12, 24,823 notifications were recorded, representing only 22 per cent of intakes. This means that 78 per cent of intakes received no follow-up action'[xii].

Hence the burden on the statutory system was not the number of children in protection but rather the number of reports received by the Department. The cause was attributable to 'over-reporting or increased mandatory reporting requirements'[xiii].

The Remedy

To alleviate the number of reports the remedy was to redefine reporting and notification thresholds. This occurred in two parts.

Firstly, the Commission proposed an amendment to section 10(a) of the Act "to state explicitly that a child must be at risk of significant harm to meet the definition of a 'child in need of protection'. This change was seen as consistent with the standard in some Australian jurisdictions such as Victoria and New South Wales. The Act currently includes the qualifier 'significant' in its definition of 'harm', where harm is defined as meaning 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing".

The Commission suggested that: "The inclusion of the term 'significant' in section 10(a) would reinforce the message to reporters that harm must be of a significant nature"[xiv]. The concern in this passage is that Section 10 has nothing to do with reporters or mandatory reporting, and everything to do with the Department's own intake assessment and notification threshold test.

The Commission made recommendation 4.1:

> 'That the Minister for Communities, Child Safety and Disability Services propose that section 10 of the Child Protection Act 1999 be amended to state that 'a child in need of protection is a child who has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm'[xv].

The second and more concerning change occurred as part of the new 1AA insertion resulting in Sections 13 E and 13H of the Act. A hendiadys to the mandatory reporting requirements was added with the requirement for mandatory reporters to satisfy two criterions before making a reportable suspicion about a child. Section 13E (2) requires that:

> 'For this section, a reportable suspicion about a child is a reasonable suspicion that the child—
> (a) has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and
> (b) may not have a parent able and willing to protect the child from the harm'.[xvi]

Outcome

The effect of these changes on mandatory reporters has been two fold:

1. There is an added layer of complexity as to what constitutes "significant harm" compared to harm otherwise suspiciously obtained.
2. A requirement to determine the extent or otherwise of the existence of a parent who is able and willing to protect the child from the harm before a report is made.

The result of these changes has been to effectively transfer the intake assessment role of the Department with respect to making a notification decision, to the role of the mandatory reporter at the point of making a reasonable reportable suspicion report.

There are no recommendations in The Commission's report that sections 13E or 13H that relate to mandatory reporting or conferrals with colleagues should contain a provision to make an assessment about the availability of a parent who is able and willing to protect a child from harm. There are no other Australian jurisdictions that place such a complex decision making burden on mandatory reporters about a reportable suspicion.

The Commission notes that 'many of the professionals with mandated reporting requirements may not be child protection experts, nor is child protection their principal concern. Rather, they come from various disciplines and backgrounds and have diverse skills and knowledge. These professionals may not easily recognise the signs of a child at risk of abuse or in need of protection. Indeed, in many circumstances, reporting a family to statutory child protection authorities is a difficult decision'[xvii]. The mandatory decision making "threshold" has only furthered that difficulty.

Of additional concern is the development of a practice in health care whereby the complexity of the mandatory reporting decision making has resulted in internal deference from mandatory reporters (ie. doctors and nurses) to child protection liaison officers (non- mandatory reporting persons) as conferring colleagues under section 13H. The distribution of responsibility for the report reduces the likelihood of the report being made and more so an absence of accountability for it being made.

The Department's own data demonstrates that 'over the past year, the number of intakes decreased by 7.7 per cent, from 107,585 for 2014-15 to 99,293 for 2015-16'. The Department attributes the 'decrease coincides with the introduction of reforms in January 2015, including Family and Child Connect and Intensive Family Support services and streamlined reporting arrangements.'[xviii]

A further analysis of the Department's "notifications by region" data for Far North Queensland for the period between 2013-14 and 2015-16 notifications have fallen by 18.7%[xix]. Far North Queensland including Torres and Cape Hospital and Health Service does not have access to Family and Child Connect and Intensive Family Support services. The decline is directly attributable to lower reporting rates.

RCA details- a true sentinel event

The Torres and Cape Hospital and Health have undertaken a Root Cause Analysis that exemplifies the concerns raised in this submission.

On 6 July 2016 a 9 week old baby boy was bought into a Primary Health Centre with signs of neurological and physiological symptoms and transferred to a tertiary Hospital. Investigations undertaken during the admission found the baby had suffered severe injuries including numerous fractures, and closed head injury resulting in likely permanent blindness and neurological damage. The injuries were suspected to be the result of an earlier non-accidental injury to the child that was not reported to the Department of Communities, Child Safety and Disability Services.

The RCA sought to determine why an infant transferred with a provisional diagnosis of non-accidental injury was not reported to the Department. The report identified that on initial presentation the signs (peri-orbital ecchymosis) were consistent with non-accidental injury, but that no radiologically significant injury could be identified. The child was "referred" to the health service's child protection liaison officers who felt the absence of significant harm and the possible presence of parent able and willing to protect the child from harm, precluded the matter from a reasonable suspicion report.

The analysis found a contributing factor was:

> 'Due to a hendiadys within section 13E(2) of the *Child Protection Act 1999* , a subordination exists where the mandatory reporter must also consider the existence of whether "*the child may have a parent who is able and willing to protect the child from harm*" in addition to the consideration of harm itself. The complexity of determining this threshold for the mandatory reporter increases the reliance on the Child Protection Liaison Officers (CPLO) conferral to make that element of assessment for the mandatory report. CPLO training and practice documents emphasise the extent to which *the parent may be willing to protect the child from harm* as integral to the making of a report. This resulted in the absence of mandatory reporting in the presence of a parent and the apparent absence of (significant) harm. This may have contributed to the absence of a mandatory report and allowed the infant to return to a harmful environment and further exposure to non-accidental injuries'.

Training and Guidance

The Inquiry, noted that 'while the Commission does not expect that all reports to Child Safety Services made by mandatory reporters must meet the threshold for notification, there is room for more efficiency. Accordingly, Chapter 4 (of the Commission's report) recommends changes to the Act to provide:

- greater certainty about what constitutes harm
- a legislative framework for mandatory reporting
- a review of the policies of reporting agencies
- training for mandatory reporters (both those mandated by legislation and policy)
- adherence to the reporters guide, and

- the QPS to remove the policy that mandates the reporting of all domestic violence incidents where a child resides with one of the parties to Child Safety'xx.

In the health setting, child protection liaison officers undertake training of staff with mandatory reporting responsibilities. Training specifically emphasizes the importance of "a parent who is able and willing to protect the child from harm", and "significant harm" as part of the reporting process according to the Department's child safety training manual[xxi]. Staff report this to be confusing and counter intuitive to their understanding of mandatory reporting obligations.

A "reporters on-line guide" emulates the written Queensland Child Protection Guide[xxii] has been created by the Department. Both exemplify the paradox. In the instance where a reporter may be suspicious of a sexually transmissible disease in a 5 year old, the decision outcome results in the provision of treatment only, without the necessity of a report to the Department where there is "a parent who may be able and willing to protect the child from harm".

Summary

A reportable suspicion report is not something health professionals undertake without due consideration. The Commission noted reporting a family to statutory child protection authorities is a difficult decision. Since the introduction of section 13E and 13H that decision has become more difficult.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has been shown not to have been a consideration of The Commission or contained within its recommendations.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has been shown to transfer the intake assessment role of the Department with respect to making a notification decision, to the role of the mandatory reporter at the point of making a reasonable reportable suspicion report and is entirely inappropriate.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has been shown to have resulted in distributed decision making outside the mind of the mandatory reporter reducing the likelihood of the report taking place.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has impacted mandatory reporting training and the Departments own decision making guides.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has been shown to have contributed to child harm in a specific recent case.

The introduction of *a parent who may be able and willing to protect the child from harm* into sections 13E and 13H has reduced reporting to the Department. Reduced mandatory reporting as a measure of legislative amendment success is highly questionable.

The TCHHS suggests omission of the requirement on mandatory reporters and conferral colleagues to consider whether *a parent who is able and willing to protect the child from harm* under section 13E (2) (b) and section 13H (1) (b) of the Act. This will not affect the threshold required for a notification.

The TCHHS respectfully requests the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee to consider this matter as an additional priority to the Child Protection Reform Amendment Bill.

Yours Sincerely,

[redacted]

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[i] *Child Protection Reform Amendment Bill 2014, explanatory notes pg.1*
[ii] *Child Protection Reform Amendment Bill 2014, explanatory notes pg.7*
[iii] *Taking Responsibility: A Roadmap for Queensland Child Protection. Queensland Child Protection Commission Commission of Inquiry (2013) p.4*
[iv] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.84
[v] *Taking Responsibility: A Roadmap for Queensland Child Protection.* Queensland Child Protection Commission Commission of Inquiry (2013) p.83
[vi] *Taking Responsibility: A Roadmap for Queensland Child Protection.* Queensland Child Protection Commission Commission of Inquiry (2013) p.22
[vii] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.22
[viii] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.15
[ix] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.23
[x] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.23
[xi] *Taking Responsibility: A Roadmap for Queensland Child Protection.* Queensland Child Protection Commission Commission of Inquiry (2013) p.83
[xii] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.23
[xiii] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.6
[xiv] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.89
[xv] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.90
[xvixvi] Child Protection Act 1999 Section 13E
[xvii] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.86
[xviii] Our Performance: Department of Communities Child safety and Disability Services. https://www.communities.qld.gov.au/childsafety/about-us/our-performance/intake-phase Downloaded 29.08.2017.
[xix] Our Performance: Department of Communities Child safety and Disability Services. https://www.communities.qld.gov.au/childsafety/about-us/our-performance/intake-phase Downloaded 29.08.2017.
[xx] *Taking Responsibility: A Roadmap for Queensland Child Protection*. Queensland Child Protection Commission Commission of Inquiry (2013) p.86
[xxi] Stronger Families Legislation Session Plan: Department of Communities, Child Safety and Disability Services v 2.0 (2014) p.7
[xxii] The Queensland Child Protection Guide: Structured Decision Making System for Child Protective Services (2015)