THE UNION FOR QNU NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

Submission to The Health and Community Services Committee

Child Protection Reform Amendment Bill 2014

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Introduction

The Queensland Nurses' Union (QNU) thanks the Health and Community Services Committee (the Committee) for providing the opportunity to comment on the *Child Protection Reform Amendment Bill 2014* (the Bill).

Nurses[1] are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Our submission addresses specific sections of the Bill that will impact on the mandatory reporting requirements placed on nurses and we provide a hypothetical case study to demonstrate our concerns about changes to reporting thresholds.

Mandatory Reporting

We recognise there are considerable demands on the Queensland statutory child protection system due to the high number of intakes to Child Safety and there needs to be a more effective reporting system. The Bill embarks on this process by consolidating various mandatory reporting obligations currently contained in other legislation and departmental policies into the *Child Protection Act 1999* (the Act).

Based on the experience of our members, we comment on the following sections of the Bill we believe need further consideration by the Committee.

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing.

Clause 5

Clause 5 of the Bill amends section 10 of the Act to read

(a) has suffered **significant** harm, is suffering **significant** harm, or is at unacceptable risk of suffering **significant** harm; and
(b) does not have a parent able and willing to protect the child from the harm.

Section 9 (1) of the Act currently defines 'harm' as

(1) any detrimental effect of a *significant* nature on the child's physical, psychological or emotional wellbeing.

Thus the amendment does not meaningfully alter the referral threshold since the current definition of 'harm' already denotes a significant detrimental effect on the child's wellbeing.

Recommendation

The QNU recommends a more fulsome definition of '**significant** harm' since this appears to be the major way in which the legislation seeks to filter referrals and thereby address the workloads of Child Safety staff. We accept that in 2011-12 approximately 80 per cent of all reports did not reach the threshold required for Child Safety to take action under the *Child Protection Act 1999* because the child was not reasonably suspected to be a child in need of protection (Queensland Child Protection Commission of Inquiry, 2013, p.3). However, nurses and other reporters will need a clearer guideline on making a determination whether to report a matter to Child Safety or refer it along a different pathway.

We support recommendation 4.2 of the report of the Queensland Child Protection Commission Inquiry (2013) to provide joint training in the understanding of key threshold definitions to help professionals decide when they should report significant harm to Child Safety Services and encourage a shared understanding across government.

Clause 6

The new section 13C of the Bill - Considerations when forming a reasonable suspicion about harm to a child - reads

(1) This section applies to a person informing a reasonable suspicion, for section 13C(1) or division 2, about whether a child has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm.
(2) The matters that the person may consider include –
(a) Whether there are detrimental effects on the child's body or the child's **psychological or emotional** state……

Section 13C(2)(a) appears to offer a broader definition of the range of detrimental effects that a child may suffer than that of section 13E(2)(a) which reads

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**;
(b) **may not** have a parent able and willing to protect the child from the harm.

As section 13E(2)(a) does not include the child's psychological or emotional state, it implies that mandatory reporting is required only for physical or sexual abuse, even if a parent is able to protect the child from the harm.

Recommendation

The QNU recommends that section 13E(2)(a) should read

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, emotional or sexual abuse**;

and section 13E(2)(b) should read

'does not have a parent …' instead of 'may not have a parent …'

The QNU is seeking clarification of two key questions that arise from the proposed changes, viz:

- How do recurrent episodes become flagged for mandatory reporting if the threshold for mandatory reporting does not occur from a single event, but may do so on accumulative effects?
- How does this occur interdepartmentally and cross-jurisdictionally between organisations?

Case Study

The QNU provides the following hypothetical case study developed by an experienced registered nurse to demonstrate the day to day reporting situations health practitioners encounter when dealing with young people who appear to be at risk of harm. This is not an atypical case. Its purpose is to show how a child may be vulnerable to a number of dangers that may not separately indicate 'significant harm' and could be referred to different agencies, yet cumulatively represent a child at serious risk of physical, emotional and sexual harm that should be referred to Child Safety.

It is the end of the school year.

A mother of a 13 year old female contacted the High School Principal to advise that she is worried about her daughter.

Her daughter appears to be depressed and has suicidal thoughts. The mother is making arrangements for her daughter to see their GP for a mental health referral.

The mother alleges that her daughter has disclosed to her recently a history of sexual abuse over the past two years by the daughter's stepfather. The stepfather was living in the house until recently.

The high school principal contacted the School Based Youth Health Nurse (SBYHN) requesting that she make an individual appointment with the 13 year old female.

At this appointment the SBYHN advises the 13 year old that information she discloses is confidential unless there is concern for her safety, then this

information may be disclosed to others for her care.

The 13 year old claims significant emotional and verbal abuse at home by her stepfather, but denies any history of sexual abuse. She discloses that she has a half sister who is 18 months old and the stepfather is applying for custody.

The SBYHN notes that there is evidence of self harm with recent "cutting" injuries on her arms.

The 13 year old female is also complaining of painful urination to the SBYHN and has stated that she has just become sexually active with her 14 year old boyfriend.

The SBYHN contacts the mother and ascertains that she is able and willing to protect the child from the alleged harm, for example she has made a GP appointment and she has removed her daughter's access to her stepfather.

The SBYHN advises the mother that a public referral can be made to the Child Youth Health Mental Health Service, however the mental health referral agency advises that the waiting period is eight weeks as they are going into the Christmas, New Year closure periods in a few weeks.

The mother takes the child to the GP for the appointment for private mental health referral and a urine test. The urine test identifies the sexually transmitted disease, chlamydia.

Contact tracing of the boyfriend identifies that the boyfriend also has chlamydia. Both the boy and girl are treated for chlamydia.

The GP is aware but does not disclose to the mother that he has also recently treated the stepfather for chlamydia.

The GP has been treating the mother for alcoholism and substance abuse precipitated by physical and verbal episodes of domestic violence for the past 3 years.

The mother did not advise the GP that she has spoken to the school principal or the SBYHN.

The following questions arise from this case study:

- Is there a reasonable suspicion of child sexual assault requiring reporting to Child Safety?
- Has the threshold been met for mandatory reporting?
- Who, would be required to make a mandatory report to Child Safety (Principal, SBYHH, GP, pathologist)?
- Is there an accumulative effect that would reach the mandatory reporting threshold?
- If so, who would make the mandatory report?

Conclusion

The QNU regards the provision of optimum services to protect the safety, wellbeing and best interests of vulnerable families as a fundamental obligation of government. Nurses play an important role in this process and we urge the committee to take their comments into account when considering the impact of this important new legislation.

References

Queensland Child Protection Commission of Inquiry (2013) *Taking Responsibility: A Roadmap for Queensland Child Protection.*