# Seeing They *are* Safe

*Responsiveness to 5 day and 10 day notifications of child harm in Queensland*

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**Family & Child**
Commission
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## Acknowledgement of Country

The Queensland Family and Child Commission acknowledges the Traditional custodians of the nations across Australia and Aboriginal and Torres Strait Islanders as the first peoples of Australia.

We acknowledge the Countries and blood lines of the First Nations peoples and pay respect to their culture, identity and connection to land and sea.

We respect their enduring spiritual relationship to the Country on which we walk, live and work and their wisdom in raising generations of strong, thriving children.

We recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander families and communities and pay our respect to their Elders past, present and emerging.

## A note on the COVID-19 crisis and post-crisis impacts on the child protection system

Several impacts are expected to result from the COVID-19 pandemic that are projected to increase demand on the child protection system. While it is too early to predict the extent of these impacts, the expectation is there will be increased incidence of family hardship, domestic and family violence and mental health issues—known to be key risk factors for involvement with the child protection system. It is also expected there will be decreased visibility of abuse and neglect due to social isolation, increased demand on family support services and instability for children and young people in care.

The impacts may not be observable in the short term, but immediate action is still required.

This review has focused on the importance of system functionality for timely responses to vulnerable children subject to 5 day and 10 day responses to notifications of harm. It has demonstrated the importance of sighting (physically seeing) children subject to notifications as early as possible. This is now more critical than ever, as there are likely to be fewer 'eyes on the child' during periods of social isolation.

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**ISBN: 978-0-6451352-3-7**

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# Glossary

## Table 1 details the key terms and abbreviations used throughout this report. Where possible, the definitions have been taken from the *Child Safety Practice Manual*.[1]

Table 1. *Glossary*

| Term | Definition |
|---|---|
| Assessment and Service Connect (ASC) | Assessment and Service Connect is a short-term support service for families involved in a child safety investigation and assessment process. ASC non-government service providers are funded to work with the Department of Child Safety, Youth and Women in assessing and responding to children and families to increase safety. |
| Child safety officer (CSO) | A child safety officer is an authorised officer under the *Child Protection Act 1999* and is responsible for delivering statutory child protection services in accordance with legislation, policies and procedures. This includes investigating and assessing allegations of suspected child abuse and neglect and intervening to ensure the safety and wellbeing of children subject to ongoing intervention. |
| Child Safety Service Centre (service centre or CSSC) | Child Safety Service Centres are located across the state, and staff in service centres deliver statutory child protection services and support to children, young people, families and carers to ensure children's safety and wellbeing and prevent children from being harmed. |
| Commencement | The process of commencing an investigation involves responding to a report of harm or risk of harm that reaches the legislative threshold for investigation and assessment.<br><br>To commence an investigation and assessment *within 24 hours*, child safety officers sight (physically see) and interview the subject child (or one of the subject children) as age and developmentally appropriate.<br><br>To commence an investigation and assessment *within 5 or 10 business days*, child safety officers take one of the following actions. They:<br>• sight and interview the subject child (or one of the subject children) as age and developmentally appropriate<br>• interview the pregnant woman if she consents to the investigation and assessment for an unborn child<br>• seek and receive new information that informs the assessment about the safety of the child or the safety of the unborn child after he or she is born:<br>– from an external agency, including:<br>– a government or non-government agency<br>– a service provider, including National Disability Insurance Agency and National Disability Insurance Scheme (NDIS) providers<br>– a health professional, such as a general practitioner<br>– through any of the following methods:<br>– email exchange<br>– phone or face-to-face discussion<br>– receipt of an information request under section 159N of the *Child Protection Act 1999*<br>– a Suspected Child Abuse and Neglect[2] (SCAN) team meeting (if the referral criteria are met)<br>– a locally convened panel process with relevant partners. |

Table 1. *Glossary continued*

| Term | Definition |
|---|---|
| Cultural practice advisor (CPA) | A cultural practice advisor is a service centre-based, Aboriginal and Torres Strait Islander (identified) officer who provides individualised and culturally appropriate casework support to children and families, and cultural leadership in the service centre, to support culturally appropriate work with children and families. |
| Family Participation Program (FPP) | The Family Participation Program is an external program run by Aboriginal and Torres Strait Islander community controlled organisations, funded by the Department of Child Safety, Youth and Women. The program facilitates Aboriginal and Torres Strait Islander family-led decision making processes[3] and may assist children and families to identify an independent person to facilitate their participation in significant decisions being made under the *Child Protection Act 1999*. |
| Intake | Intakes are the initial reports of harm to children. They are assessed to determine whether they reach the legislative threshold for recording a notification. |
| Investigation and Assessment (I&A) | An investigation and assessment is Child Safety's response to all notifications, and is the process of assessing a child's need for protection, if there are allegations of harm or risk of harm to the child (*Child Protection Act 1999*, section 14 (1)). |
| Notification | A notification is recorded if there is a reasonable suspicion that a child is in need of protection—that is, has been significantly harmed, is being significantly harmed, or is at risk of significant harm—and does not have a parent able and willing to protect them. |
| Response timeframes | Response timeframes are drawn from 'response priority', which is a Structured Decision Making® (SDM) tool to guide decisions about when an investigation and assessment is to be commenced.<br><br>In Queensland, the response timeframes are 24 hours, 5 business days or 10 business days. If there is:<br>• actual/high likelihood of harm/abuse, the response timeframe is within 24 hours<br>• a risk of delayed response and/or escalation pattern and/or prior substantiations or reported events, the response is within 5 days<br>• a lower level of risk across the above factors but the response is still required, the timeframe is within 10 days. |

# Foreword

**As Principal Commissioner of the Queensland Family and Child Commission (QFCC), my role is to make sure children are safe, protected and thriving. For children subject to a notification – where there is a reasonable suspicion that they are in need of protection – this means seeing they are safe as soon as possible.**

In Queensland, all notifications are investigated. Until recently, this meant an authorised officer under the *Child Protection Act 1999* would physically sight a child and conduct a safety assessment. Queensland was the first Australian jurisdiction to introduce this high standard of investigation and assessment (I&A) practice.

In 2019 the Department of Child Safety, Youth and Women developed a state-wide strategy to improve the timeliness and quality of I&A practice. This included updating I&A commencement criteria and completion timeframes to improve responsiveness when concerns are received about harm to a child.

I provided in-principle support for the Department's amendments to the then Minister for Child Safety, Youth and Women and Minister for the Prevention of Domestic and Family Violence. This was on the condition that the changes would result in children being seen sooner, families would have increased access to and engagement with family support services, and public confidence in the child and family support system would improve. With the Minister's and the Department's co-operation, the QFCC undertook to monitor and evaluate the revised I&A strategy to determine if these conditions were being met.

This report, *Seeing They are Safe*, presents our findings on the implementation and early consequences of these policy changes. *Seeing They are Safe* has been a critical part of the QFCC's oversight role through 2020 because we have had the time to assess changes as they are occurring and not in response to a tragedy. Reviews of this type are fundamental to preventing harm and making sure the system is operating effectively, not just efficiently. Our evaluation demonstrates that while the intent of the changes may have been sound, in practice further improvements are needed.

The QFCC found evidence to suggest response times for 5-day and 10-day notifications are improving. There is considerable uptake of these policy changes at the frontline of service delivery, and improvements in the proportion of notifications commenced within timeframes. However, despite these changes, there remain unacceptable delays in commencing investigations and physically sighting a child.

We found that the Department relies heavily on partnerships to deliver the investigation and assessment function. While partnerships with government agencies are generally strong, there is room to improve collaborative relationships with non-government entities. The QFCC is of the firm view these should be strengthened as a priority, as often these are more appropriate responses for children and families.

I continue to be concerned about the over-representation of Aboriginal and Torres Strait Islander children in the child protection system. Our review determined the resources and supports for Aboriginal and Torres Strait Islander children and the frontline staff who work with them were inadequate, insufficient and in some instances, inappropriate. The system still has inequality and biases that continue to influence decision-making and contribute to over-representation.

I would like to thank the Queensland Government agencies who contributed to this review. They include the Queensland Police Service, the Department of Child Safety, Youth and Women, Queensland Health and the Department of Education. I also thank the individuals representing non-government organisations who provided information to support this review.

Complexity is the hallmark of any human system. While there is no single solution, clearly the child safety system has a better chance of success if all its elements – government, non-government and community – work more closely together. *Seeing They are Safe* highlights areas needing to be addressed as a priority. I commend these findings to you and encourage you to focus on the changes which are needed to protect children and their right to be safe.

**Cheryl Vardon**
*Principal Commissioner*
Queensland Family and Child Commission

# Executive summary

**Statutory child protection systems use response timeframes to decide how quickly reports of harm to children should be investigated. They vary across Australia and internationally. In Queensland, the current response timeframes are 24 hours, 5 days and 10 days.**

Since 2014, over 90 per cent of notifications (reports of harm that meet the legislative threshold for investigation) that were given a 24 hour response were commenced (officially started) within timeframe, but less than a third with 5 or 10 day responses were.

In 2018–2019, the Queensland Child and Family Commission (QFCC) undertook a project (stage 1) to identify why. The team quantitatively analysed 195 notifications categorised as requiring a 5 or 10 day response and consulted with approximately 100 Department of Child Safety, Youth and Women (Child Safety) staff.

The findings were provided to senior decision makers within Child Safety by the Principal Commissioner of the QFCC in March 2019 in the hope that they would contribute to a discussion about the complex nature of investigating and assessing reports of harm to children.

Since then, Child Safety has developed the *Investigation and Assessment Strategy 2019*, introducing policy changes to how a notification of harm could be commenced and how long a child safety officer could take to complete an investigation and assessment.

From 1 September 2019, 5 day and 10 day matters are commenced through the receipt or seeking new information from an external agency that informs the assessment about the safety of the child *(refer to the definition on page ii for further details)*.

Changes to commencement criteria from 1 September 2019 did not affect 24 hour matters.

They also increased the time for completing an investigation and assessment from 60 calendar days to 100 calendar days.

In July 2019, Queensland's Minister for Child Safety, Youth and Women and Minister for the Prevention of Domestic and Family Violence sought support from the QFCC for these policy changes. The QFCC supported them in principle, noting they should result in children being seen sooner, families having greater engagement with family support services, and increased public confidence in the system.

This report describes how these policy changes are being implemented and if there has been any improvement in Child Safety Service Centres (service centres) responding to notifications of child harm in a timely manner.

The Maroochydore, Bundaberg and Western Downs Intake and Assessment service centres were selected for this review, as they all use different models and business processes to respond to notifications of harm. Staff from the QFCC spent time in each, conducting interviews with frontline workers from Child Safety and with partner agencies.

## Implementation of investigation and assessment policy changes

- Child Safety data for the September–December 2019 quarter (the first after the policy changes) suggests the revised policy has resulted in an increased number of commencements and completions occurring within timeframes. This was not unexpected.
- Despite this, Child Safety data for the September–December 2019 quarter shows nearly 55 per cent of notifications were not responded to within 5 day or 10 day timeframes.
- Child Safety (service centre-specific) data shows an average of two to four weeks pass between when an investigation and assessment is commenced by information gathering and when a child is sighted.

## Effectiveness and functionality of investigation and assessment approaches

- Service centres have some autonomy to adapt their investigation and assessment approaches to the local context and adopt new ways of working.
- There are variations in the tools, procedures and policies service centres use for triaging, allocating and conducting investigations and assessments and monitoring performance. In some cases, these have detracted from system effectiveness as they have created 'busy work', inefficiencies and delays. Some examples cited were overuse of manual tracking tools and rigid home visitation schedules.
- Operational data is being used to manage and continuously improve investigation and assessment approaches.

## Value of partnerships to investigations and assessments

- Investigation and assessment responses benefit from the involvement of government and non-government partners. The information these partners can share is critical to understanding a child's safety and circumstances.
- The relationship between service centres and government partners, particularly the Queensland Police Service, is positive.
- There is room to improve the relationships between service centres and non-government services in supporting investigations and assessments and in early interventions. This is particularly important given the over-representation of Aboriginal and Torres Strait Islander children in the child protection system.

## Conclusion

This review found that the revised policy on commencement criteria reflected what routinely occurred in practice prior to the revision.

It also found that local innovation in investigation and assessment approaches can lead to promising outcomes, such as the creation of a 'differentiated child safety officer' position in Maroochydore to specifically focus on using information to commence investigations and assessments, and the establishment of Early Indigenous Response Collectives to act earlier for Aboriginal and Torres Strait Islander children.

Child Safety relies on partnerships to respond to children's safety needs. While many are strong, some require attention and strengthening—particularly those with non-government services.

The QFCC remains concerned about the efficiency and effectiveness of these partnerships. There is little evidence they have helped families receive the right support at the right time, or that children are being seen sooner when concerns are received about their safety and wellbeing.

Overall, this review has found there is good foundational work underway to build stronger, more responsive investigation and assessment approaches. However, there is more work to be done to see and keep children safe.

# Contents

# 1 Introduction

## 1.1 Overview

The Department of Child Safety, Youth and Women (Child Safety), as Queensland's statutory child protection agency, is required by law to promote the safety, wellbeing and best interests of children and young people. When Child Safety receives information about harm or risk of harm to a child and suspects the child may require protection, a child safety officer must undertake an investigation and assessment process to determine the ongoing safety of a child.

Annually, more than 22,000 notifications[4] are recorded by Child Safety state-wide, with over 25,000 notifications recorded in 2018–19.[5] This number is increasing—as at 30 June 2019, notifications were up 7.3 per cent from 30 June 2018 and 13.5 per cent from 30 June 2015.[6] As all notifications relate to suspected risk or occurrence of 'significant harm'[7] to a child (or children), timely responses are imperative.

Investigations and assessments require intensive resourcing and practice discipline. Combined with the increase in incoming notifications, this is likely to contribute to system strain and backlogs, which can result in staff not being able to sight (physically see) children to confirm that they are safe.

This Queensland Family and Child Commission (QFCC) systemic review has examined Child Safety's introduction of an investigation and assessment policy intended to improve the timeliness of responses to reports of child harm. The review looked at the business processes of three Child Safety Service Centres (service centres) for allocating, commencing and responding to notifications of harm to a child.

This report presents the themes and findings of the review.

## 1.2 Queensland Family and Child Commission's oversight function

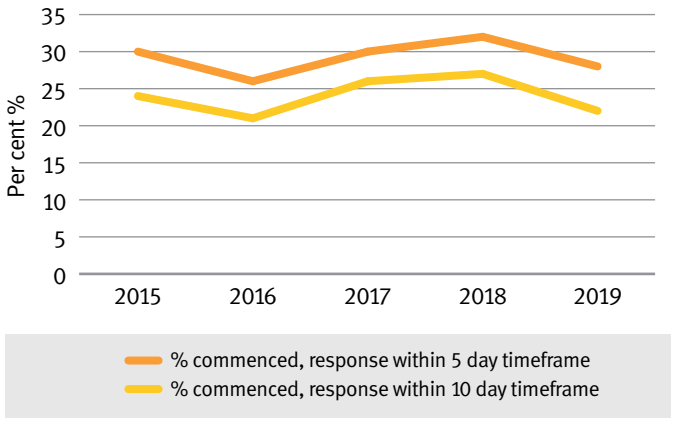
Under section 9 of the *Family and Child Commission Act 2014*, the QFCC is required to oversee the child protection system. The QFCC conducts oversight reviews when a persistent or recurring systemic issue in service provision is identified and when a review may help improve these services.

## 1.3 Background

Notifications are recorded when information received by Child Safety suggests a child may need protection. This means they may have suffered or are at risk of suffering significant harm and do not have a parent able and willing to protect them. When a notification is recorded, Child Safety must investigate and assess the concerns. The current response timeframes for commencing an investigation and assessment are 24 hours, 5 days and 10 days.

Since 2014, over 90 per cent of notifications with a 24 hour response have been commenced within the set timeframe. However, Child Safety data shows responses have not historically been timely for many children subject to 5 day and 10 day notifications *(see Figure 1)*.[8] This trend has occurred persistently across Queensland, which suggests it is a systemic issue.

**Figure 1:** *Proportion of 5 day and 10 day notifications commenced within timeframe 2014–2019*




*(Source: Department of Child Safety, Youth and Women 2019: Our Performance)*

In 2018–2019, the QFCC undertook an exploratory project (stage 1) in order to understand the range of factors impacting on responsiveness in investigating and assessing reports of significant harm to children. During this period, the QFCC worked with Child Safety to gain a better understanding of why only one in four investigations of 5 and 10 day notifications were being commenced within the set timeframes.

Stage 1 involved an in-depth examination of quantitative and qualitative information and included analysing 195 case records from Child Safety and engaging with frontline and head office Child Safety staff.

The findings of stage 1 were provided to senior decision makers within Child Safety by the Principal Commissioner of the QFCC in March 2019, and included the need for them to:

- make changes to workplace practices
- clarify roles and responsibilities
- provide a stronger evidentiary basis for decision making.

In response to the QFCC's stage 1 work, and in the face of continued media scrutiny and focus by opposition parliamentary questions, Child Safety developed the *Investigation and Assessment Strategy 2019*. The goal of this strategy was to strengthen investigation responses and practice. A key aspect of the strategy was changes to commencements and completions.

During the July 2019 Estimates Hearings, the Honourable Di Farmer, Minister for Child Safety, Youth and Women and Minister for the Prevention of Domestic and Family Violence, announced the policy requirements for recording of commencement of investigations and assessments would be expanded. Additionally, the minister acknowledged the QFCC's role in monitoring and supporting this work.[9]

The QFCC supported the policy changes in principle, noting they should result in:

- children being seen sooner
- families having greater engagement with family support services
- increased public confidence in the system.

However, the QFCC stressed that the changes must not come at the expense of sighting the child and conducting a safety assessment as soon as possible, to *see they are safe*.

## 1.4 Scope

This report describes how the Child Safety investigation and assessment policy changes are being implemented and examines whether there has been any improvement in the ability of service centres to respond to notifications of child harm in a timely manner.

The *Seeing they are Safe* review primarily focused on the business processes service centres use to support investigations and assessments. It considered:

- investigation and assessment structures, strategies and approaches and the application and adaptation of Child Safety policies, procedures and tools
- the cultural appropriateness of policies and procedures; and partnerships with Aboriginal and Torres Strait Islander organisations and communities in the response to notifications of child harm
- collaboration with government and non-government agencies
- processes for monitoring and reporting on targets and outcomes
- the use of technology and communications
- leadership, accountability, continuous improvement processes and workplace culture
- workforce capacity and capability, support, and the roles and responsibilities of those involved in investigation and assessment processes.

The QFCC did not examine investigation and assessment practice decisions or assess the quality of assessment, investigation and/or responses to notifications.

## 1.5 Methodology

Three service centres were selected, based on structural and procedural differences in their investigation and assessment models and approaches. These were the Bundaberg, Maroochydore and Western Downs Investigation and Assessment (WDIA) service centres.

The QFCC visited each service centre twice in late 2019 to conduct interviews with stakeholders who were involved in or had detailed knowledge of investigation and assessment processes. We met with Child Safety staff and government and non-government stakeholders who partner in investigation and assessment processes (such as Assessment and Service Connect co-responders, community controlled organisations, and joint response teams within the Queensland Police Service).

We consulted with a total of 83 stakeholders, of which 74 per cent represented government and 26 per cent represented non-government organisations. A breakdown is provided in *Table 2*.

Table 2: *Seeing They are Safe—stakeholders consulted*

| | Government | Non-government | Totals |
|---|---|---|---|
| Bundaberg | 27 (79%) | 7 (21%) | **34** (100%) |
| Maroochydore | 13 (62%) | 8 (38%) | **21** (100%) |
| WDIA *(Toowoomba)* | 21 (75%) | 7 (25%) | **28** (100%) |
| **Totals** | **61** (73%) | **22** (26%) | **83** (100%) |

We also reviewed relevant documentation, including corporate and operational data, and made 'on the ground' observations while on site.

A set of interim 'highlight reports' was produced following each site visit. The first set provided a high-level overview of the structure and approach to investigation and assessment at each service centre. The second provided greater depth on the business processes supporting investigations and assessments.[10]

# 2 Findings

This report presents the findings from the *Seeing they are Safe* review. During the period of the review, the QFCC found evidence the policy changes to commencement and completion of investigations and assessments had improved timeliness of responses. However, we also found concerning systemic issues preventing children from being seen sooner. These are addressed under the headings of:

- implementation of investigation and assessment policy changes
- effectiveness and functionality of investigation and assessment processes
- value of partnerships to the investigation and assessment process.

## 2.1 Implementation of investigation and assessment policy changes

### *Overview*

- Child Safety data for the September–December 2019 quarter (the first quarter reflecting the policy changes introduced in September 2019) suggests the revised policy has resulted in an increased number of commencements and completions occurring within timeframes. This was not unexpected, as the revised policy makes it easier to record a commenced investigation and assessment and allows more time to complete it.
- Despite the expanded criteria for commencing an investigation and assessment, Child Safety data for the September–December 2019 quarter shows nearly 55 per cent of notifications were not responded to within the 5 or 10 day timeframes.
- Child Safety (service centre-specific) data shows an average of two to four weeks pass between the time an investigation is commenced by information gathering and the time a child is sighted.

### 2.1.1 *Revised investigation and assessment policy*

In late 2019, the *Child Safety Practice Manual* (the manual) was updated to reflect contemporary practice and support quality and consistency in practice. The investigation and assessment chapter of the manual came into effect on 1 September 2019 and contained important changes to policy, the most significant of which related to:

- commencement criteria—the required actions to commence an investigation and assessment with a 5 day or 10 day response timeframe were expanded. Previously, an investigation and assessment could only be considered 'commenced' if an authorised officer (i.e. child safety officer) sighted and interviewed the subject child.

  The policy now includes provision for commencement if new information is sought and received that informs the assessment about the safety of a child or the safety of an unborn child after he/she is born.
- completion timeframes—the timeframe allowed to conduct, complete and approve an investigation and assessment was extended from 60 to 100 days.

The QFCC has identified a range of benefits and risks associated with the policy changes to commencement and completion *(see Table 3 for a sample of these)*. It was the potential consequences of the risks—particularly the first risk listed in Table 3—that led us to monitor this issue.

Table 3: *Benefits and risks of policy changes to investigation and assessment commencement criteria and completion timeframes*

| | |
|---|---|
| Benefits | Commencement and completion data shows improvement, which may lead to improved public confidence. |
| | More comprehensive information is gathered from people who know the child (e.g. a teacher or general practitioner). |
| | Child safety officers are better prepared and equipped to interview the child and family and conduct a safety assessment. |
| | Child safety officers can re-prioritise allocated cases based on information as evidence of immediate risk of harm. |
| | Child safety officers and family support services have more time to work intensively with children and families. |
| Risks | Timely commencements may not equate to safety for subject children; and information gathering does not replace the need for an initial safety assessment. |
| | This increases information requirements from other agencies and reliance on third party information. |
| | This may create an over-reliance on information and create delays in sighting subject children. |
| | This may increase the number of investigations and assessments allocated to child safety officers, or make it harder for them to start new cases. |
| | This may lead to increased workload pressures on child safety officers, who have to provide support services as well as conduct investigations and assessments. |

*(Source: QFCC 2020, not intended to be exhaustive)*

The QFCC observed that Child Safety staff were aware of the policy changes and did not find investigation and assessment practice to have materially changed as a result of the policy shift.

Child safety officers noted they have routinely sought information about the safety and wellbeing of a subject child prior to commencing an investigation. However, they viewed the revised policy favourably, believing it acknowledges the importance of the substantial investigative work already occurring prior to sighting the child (i.e. contacting people who know the child and gathering information about the child's situation).

There was consensus among service centre staff that when a child safety officer commences an investigation by gathering information, there is a commitment to sighting the child and conducting a safety assessment as soon as possible afterwards.

The effect of implementation of the policy change on completion timeframes was less evident. Child safety officers reported that they continue to work to 60 day completion timeframes with an aim to close cases as soon as possible. However, the extension to completion timeframes was seen to be a positive change for more complex cases, such as those where families required ongoing support and needed more encouragement to connect with support services.

### 2.1.2 *Investigation and assessment response timeliness*

Child Safety data from the first quarter of implementation of the revised policy shows the new means of commencement has been adopted to varying degrees by child safety officers in each of the three service centres *(see Table 4)*.

For example, the Maroochydore service centre commenced over half of incoming notifications by information (rather than by sighting). It has the highest rate of the three sites. This is likely due to it employing a 'differentiated' officer whose role is to gather the required information to commence as many incoming investigations and assessments as possible.

In contrast, less than a quarter of incoming investigations and assessments in the WDIA service centre were commenced by information. This is potentially an unintended consequence of new safeguards they put into place when this policy was introduced. Meant to promote consistent practice and justify use of the new commencement method, the additional steps in the process have been found to deter child safety officers from commencing by information.

Table 4: *Summary of investigation and assessment data following implementation of revised policy—by Child Safety Service Centre (CSSC): 1 Sept to 31 Dec 2019*

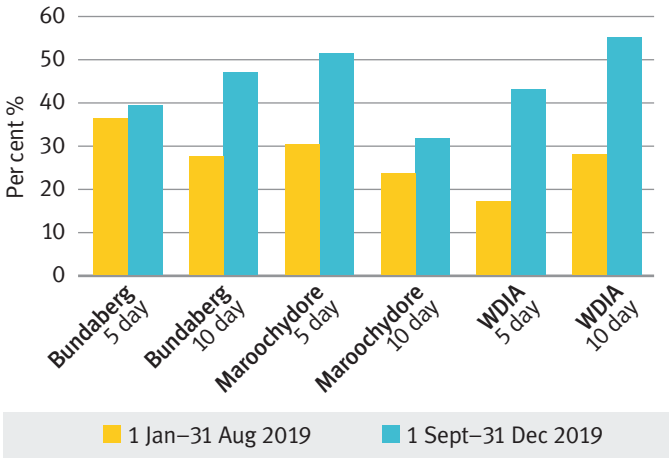
| | % Notifications commenced by information | | % (point) change in proportion commenced within timeframe[11] | | Avg. number of days from commencement date to child sighted | | Percentage of notifications with a 100 day completion timeframe, completed within timeframe, as at 30 September 2019 | |
|---|---|---|---|---|---|---|---|---|
| CSSC | 5 day | 10 day | 5 day | 10 day | 5 day | 10 day | 5 day | 10 day |
| Bundaberg | 40.8% | 38.6% | ↑ 3.1% | ↑ 19.4% | 18.4 | 16.4 | ↑ 94.5% | ↑ 100.0% |
| Maroochydore | 56.7% | 50.5% | ↑ 21.2% | ↑ 8.2% | 20.3 | 28.9 | ↑ 78.1% | ↑ 62.1% |
| WDIA | 22.3% | 23.9% | ↑ 26.1% | ↑ 27.2% | 18.3 | 13.7 | ↑ 89.0% | ↑ 87.0% |

*(Source: Department of Child Safety, Youth and Women 2020)*

There has been an increase in the percentage of commencements occurring within timeframes. All service centres showed an improvement from the previous two quarters, with the greatest increases in the WDIA service centre *(see Figure 2)*.

This is a promising early result. As this period only covers initial implementation of the revised policy, further gains may be made as the associated behavioural change embeds.

Figure 2: *Comparison of percentage of 5 day and 10 day notifications commenced within timeframes pre- and post-policy changes—by Child Safety Service Centre*




*(Source: Department of Child Safety, Youth and Women 2020)*

Stakeholders had differing views on counting timeframes for 5 day and 10 day responses—that is, at what point the clock starts counting down, and whether or not weekend days are counted in the 5 or 10 days.

The Child Safety Practice Manual[12] is clear that:

- the timeframe begins when the decision is made that the concerns meet the threshold for a notification—that is, while the matter is still with the Intake Team
- a 5 day or 10 day response refers to business days.

While this may seem a minor issue, it has implications on morale and perceptions of response timeliness.

Response timeliness is a reflection of a child safety officer and service centre's performance, statistically, so it is important there is a clear understanding of these rules. It is also important for matters to transition from the Intake Team to the Investigation and Assessment Team quickly. While the QFCC Stage 1 review *(see pages 2–3)* did not highlight any issues in this regard, several child safety officers expressed concerns about the speed with which matters transition over from Regional Intake Services. From their perspectives, any time that passes while a notification remains with intake (e.g. while the decision awaits approval) must be deducted from the 5 day or 10 day timeframe once received and allocated to the child safety officer to investigate the matter, thereby increasing the time pressure on that officer. This is exacerbated when a notification is received on a Friday by an officer who believes weekend days count towards the 5 or 10 days.

The QFCC is more concerned about the amount of time that passes before a child is sighted following commencements by information. The data in Table 4 shows this ranges from 13 to 29 days—or two to four weeks—in these locations.

The QFCC is of the firm position a child subject to a notification of harm needs to be sighted sooner than two weeks. Waiting four weeks to lay eyes on a child who is alleged to have experienced significant harm is concerning.

For this reason, we will continue monitoring the timespan between commencement by information and sighting the child, and we expect to see this timespan reduced. Child safety officers must, as soon as practicable, see the child is safe.

Table 4 also shows, as at 30 September 2019, the majority of investigations and assessments with 100 day timeframes were completed within timeframe. This stands to reason, as the time allowed to conduct and complete was extended by 67 per cent. The rationale for the extension of completion timeframes, according to the Minister for Child Safety, Youth and Women, was to 'reflect the way [the department] now work[s], with increasingly complex cases and work[s] more intensively along with NGO [non-government organisation] partners to de-escalate risk'.[13] The rate of completion within timeframes for both 5 day and 10 day notifications was lowest in Maroochydore, but the reason for this is not known. It is possible this relates to the way they work with families more intensively during the investigation and assessment process using processes such as the early Indigenous response collective *(see section 2.3.3)*.

Statistical improvements in administrative processes cannot be conflated with improvements in responsivity to children who have experienced or are at significant risk of harm. At this stage it is too early for the QFCC to comment on the impact that increasing the timeframe for completion may have on the system's responsiveness to incoming notifications.

### *Implementation of investigation and assessment policy changes*

**The QFCC's position:**

- **The revised policy on commencement criteria reflected what routinely occurred in practice prior to the revision. However, this must not mean children are not seen as soon as practicable.**
- **The QFCC cautions against relying too heavily on early statistical improvements in response data relating to these policy changes, as they don't necessarily equate to improved safety or risk assessment for children subject to notifications of harm.**
- **All commenced (open) investigations and assessments should prioritise sighting the child as early as possible. For 5 day and 10 day notifications, allowing two weeks to pass without *seeing the child is safe* introduces additional risk, while allowing four weeks to pass with the child unsighted is unacceptable.**
- **The QFCC will continue to monitor the timespan between commencement by information and sighting the child and emphasise the need to see they are safe.**

## 2.2 Effectiveness and functionality of investigation and assessment

### Overview

- Service centres have reasonable autonomy to adapt their investigation and assessment models and approaches to the local context and adopt new ways of working.
- There are variations in the tools, procedures and policies used for triaging, allocating and conducting investigations and assessments and monitoring performance.
- In some cases, these detract from system effectiveness as they create 'busy work', inefficiencies and delays. Some examples cited were overuse of manual tracking tools and rigid home visitation schedules (e.g. requiring home visits to occur on a set day and time).
- Operational data is being used to manage and continuously improve investigation and assessment approaches. The focus on performance is grounded in the experience for children and their families–that is, service centre leaders emphasise the underlying reasons for the performance targets. In this way, child safety officers are conscious of the quality of their response as well as meeting their targets.

We found each service centre has its strengths and areas for improvement. These are largely recognised by service centre leaders.[14]

Important strengths from the respective sites include the following:

- Bundaberg's re-structuring of the organisation reflects a culture of shared responsibility for investigations and assessments across the service centre. It is supported by a strong culture of communication internally and externally with partners.
- Maroochydore's establishment of an early Indigenous response collective (which meets weekly to review cases involving Indigenous children and families) and its current trial of a 'differentiated officer' to commence incoming investigations and assessments by information are both perceived by local stakeholders to be producing significant benefits for children, families and the frontline workforce.
- WDIA has taken a proactive approach to safeguarding implementation of the revised investigation and assessment policy to maintain high quality practice approaches and support response timeliness. They have also maintained a strong collaborative partnership with the co-located Assessment and Service Connect team.

Despite these strengths, Child Safety data (September–December 2019) for these three service centres showed nearly 55 per cent of notifications were not responded to within the 5 day or 10 day timeframe.[15]

### 2.2.1 *Service centre investigation and assessment processes*

In each location, we observed all the business practices we would expect to see in a high-functioning investigation and assessment process—executed with varying degrees of success.

Sound business processes such as communication protocols, collaborative partnerships and staff development provide the foundation for investigations and assessments and contribute to the context and workplace culture in which it is delivered. Appendices A to C provide a description of each service centre and a map of their process.

The service centres have different investigation and assessment structures, service models and approaches and use different tools to support practice. Although Child Safety policies and practice guidelines apply to all staff, some of the policies and practice tools used within service centres have been tailored, and therefore vary from site to site.

This flexibility allows service centre leaders to tailor investigation and assessment processes to suit the local context, but we found the 'localising' of tools and processes reduces service efficiency in some cases.

Stakeholders cited examples in which procedures for triage and allocation continually change which creates confusion, and in which co-response schedules are overly rigid—that is, co-responders (from Assessment and Service Connect and Child Safety) only visit families on a particular day and time, which may not correspond to the family's schedule and often results in failure to connect with the family. These issues were seen to slow progress and in some cases exacerbate delays in sighting the child and conducting the initial safety assessment.

### 2.2.2 *Monitoring performance*

Operationally, investigation and assessment performance is closely monitored using a mix of manual and automated systems. Service centre leaders are required, and child safety officers encouraged, to track personal and group performance. All service centres place an emphasis on monitoring investigation and assessment team (and individual) performance—especially notifications that haven't been commenced and children who have not yet been sighted.

The extent of monitoring processes varies by service centre and influences the workplace culture. This is largely led by service centre management but also by individual senior team leaders.

Each of the service centres has developed a strong culture of using operational and corporate data at regional, service centre and team levels to discuss performance and continuous improvement.

Across all locations, child safety officers are acutely aware of their throughput targets and caseloads. At times, this causes stress and drives the completion of work based on the target rather than the needs of the child and family.

### 2.2.3 *Support for child safety officers*

The QFCC observed a strong child-centred ethos across the three service centres. For frontline staff, this takes the form of personal sacrifice (such as long hours, after-hours work without overtime pay and limited leave due to team capacity issues). They also feel personal pressure to sight children and close investigations and assessments as quickly as practicable, because they feel responsible for children's safety and wellbeing. Staff are intrinsically motivated to achieve the best possible outcomes for children and limit their interaction with the child protection system (unless ongoing intervention is deemed necessary).

In all sites, child safety officers are supported with supervision and professional development opportunities, though access to the latter is reportedly limited by their high workloads. Child safety officers reported they are occasionally offered generalist and specialist training to build practice skills, but most learning seems to occur on the job.

New staff are paired with longer tenured staff to learn from observation and role modelling, and most child safety officers thought this worked well. In this way, more experienced staff take on a teaching and coaching role as well as their usual responsibilities for conducting investigations and assessments.

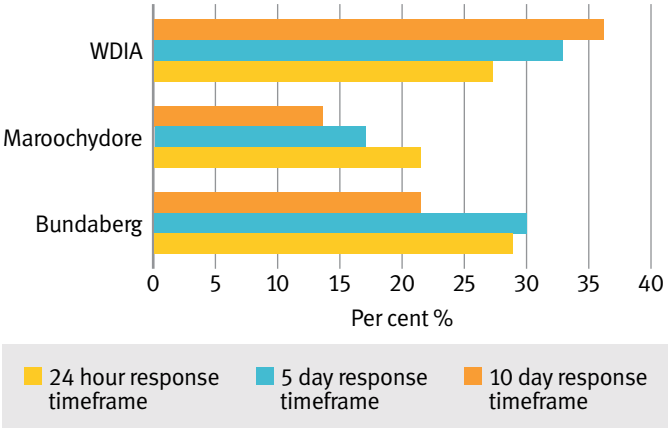
There is a risk that staff, particularly those under time and caseload pressure, may not effectively carry out both roles.

### 2.2.4 *Culturally safe leadership*

A review of Child Safety data for the three sites (July 2016 to June 2019, averaged) has confirmed that a much higher proportion of incoming notifications of harm relate to children who identify as Aboriginal and Torres Strait Islander *(see Figure 3)*.[16]

This is despite the fact that the proportion of Queensland's total population aged 0–17 who identify as Aboriginal and Torres Strait Islander is only approximately eight per cent.[17] Active efforts[18] during investigation and assessment processes can help reduce the number of Aboriginal and Torres Strait Islander children entering the child protection system.

**Figure 3:** *Percentage of Aboriginal and Torres Strait Islander children subject to notifications of harm—by Child Safety Service Centre*




*(Source: Department of Child Safety, Youth and Women 2019. All figures are approximate, as corporate data was confidentialised)*

The cultural practice advisors[19] in service centres are highly valued for their role in providing cultural advice on matters relating to Aboriginal and Torres Strait Islander children. They also have a critical role to play in building cultural safety[20] across a service centre by advising child safety officers on culturally safe practice.

In Bundaberg, child safety officers are guided and monitored by a cultural audit tool[21] designed to 'support Aboriginal and Torres Strait Islander children and young people to breathe their culture everyday'. The cultural practice advisor encourages use of the tool across the child safety continuum, including during the investigation and assessment process, to monitor child safety officers' actions in implementing the Child Placement Principle.[22]

Their capacity to support child safety officers with investigations and assessments is reported to be very limited, given the breadth of their work, and the fact that their responsibilities predominantly focus on children subject to ongoing intervention.

In the Maroochydore service centre, the cultural practice advisor is a member of the leadership group and contributes to decision making at this level. The QFCC endorses this approach, noting this must not displace the right of families to participate in the decisions that impact upon them or dilute the responsibility of child safety staff to engage in partnership with Aboriginal and Torres Strait Islander people and organisations external to Child Safety. The cultural practice advisor should provide direction to Child Safety staff as to what active efforts are required, facilitate access to culturally safe supports and services and promote full and proper adherence to the Child Placement Principle. If the child protection system is going to shift to one based on self-determination, there must be an Aboriginal and/or Torres Strait Islander voice and influence within the service centre leadership group.

### *Investigation and assessment effectiveness and functionality*

**The QFCC's position:**

- **Local innovation in investigation and assessment approaches can lead to promising outcomes but should not result in additional red tape and 'busy work' that delays sighting the child.**
- **Local data-driven approaches for monitoring performance and making improvements are encouraged.**
- **Cultural practice advisors should be:**
  - **members of the service centre leadership team**
  - **involved in the all decision making about Aboriginal and Torres Strait Islander children, not just those on court orders or requiring placement.**
- **By setting a requisite standard of active efforts, the department would demonstrate its commitment to the effective application of all five elements of the child placement principle across the child protection system (legislation, policy, practice, programs and processes), further safeguarding the safety and well-being of children.**

## 2.3 Value of partnerships in the investigation and assessment process

### Overview

- Investigation and assessment responses benefit from the involvement of government and non-government partners. The information these partners share is critical to understanding a child's safety and circumstances.
- The relationship between service centres and government partners, particularly the Queensland Police Service, is positive.
- There is room to improve the relationships between service centres and non-government services supporting the investigation and assessment function.

The quality of collaborative relationships affects children's and families' experiences of the investigation and assessment process. A lack of partnership between government and non-government service providers inhibits their access to available resources and programs. Also, partners often hold information about a child or family integral to Child Safety's assessment of the risk of ongoing harm to a child. It is essential this information is shared openly and quickly to facilitate timely responses.

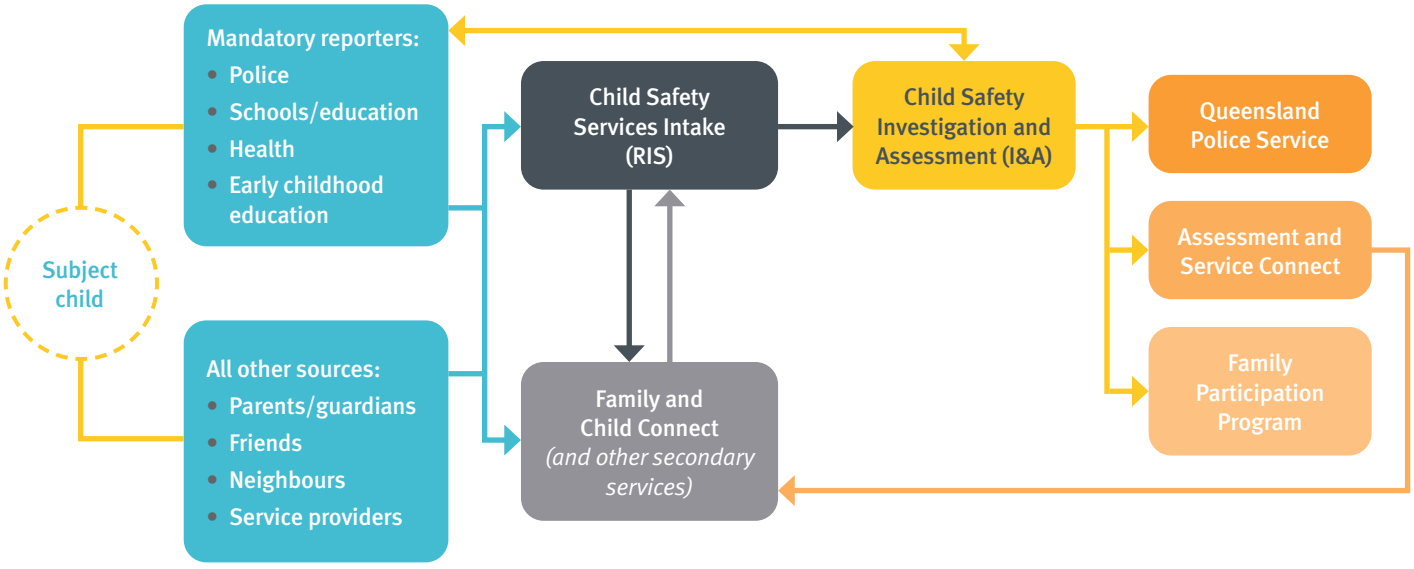
Child safety officers are supported by core partners in carrying out investigations and assessments. They undertake joint investigations with the Queensland Police Service's Child Protection Investigation Unit[23], and 'co-respond' with non-government services funded to provide Assessment and Service Connect.[24]

There is also a critical role for Aboriginal and Torres Strait Islander community controlled organisations funded to provide the Family Participation Program, which supports children and their families with family-led decision making processes.

The QFCC observed relatively strong professional relationships between government agencies delivering the investigation and assessment process. However, partnerships between service centres and non-government service providers appear to be more challenging.

Figure 4 provides a snapshot of investigation and assessment partnerships.

Figure 4: *Investigation and assessment participants and partnerships (QFCC 2020)*




**Notes:**

**RIS**—*regional intake services, which are regional offices that receive information and child protection concerns from community members and government and non-government agencies*

**Mandatory reporters**—*people in certain employment categories who are required by law to report suspected child abuse and neglect to government authorities*

**Secondary services**—*services available to families who have needs that, if unmet, are likely to lead to children becoming in need of protection*

Joint responses with the Queensland Police Service's Child Protection Investigation Unit have clearly become 'business as usual' following the trial of Child Protection Joint Response Teams in 2017–2018.[25]

The QFCC observed strong collaborative partnerships with the Child Protection Investigation Unit due to the clarity of the respective roles and responsibilities and strong communication processes. A good example was found in Maroochydore, where leaders from the Child Protection Investigation Unit and the service centre have an agreement to quickly mobilise and respond where cases of child harm are known but haven't yet been screened through the regional intake service.[26] Built on trust, open communication and information sharing, this arrangement has resulted in quicker responses and earlier sightings of children at risk of harm.[27]

Across the sites, many child safety officers are untrained (or under-trained) to effectively contribute to joint investigations. Stakeholders considered ICARE forensic interviewing skills to be essential for the relevant child safety officers, given a core function of investigations and assessments is interviewing vulnerable children.[28] Several child safety officers noted they were not ICARE trained, but they had participated in joint investigations. Those who had ICARE training considered it to be valuable.

The ICARE skills gap often results in Child Protection Investigation Unit officers having to take the lead. This diminishes the quality of the 'joint' response and puts the onus on the police officers.

### 2.3.1 *The role of Assessment and Service Connect*

The Assessment and Service Connect (ASC) 'co-response' does not appear to have become standard practice despite having been in operation for over three years. Stakeholders reported persistent challenges with sharing information, collaboration and transparency of roles and responsibilities.

Because co-responses involve collaboration with external, non-government partners, some child safety officers are concerned about case accountability and risk. They told us about their unease regarding the risk they carry for each open investigation and assessment case, especially for ASC co-responses, until the investigation and assessment is officially closed.

Having heard the views of local stakeholders, the QFCC observed that a lack of clarity on who is responsible for the risk and accountability has resulted in low morale, inefficient service delivery and counter-collaborative behaviour. Further consideration should be given to the levels at which risk and accountability are held during co-responses, and there should be more clarity about which individual or agency holds the risk.

In some cases, mistrust in the professional ability or capacity of a non-government provider (or individual representing the service) has marred the process. Some child safety officers have been hesitant and others have outright refused to refer to the ASC service.

In the WDIA service centre, the ASC provider is co-located in the office. The co-location is viewed positively in terms of building relationships and facilitating information exchange and accountability for shared cases. The team leader, as a former child safety officer, has a well-established relationship with staff which has also helped strengthen this partnership.

In the other two service centres, concerns were raised about closing investigations and assessments prior to finalising the ASC process. In practice, the co-response appears to be more of a 'warm handover' (assisted referral) from the service centre to the ASC service. In these two service centres, the investigation and assessment is closed once the family consented to the ASC service. Unfortunately, this has led to families ending their engagement with the ASC service, potentially leaving the subject child at continued risk of significant harm, without intervention.[29]

To date, there has been no evaluation of Assessment and Service Connect. In fact, little is known about the operational effectiveness of all non-government providers funded by Child Safety. Operational and service data is limited and is often not publicly available. Given the size of this investment the government has made and the potential benefits these services offer to children and their families and the child protection system, this needs to be addressed as quickly and efficiently as possible.[30]

### 2.3.2 *The role of community controlled organisations*

The QFCC observed and heard from stakeholders about the challenges in collaborative relationships between service centres and community controlled services, particularly the Family Participation Program.

These services are funded (by Child Safety) to increase the participation of Aboriginal and Torres Strait Islander families in decisions that impact upon them using tools such as family-led decision making. In practice, decisions about the safety and wellbeing of Aboriginal and Torres Strait Islander children are commonly made by non-Indigenous professionals who are asked to determine an Aboriginal and/or Torres Strait Islander child's best interests through a non-Indigenous lens—that is, without the insights Aboriginal and Torres Strait Islander people would have.

The right to self-determination is about finding agreed ways in which Aboriginal and Torres Strait Islander people and their communities can have control over their own lives and have a collective say in the future wellbeing of their children and young people.

Aboriginal and Torres Strait Islander service providers must be recognised as essential partners in the investigation and assessment process to provide children and families with culturally appropriate supports and services and enable their participation in decisions being made about them.

It was evident to us, when conducting this review, that there are different understandings among local stakeholders as to what the Family Participation Program could or should deliver for children and their families. This is due, at least in part, to the program continuing to operate according to draft guidelines after nearly two years of operation. (The final Family Participation Program guidelines have since been released on 5 February 2020.)

The program, according to the draft departmental guidelines, is designed to support Aboriginal and Torres Strait Islander families in participating in decision making by giving authority to parents, families and children to solve problems and make decisions in a culturally safe space, including during the investigation and assessment process.[31]

Feedback from stakeholders suggests this isn't occurring until late in the process, when assessment or protection orders are being sought, at which stage the child is likely to be destined to enter the child protection system.

This conflicts with the principle of self-determination and contravenes the government's commitment for 'Aboriginal and Torres Strait Islander peoples and organisations [to] participate in and have control over decisions that affect their children'.[32]

Service centre staff consider the Family Participation Program service, typically eight weeks in duration, to take 'too long'. This makes referrals difficult for child safety officers who are committed to closing investigation and assessment cases as quickly as possible. However, the QFCC does not believe duration to be a problem if the engagement is effective, sustained and results in direct access to the supports families need to keep their children safe and well, in family. If the child's needs (rather than the system's) are truly at the centre, sighting the child is the timeframe that matters most.

The QFCC notes the extension to completion timeframes under the policy changes introduced by Child Safety in 2019 would allow enough time for the Family Participation Program process to occur if it was started at the beginning of the investigation and assessment process, rather than the end. In fact, the new Family Participation Program guidelines (within the Child Safety Practice Manual) instruct Child Safety Officers, at commencement of an investigation and assessment process, to engage the Family Participation Program before contacting or interviewing an Aboriginal or Torres Strait Islander child and family to determine whether, and at what stage of the investigation and assessment process, it plans to visit the family.[33] In practice, however, this appears to be discretionary. If the child safety officer doesn't ask the family for consent to engage with the Family Participation Program or think it's the best option, they don't make a referral. This suggests there is still a belief that children, families and Aboriginal and Torres Strait Islander organisations' participation in decision making is discretionary rather than mandatory, and reflects disregard for the Aboriginal and Torres Strait Islander Child Placement Principle which is supposed to apply to all provisions, powers and functions under the *Child Protection Act 1999*.

It is also the view of the QFCC that the right to self-determination, and the potential for families to address the child protection concerns using natural and secondary supports available to them, are of greater priority than closing a case within completion timeframes.

There was little evidence the Family Participation Program was being used or promoted effectively in these locations. They have been underutilised or drawn in late in the investigation and assessment process, despite their availability and potential to offer children and families a more appropriate response. This is worrying, as it impinges upon the children's human rights and fails to honour the Child Placement Principle, which is enshrined in legislation in Queensland.

The leadership teams in all three service centres are aware of the need to prioritise the relationships between their staff and community controlled Aboriginal and Torres Strait Islander organisations. Efforts are being made in each location to strengthen these relationships.

### 2.3.3 *The role of the Early Indigenous Response Collective (Maroochydore)*

In Maroochydore, an early Indigenous response collective works in partnership with the service centre. Each week, members of the Aboriginal and Torres Strait Islander community within the Maroochydore service centre catchment meet to review incoming notifications, to determine whether there are available supports for children and their families. They also review the cases during investigations and assessments.

The intention is two-fold. Firstly, Aboriginal and Torres Strait Islander people are integral to decisions affecting Aboriginal and Torres Strait Islander children and families. Secondly, families are more likely to receive culturally safe services early, which enables their children to be diverted from the statutory child protection system.

During this review, the QFCC was able to observe a meeting of the early Indigenous response collective and have access to data indicating, as at September 2019:

- a (seven per cent) decrease in the number of child protection orders opened
- a large decrease (75 per cent) in the number of Aboriginal and/or Torres Strait Islander children requiring Interventions with Parental Agreement in Maroochydore, as a result of the operation of the collective.

In order for collectives such as this one to have sustained impact on the numbers and trajectory of Aboriginal and Torres Strait Islander children within the child protection system, Child Safety must relinquish some control in investigations and assessments and commit to partnering with Indigenous communities and service providers to protect and care for Aboriginal and Torres Strait Islander children.

### 2.3.4 *The Murri Response (Toowoomba)*

At the WDIA service centre, the leadership group is currently developing a pilot project—the Murri Response. Modelled on the 'HALT' collective response in Brisbane,[34] the Murri Response is designed to divert Aboriginal and/or Torres Strait Islander children and their families away from the child protection system by 'slowing down for a conversation', developing an action plan and seeking appropriate alternatives at the intake phase.

The Murri Response panel will be made up of Child Safety staff and representatives from Aboriginal organisations who bring community and cultural knowledge about the strengths, protective factors and supports available for a child and their family to keep the child safe.

Collective response efforts like these align with the government's commitment to change the way business is done by providing earlier responses with potential to divert children and families away from the statutory child protection system.

### *The value of partnerships in investigation and assessment*

**The QFCC's position:**

- **The QFCC recommends a review of the requirements for Child Safety Officers to be ICARE trained. This would strengthen joint responses between the Queensland Police Service and service centres.**
- **The QFCC remains concerned about the efficiency and effectiveness of Child Safety's relationships with non-government partners in investigations and assessments. There is little evidence the significant investment in this part of the system has helped families receive the right support at the right time, or has resulted in children being seen sooner when concerns are received about their safety and wellbeing.**
- **To date, no evaluation of the Assessment and Service Connect has been undertaken but is recommended as it holds the potential to inform and improve co-responses.**
- **Active efforts must be made by Child Safety staff to include the Aboriginal and Torres Strait Islander community controlled organisations delivering the Family Participation Program as early as possible in the investigation and assessment process.**

# 3 Conclusion

**When a notification of child harm is received, the system must be responsive—not only in gathering of information but also in physically sighting a child so a thorough assessment can be made of their circumstances and risk of future harm.**

Responding in a timely way can at times be challenging, as the in-flow of notifications to Child Safety is steadily increasing and unrelenting. To mitigate the strain on the system and avoid backlogs, Child Safety has had to prioritise resources and introduce other efficiencies.

However, throughput is not the only thing, or even the most important thing. Child Safety must also focus on the quality of responses to make each child's experience within the system as positive, supportive and culturally safe as possible.

There are risks and benefits to the 1 September 2019 policy changes to investigation and assessment commencement criteria and completion timeframes. The revised policy on commencement criteria made sense, as what it introduced routinely occurred in practice prior to the change. That said, this change in policy *must not* result in children not being seen in a timely manner.

Information gathering can never replace making a safety and risk assessment by sighting the child. The QFCC will continue to monitor the ongoing implementation of these policy changes and will expect to see a marked improvement in the time taken to sight a child at risk of harm.

Innovation in investigation and assessment processes, such as the creation of the differentiated officer in Maroochydore[35] and the establishment of early Indigenous response collectives, can lead to promising outcomes, particularly when they build relationships and partnerships.

Child Safety relies on partnerships to respond to children's safety needs. While many partnerships are characterised by strong relationships and open communication, some require attention and strengthening—particularly those with non-government services.

The QFCC remains concerned about the efficiency and effectiveness of Child Safety's relationships with non-government partners in investigations and assessments. To date, there is little evidence that the government's investment in these partnerships has delivered results—either in terms of helping families or responding quickly to children at risk of harm.

It is essential that Child Safety continues to strengthen and leverage partnerships. This will expand its capacity and capability to see children sooner, increase families' connections with support services and improve community confidence in the system.

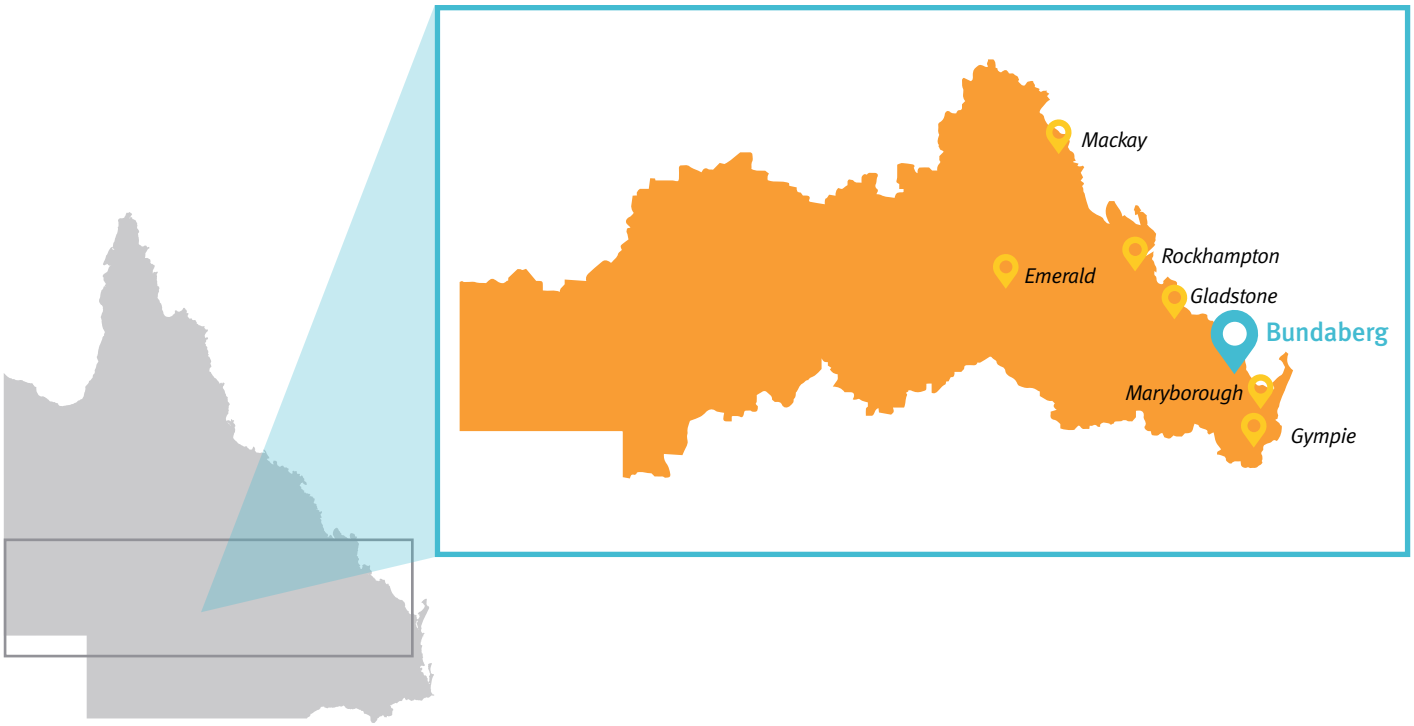
This review has found there is good foundation work underway to build a stronger, more responsive investigation and assessment process and the will to do more.

# 4 Appendices

*Appendix 4.1*

# Key findings

## Bundaberg Child Safety Service Centre




### Location

*Central Queensland Region,*
*Department of Child Safety, Youth and Women*

### Site boundaries

*Bundaberg city and surrounds*

### Site characteristics

In rebuilding phase—significant staff turnover into the secondary system

Incoming notifications are predominantly allocated to I&A team with some completed by ongoing intervention teams

Strong and consistent messaging to staff—'we're all in this together'

Strong relationships amongst colleagues—characteristic of regional ethos

Some challenges with recruitment—characteristic of regional settings

Continuing challenges with reporting behaviour due to feedback issues

## Operational strategy

- Investigation and Assessments (I&As) are allocated to child safety officers (CSOs) across the CSSC resulting in a genuine culture of shared responsibility and eliminating the backlog of uncommenced I&As
- CSOs still predominantly commence I&As by sighting and prioritise sighting the child if commencing by information
- CSOs continue working to 60 day completion timeframes despite the revised policy extending completion timeframes to 100 days

## Culturally safe policy and practice

- There is a CSSC-wide project to encourage staff along their cultural journey, and cultural training provided to all staff
- There is confusion about Family Participation Program and Independent Person/Entity resulting in a lack of referrals and strained relationships
- A process is in development for tracking implementation of the Child Placement Principle
- The CSSC leadership group is working to strengthen relationships with Aboriginal and Torres Strait Islander services

## Technology

- There is a mix of automated and manual systems support I&A; ICMS (the client management system) is regularly maintained and kept up-to-date
- Manual methods for tracking open I&As are preferred (e.g. spreadsheets, boards) as they support greater visibility and accessibility of information to the I&A team leader and CSOs

## Leadership and human resource management

- A cohesive leadership group is focused on performance, communication, workplace culture, work/life balance and outcomes for children
- Staff are supported with supervision, generalist and specialist training and on-the-job mentoring with more experienced staff; not all I&A CSOs are ICARE (forensic interviewing) trained, which was seen as an opportunity for improvement

## Roles and responsibilities

- All staff share a role in building relationships with core I&A partners, families and the community
- Specialist and generalist roles contribute to the I&A function; roles and responsibilities are generally clear and understood between government partners, but there is room for improvement (in process and communications) with non-government partners
- There is a clear delineation between CSSC functions despite the shared responsibility for I&As across the service centre

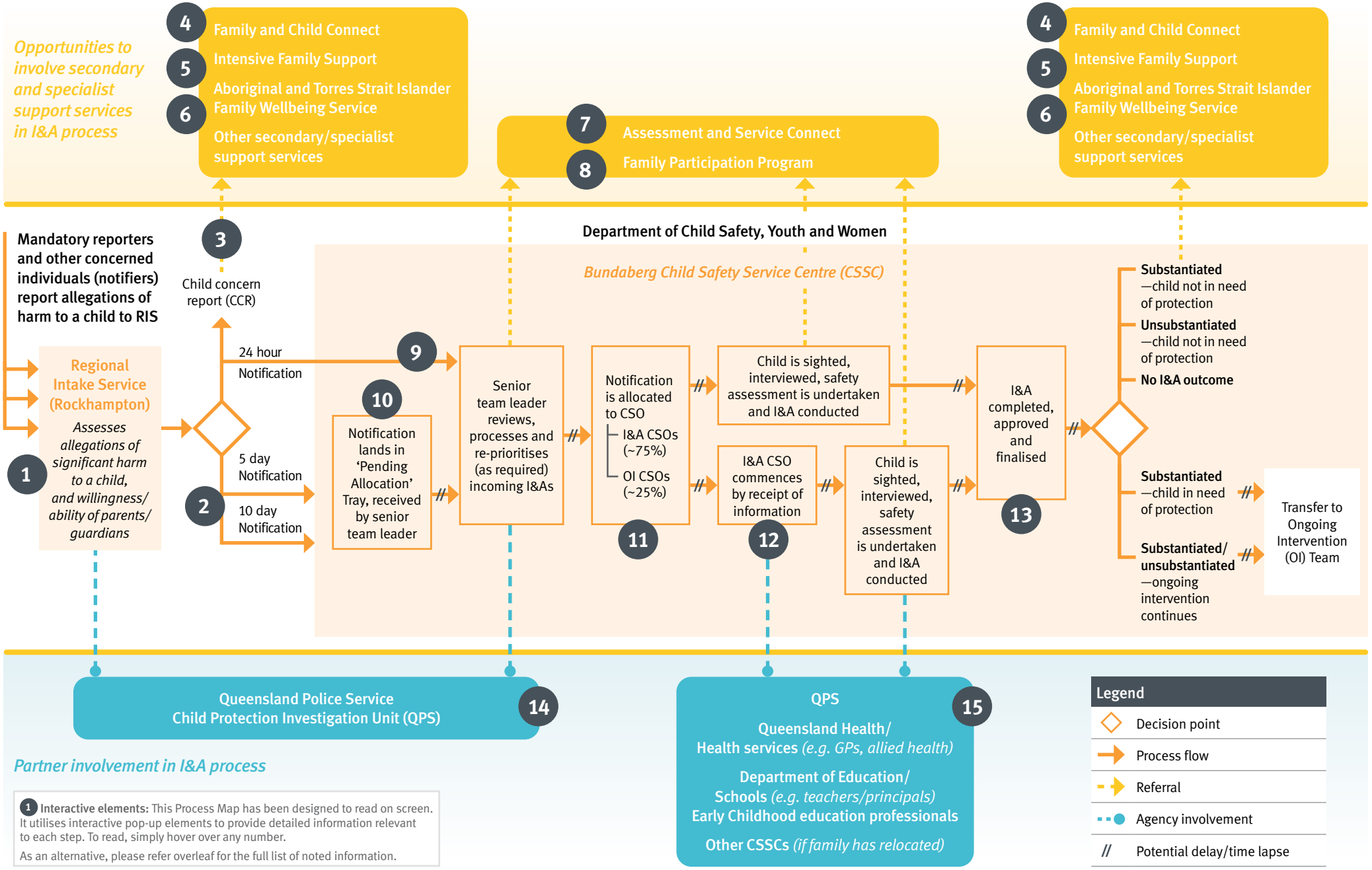
## Communication

- A strong culture of internal communication has been successfully used to manage expectations and promote buy-in for a major restructure of I&A allocation processes
- Multiple channels are used to keep staff informed including informal discussions, supervision, workshops, work group meetings and internal emails

## Accountability

- There are strong government partnerships but there remains room for improvement in collaboration with non-government partners
- There is a strong focus on performance monitoring at regional, organisational and team levels for quantitative measures and targets; data is used retrospectively and proactively for continuous improvement
- The quality of responses is a leadership team focus and is monitored using operational data

Figure 5: *Investigation and assessment process flow map, Bundaberg Child Safety Service Centre* (Source: QFCC 2020)




1 **Interactive elements:** This Process Map has been designed to read on screen. It utilises interactive pop-up elements to provide detailed information relevant to each step. To read, simply hover over any number.

As an alternative, please refer overleaf for the full list of noted information.

## Notes for Figure 5

1. Regional Intake Services receive, assess and record child protection concerns from notifiers, decide the response in line with Child Safety's legislative authority and provide information about local support services. **Stakeholders reported concerns about delays at Intake, suspected to be related to capacity issues (i.e. high volumes at Intake). Child safety officers reported that these delays meant they often received incoming notifications which were already timed out of the response timeframe.**
2. A 5 day or 10 day response timeframe refers to 5 or 10 business days. **Stakeholders had differing views on counting timeframes—some believed weekend days were counted in the 5 day or 10 day timeframe, others did not. This has implications for 'timeliness', on paper. It matters because response timeliness is a reflection of a child safety officer and CSSCs' performance, statistically, and an inability to provide timely responses affects morale.**
3. A child concern report (CCR) is recorded when the information received does not suggest a child is in need of protection. If a CCR response is decided, intake officers can refer families to these family support services which are voluntary and require the family to proactively engage.
4. Family and Child Connect are local, community-based services that helps families to care for and protect their children at home, by connecting them to the right services at the right time. They provide information to and refer families to the appropriate services and may assist with the connection to those services.
5. Intensive Family Support services work with vulnerable families who have complex needs. They are intended to provide families with the necessary support to avoid, where possible, intervention from Child Safety Services.
6. Aboriginal and Torres Strait Islander Family Wellbeing services provide culturally responsive support to families to improve their social, emotional, physical and spiritual wellbeing. Their intent is to build parents' capacity to safely care for and protect their children, and where possible, avoid intervention from Child Safety Services.
7. Assessment and Service Connect (ASC) is a model in which non-government services work with child safety officers as 'co-responders' to assess and respond to children and families, address risk factors and increase the child's safety. **Stakeholders reported significant concerns about the capacity and limited functionality of the ASC in this catchment. This service centre's operational policy calls for closure of an investigation and assessment process once the ASC engages the family, which limits the co-response to the early stages of the I&A process and introduces risk if a family disengages with the ASC service once the I&A is closed.**
8. The Family Participation Program (FPP) supports Aboriginal and Torres Strait Islander families in participating in child protection decision making. The FPP facilitates family-led decision making, a process whereby authority is given to parents, families and children to work together to solve problems and lead decision making in a culturally safe space. **There is confusion about what the FPP can offer families. Child safety officers reported this process takes 'too long' and introduces unacceptable delays, so many choose not to use the service. When they do refer families to the FPP, it is typically late in the I&A process when the child is likely destined for ongoing intervention with Child Safety Services.**
9. The Intake senior team leader phones the Investigation and Assessment senior team leader to flag incoming 24 hour notifications, given their urgency and priority. 24 hour notifications are received in ICMS (the client management system) into the 'pending allocation' tray.
10. The Intake senior team leader emails the Investigation and Assessment senior team leader to flag incoming 5 and 10 day notifications. These are considered less urgent than 24 hour notifications. These are also received in ICMS and are accessed in the pending allocation tray. **A safeguard has been put into place when the Investigation and Assessment senior team leader is absent, whereby a delegate is nominated to receive and allocate incoming notifications to avoid delays.**
11. I&As are allocated to child safety officers across the service centre, including those in the Ongoing Intervention team. This is a different structure to most service centres, which separate Investigation and Assessment and Ongoing Intervention teams. **This allocation process has reduced delays caused by capacity limitations. By expanding allocation of I&As to include child safety officers in the Ongoing Intervention team, this service centre has successfully broadened the pool of officers who are able to respond to a 5 day or 10 day matter.**
12. Information sought and received must be new information that informs the assessment about the safety of the child. **Stakeholders were largely positive about information sharing relationships in this catchment.**
13. The completion timeframe for I&A was extended from 60 to 100 days. **Child safety officers continue working to 60 day completion timeframes and aim to close cases as soon as possible. The extension to completion timeframes was viewed favourably by child safety officers for more complex cases requiring ongoing support and encouragement for families to connect with support services.**
14. Child Safety has a legislative responsibility to immediately notify QPS where it is reasonably believed that harm to a child may involve the commission of a criminal offence relating to the child. **The service centre will not pre-emptively sight a child known to Child Safety's Regional Intake Service until it has screened through to the I&A team, as per standard operating procedures. This introduces risk and delays that are potentially avoidable if CSSC leaders were willing to operate outside of formalised procedures to expedite action on urgent matters.**
15. Agencies support service centres by sharing information and facilitating engagement with children and their families. Formalised information sharing processes such as SCAN meetings involve a group of core government partners. **Child safety officers have regular contact with representatives from partnering agencies and spend a considerable amount of time gathering information from them, demonstrating the importance of good working relationships. The SCAN process reportedly works well in this catchment and assists child safety officers with I&A responses.**

*Appendix 4.2*

# Key findings

## **Maroochydore** Child Safety Service Centre


### Location

*Moreton Region,*
*Department of Child Safety, Youth and Women*

### Site boundaries

*80+ suburbs serviced*

*North to Noosa*
*West to Obi Obi*
*South to Mooloolah River*

### Site characteristics

- High-volume service centre in regional metropolitan area
- Catchment boundaries significantly expanded in 2018
- Some areas have few or no support services
- Regional 'hot spots' require significant resourcing
- Relative stability of workforce due to strong retention
- Strong focus on reducing over-representation of Aboriginal and Torres Strait Islander children in the system

## Operational strategy

- The revised I&A commencement policy is being implemented with reported success; a dedicated information officer, referred to as the 'differentiated' child safety officer (CSO) commences the majority of incoming I&As, resulting in numerous perceived benefits including reducing workload of CSOs and improving response timeliness
- Most I&As are already commenced when CSO sights the child; CSOs benefit from better information about the child/family's situation
- CSOs continue working to 60 day completion timeframes despite the revised policy extending completion timeframes to 100 days

## Culturally safe policy and practice

- Policies, procedures, tools, and partnerships are used to respond early to children who identify as Aboriginal and/or Torres Strait Islander
- Early Indigenous response collective is producing positive results and strengthening existing collaborative partnerships

## Technology

- There is a mix of automated and manual systems support I&A; ICMS (the client management system) is regularly maintained and kept up-to-date
- Manual methods for tracking open I&As are preferred (e.g. spreadsheets, manual boards) as they support visibility/accessibility of information to the I&A team leader and CSOs

## Leadership and human resource management

- Strong regional leadership is willing to trial new ways of working; there is an authorising environment for working differently
- The service centre is a high volume environment but has a child-centred ethos; there is a strong focus on sighting the child as soon as possible and closing I&A quickly to minimise disruption to child/family's life

## Roles and responsibilities

- All staff are involved in building relationships across the office and with partners, communities and families
- There is clarity of roles and responsibilities across teams within CSSC and with core I&A partners (ASC, QPS) involved in the I&A process; staff report confidence and trust in professional partners

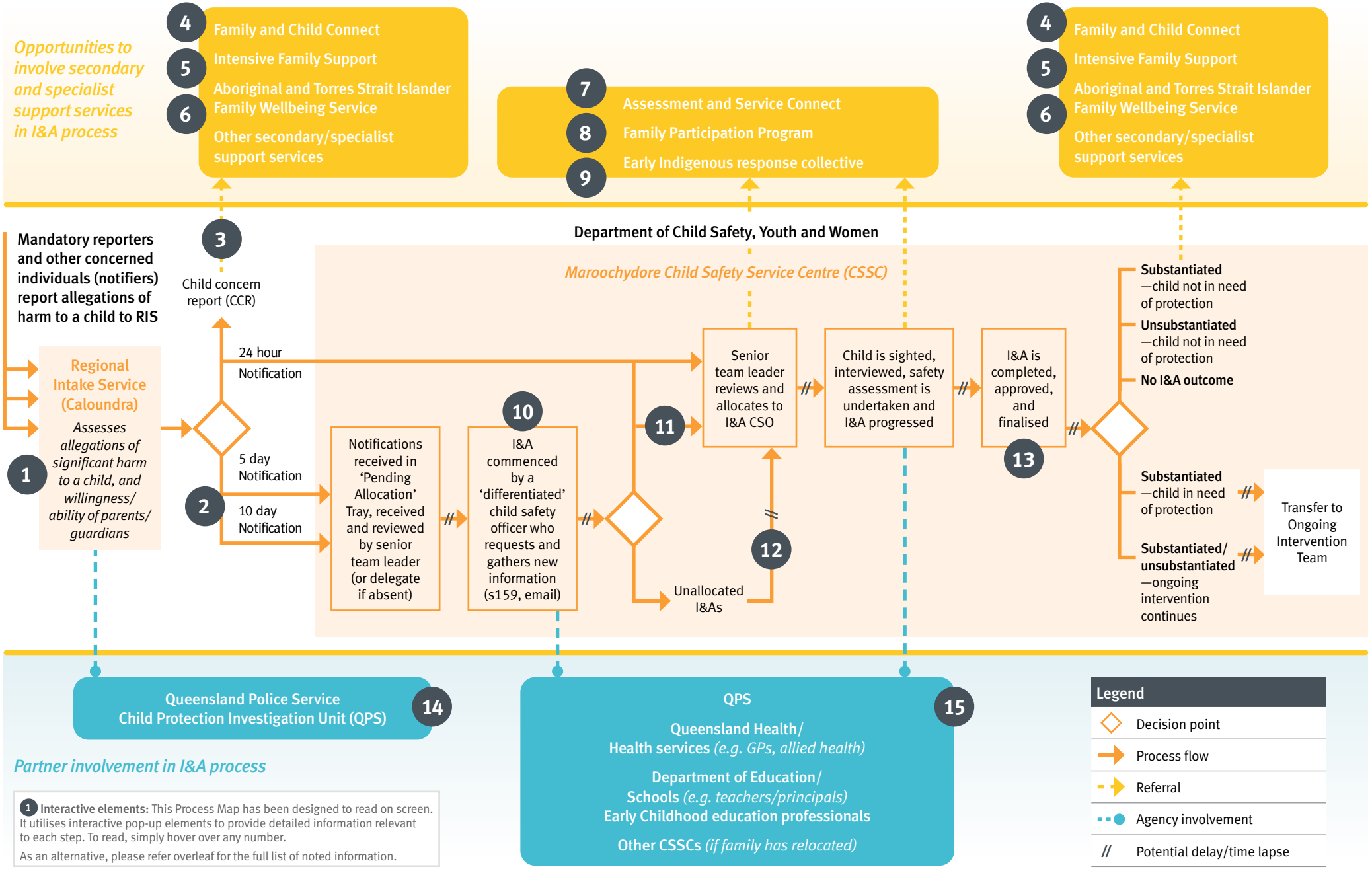
## Communication

- There is strong communication and positive information sharing relationships between core I&A partners, from CSOs to regional leaders
- Communication occurs through a variety of channels including communities of practice, forums/networks, collaboratives, and individually through face-to-face discussions, meetings and emails

## Accountability

- There are strong relationships internally and externally; responsibility is shared for children's wellbeing
- There are genuine collaborative relationships with core I&A partners (Queensland Police Service, Assessment and Service Connect)
- Regular performance monitoring occurs at the regional, organisational (CSSC) and team level
- Quantitative measures (i.e. throughputs) are monitored for trouble shooting and continuous improvement
- The primary focus is on quality of response; CSOs and team leaders aren't heavily focused on performance measures

Figure 6: *Investigation and assessment system flow map, Maroochydore Child Safety Service Centre* (Source: QFCC 2020)




1 **Interactive elements:** This Process Map has been designed to read on screen. It utilises interactive pop-up elements to provide detailed information relevant to each step. To read, simply hover over any number.

As an alternative, please refer overleaf for the full list of noted information.

## Notes for Figure 6

1. Regional Intake Services receive, assess and record child protection concerns from notifiers, decide the response in line with Child Safety's legislative authority and provide information about local support services. **Stakeholders reported concerns about delays at Intake, suspected to be related to capacity issues (i.e. high volumes at Intake). Child safety officers reported that these delays meant they often received incoming notifications which were already timed out of the response timeframe.**
2. A 5 day or 10 day response timeframe refers to 5 or 10 business days. **To clarify and manage child safety officers' expectations, response timeframes were adjusted to account for weekend days (i.e. child safety officers have 7 days for a 5 day notification or 12–13 days for a 10 day notification, respectively, to respond). This was seen to mitigate confusion from counting rules.**
3. A child concern report (CCR) is recorded when the information received does not suggest a child is in need of protection. If a CCR response is decided, intake officers can refer families to these family support services which are voluntary and require the family to proactively engage.
4. Family and Child Connect services are local, community-based services that help families to care for and protect their children at home, by connecting them to the right services at the right time. They provide information to and refer families to the appropriate services and may assist with the connection to those services. They provide information and refer families to the appropriate services and may assist with the connection to those services.
5. Intensive Family Support services work with vulnerable families who have complex needs. They are intended to provide families with the necessary support to avoid, where possible, intervention from Child Safety Services.
6. Aboriginal and Torres Strait Islander Family Wellbeing services provide culturally responsive support to families to improve their social, emotional, physical and spiritual wellbeing. Their intent is to build parents' capacity to safely care for and protect their children, and where possible, avoid intervention from Child Safety Services.
7. Assessment and Service Connect (ASC) is a model in which non-government services work with child safety officers as 'co-responders' to assess and respond to children and families, address risk factors and increase the child's safety. **Stakeholders reported strong collaborative relationships and seamless information sharing between the ASC and the service centre, which was in part attributed to co-locating ASC staff in the service centre. I&As are typically closed once the ASC engages with the family, which limits the co-response to the early stages of the I&A process and introduces risk if a family disengages with the ASC service once the I&A is closed.**
8. The Family Participation Program (FPP) supports Aboriginal and Torres Strait Islander families in participating in child protection decision making. The FPP facilitates family led decision making, a process whereby authority is given to parents, families and children to work together to solve problems and lead decision making in a culturally safe space. **There continues to be confusion about what the FPP can offer families. However, the service provider is already well-connected to the I&A function through its core membership in the early Indigenous response collective, which facilitates early access to non-government support services earlier in the I&A process.**
9. The early Indigenous response collective is comprised of service centre staff and representatives from Aboriginal service organisations in the local area. The collective meets fortnightly to discuss matters involving Aboriginal and/or Torres Strait Islander children subject to notifications of harm in this catchment. Where possible, children and families are connected to culturally safe support services to address child safety concerns and avoid further contact with the child protection system. **Originally intended to address uncommenced notifications, the early Indigenous response collective now operates in 'real time' to review incoming notifications and determine whether a statutory child protection response is appropriate for the child. Local stakeholders were overwhelmingly supportive and positive about the outcomes being achieved by the collective. Early evidence suggests they are contributing to reduced numbers of Aboriginal and/or Torres Strait Islander children entering care within the service centre catchment.**
10. This service centre dedicated a 'differentiated' child safety officer to collect information to commence investigation and assessment processes for incoming 5 day and 10 day notifications, where possible. In order to officially commence an investigation and assessment process, the information sought and received must be new information that informs the assessment about the safety of the child. If this new information suggests the matter is more urgent than previously thought, it will be re-prioritised. **More than half of incoming notifications are commenced by the differentiated child safety officer. This position was valued by service centre staff and external stakeholders as it was seen to expedite the I&A process, create stronger information sharing partnerships with agencies and result in better informed child safety officers.**
11. 5 and 10 day notifications which are re-prioritised as urgent or high priority by the differentiated child safety officer are allocated to a child safety officer to commence as a priority. Thus, those deemed most urgent receive a more timely response.

12. 5 and 10 day notifications which are assessed by the differentiated child safety officer as being less urgent will remain in the 'pending allocation' tray. All notifications that remain 'unallocated' are allocated to a child safety officer at the beginning of each month, based on their capacity (i.e. their caseload at the time). **This method of allocation introduces risk of substantial delays for lower priority cases, which may remain unallocated for an extended period of time.**
13. The completion timeframe for I&A was extended from 60 to 100 days. **Child safety officers continue working to 60 day completion timeframes and aim to close cases as soon as possible.**
14. Child Safety has a legislative responsibility to immediately notify QPS where it is reasonably believed that harm to a child may involve the commission of a criminal offence relating to the child. **QPS and Maroochydore service centre leaders have an agreement to expedite sighting a child where an urgent case is known to Child Safety's Regional Intake Service but hasn't yet screened through to the I&A Team. This eliminates process delays and results in children being seen sooner.**
15. Agencies support the service centre through sharing information and facilitating engagement with children and their families. Formalised information sharing processes such as SCAN meetings involve a group of core government partners. **All child safety officers, particularly the differentiated child safety officer (see #10), have regular contact with partnering agencies and spend a considerable amount of time gathering information from them, demonstrating why good working relationships are so important. The SCAN process reportedly works well in this catchment due to the long tenures of its members. Information is shared freely within and outside of formal SCAN meetings which assists with I&A processes and decision making.**

*Appendix 4.3*

# Key findings

## Western Downs Intake and Assessment
## Child Safety Service Centre


### Location

*South West Region,*
*Department of Child Safety, Youth and Women*

### Site boundaries

| | |
|---|---|
| *East to Helidon* | *West to Tara* |
| *North to Yarraman and South Burnett border* | *South to NSW border past Goondiwindi* |

### Site characteristics

- Standalone intake and I&A service covering majority of Darling Downs District
- Significant travel for staff to conduct I&As throughout region
- Considerable movement (transience) of families around the region/interstate
- Staff movement within child and family system has broadened skills/experience
- Regional 'hot spots' require significant resourcing and attention
- A refugee relocation site has enabled cultural and linguistic diversity

## Operational strategy

- Revised commencement/completion policy is being implemented with added safeguards so children are sighted as soon as possible after collecting relevant information
- The senior practitioner reviews and endorses all I&As commenced by information; the Investigation and Assessment (I&A) process isn't considered 'commenced' in practice until the child is sighted
- CSOs continue working to 60 day completion timeframes despite the revised policy extending completion timeframes to 100 days

## Culturally safe policy and practice

- Efforts are underway to strengthen the relationship between WDIA and local Aboriginal services; the early Indigenous response collective, the Murri Response, is in development
- There is confusion about Family Participation Program and the Independent Person/Entity which is resulting in a lack of referrals and damaged relationships
- One cultural practice advisor is advising I&A CSOs across high volume of cases involving Aboriginal and/or Torres Strait Islander children

## Technology

- There is a mix of automated and manual systems to support I&A; ICMS (the client management system) is regularly maintained and CSOs are encouraged to keep this up-to-date
- Manual methods for tracking open I&As are preferred (e.g. spreadsheets, boards), seen to support greater visibility/accessibility of information
- Limited resources (e.g. cars, supervised contact rooms) can create delays and reduce the quality of the response

## Leadership and human resource management

- There is an authorising environment for team leaders to operate and trial new ways of working, though some stakeholders had concerns about inconsistent procedures, protocols and policies
- Staff are supported with supervision, generalist and specialist training and on-the-job mentoring with more experienced staff
- There is a child-centred culture in I&A service responses and culture of 'mateship' among CSOs working on the frontline

## Roles and responsibilities

- Specialist and generalist roles contribute to the I&A function; there is a clear delineation between intake and I&A functions despite co-location in one service centre
- Roles of external partners are well understood and considerable efforts are undertaken to work collaboratively with core I&A partners

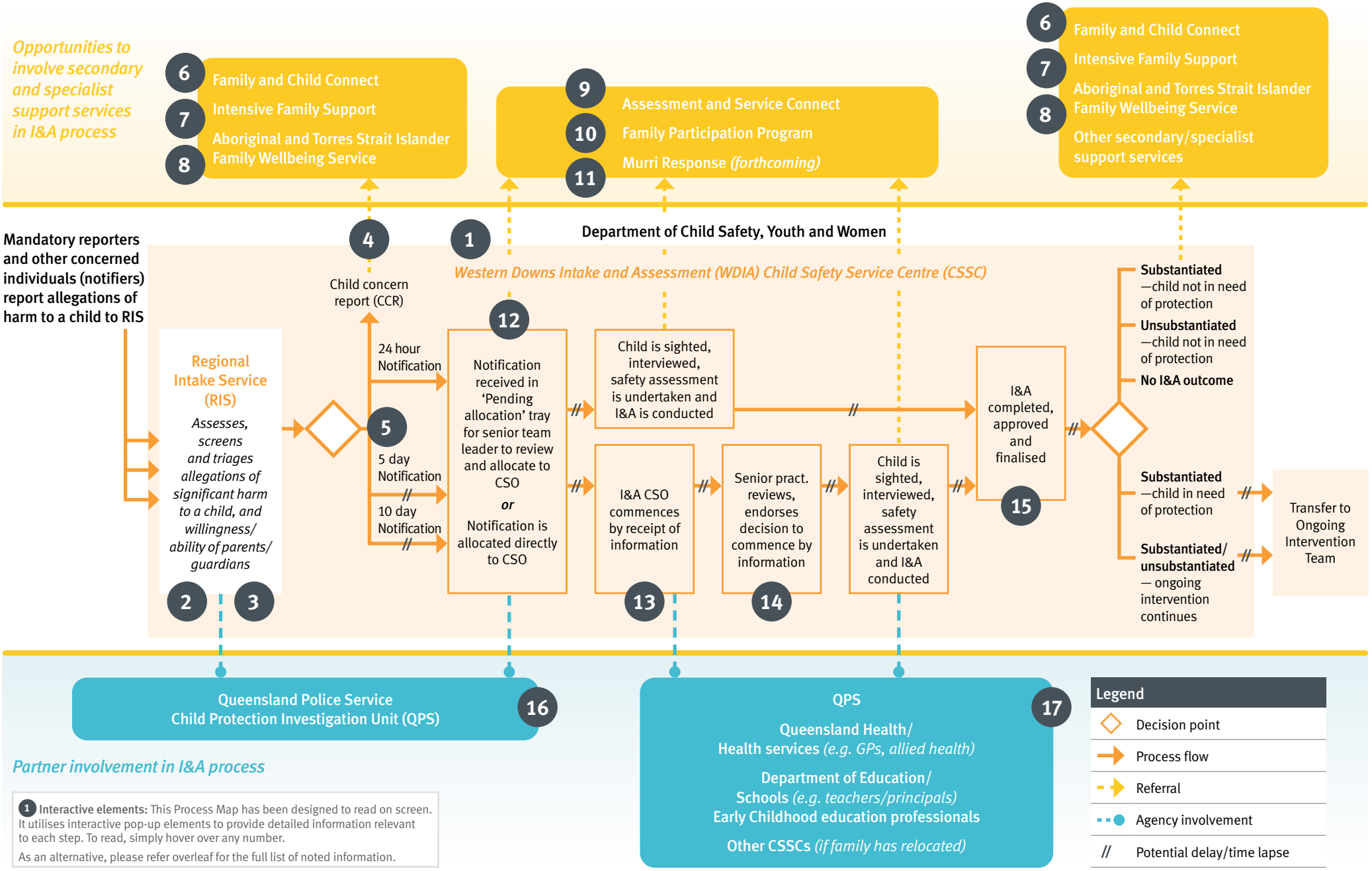
## Communication

- Unique structure of integrated 'hub' service centre (i.e. intake and I&A co-located) facilitates communication and streamlined processes but doesn't necessarily support timelier responses
- Good culture of communication with external partners and within teams; ASC is co-located and 'mini-SCAN' meetings support information sharing; I&A remains open during ASC process
- Leadership group proactively and reactively communicates with partners on identified issues; there is potential benefit in improving communication within the service centre to improve CSO buy-in to decisions

## Accountability

- There are strong relationships with core I&A partners, but limited interaction with local Aboriginal and Torres Strait Islander services during I&A
- Sharing information and collaborating with core I&A partners can be inhibited by risk averse behaviour
- There is a strong focus on performance monitoring at the regional, organisational and team level; monitoring is primarily focused on quantitative measures and achievement of targets; there is an expectation to meet targets at all levels
- Unclear if or how quality of the response is being measured or monitored, but CSOs are focused on minimising disruption and impact of I&A on children and families

Figure 7: *Investigation and assessment system flow map, Western Downs Intake and Assessment (WDIA) Child Safety Service Centre* (Source: QFCC 2020)



## Notes for Figure 7

1. This service centre has a unique structure with the Regional Intake Service and the I&A functions co-located in one service centre. **The structure of this service centre was viewed as highly favourable given the interconnectivity of the intake and I&A functions. It was seen to facilitate communication between these units and strengthen their ability to streamline responses, particularly those of high priority.**
2. Regional Intake Services receive, assess and record child protection concerns from notifiers, decide the response in line with Child Safety's legislative authority and provide information about local support services. **Stakeholders reported concerns about delays at Intake, suspected to be related to capacity issues (i.e. high volumes at Intake). Child safety officers reported that these delays meant they often received incoming notifications which were already timed out of the response timeframe.**
3. The Intake senior team leader may directly send referrals to Assessment and Service Connect (see #9) upon determining the notification is an appropriate ASC co-response. Alternatively, the I&A senior team leader or child safety officer can refer to ASC. **There appeared to be inconsistency in the way matters were referred to the ASC service. The approach taken reportedly varied depending on the preference of the individual Intake senior team leader.**
4. A child concern report (CCR) is recorded when the information received does not suggest a child is in need of protection. If a CCR response is decided, intake officers can refer families to these family support services which are voluntary and require the family to proactively engage.
5. A 5 or 10 day response timeframe refers to 5 or 10 business days. **Stakeholders had differing views on counting timeframes—some stakeholders believed weekend days were counted, others did not. This has implications for 'timeliness', on paper. It matters because response timeliness is a reflection of a child safety officer and CSSCs' performance, statistically, and an inability to provide timely responses affects morale.**
6. Family and Child Connect are local, community-based services that help families to care for and protect their children at home, by connecting them to the right services at the right time. They provide information to and refer families to the appropriate services and may assist with the connection to those services.
7. Intensive Family Support services work with vulnerable families who have complex needs. They are intended to provide families with the necessary support to avoid, where possible, intervention from Child Safety Services.
8. Aboriginal and Torres Strait Islander Family Wellbeing services provide culturally responsive support to families to improve their social, emotional, physical and spiritual wellbeing. Their intent is to build parents' capacity to safely care for and protect their children, and where possible, avoid intervention from Child Safety Services.
9. Assessment and Service Connect (ASC) is a model in which non-government services work with child safety officers as 'co-responders' to assess and respond to children and families, address risk factors and increase the child's safety. **Stakeholders reported strong collaborative relationships between the ASC and the service centre, though it was reported that communication processes could be strengthened. In this catchment the investigation and assessment remains open for the duration of the ASC co-response process. This is seen to reduce the risk of families falling through the gaps if they disengage with the ASC service. However, child safety officers were concerned about the risk they carried during the ASC response, particularly when they had limited visibility of the ASC intervention due to information sharing or communication limitations. Co-locating ASC staff in the service centre was viewed favourably to mitigate this risk.**
10. The Family Participation Program (FPP) supports Aboriginal and Torres Strait Islander families in participating in child protection decision making. The FPP facilitates family-led decision making, a process whereby authority is given to parents, families and children to work together to solve problems and lead decision making in a culturally safe space. **The FPP receives very few referrals from WDIA unless the family is already connected to other services provided by this organisation. There continues to be confusion about what the service can offer children and families. Child safety officers also reported that this process takes 'too long' and introduces unacceptable delays, so many do not use the service. When they do refer families to the FPP, it is late in the I&A process when the child is likely destined for ongoing intervention with Child Safety Services.**
11. The Murri Response is designed to divert Aboriginal and/or Torres Strait Islander children and their families from entering the child protection system by 'slowing down for a conversation', developing an action plan and seeking appropriate alternatives at the Intake phase. **The Murri Response was in development at the time this review was undertaken, so no information on its performance is available.**
12. Incoming 5 day and 10 day notifications are allocated to child safety officers immediately when received. In some circumstances these are allocated directly to the child safety officer from the Intake senior team leader, while others are allocated via the I&A senior team leader. When they are commenced depends on the capacity of the child safety officer (i.e. their existing caseload). **There were divergent views on allocation processes, some stating they are indiscriminately allocated to the 'next in line' while others reported they are allocated based on their complexity and the officer's capacity and capability.**
13. To officially commence an I&A process by information (rather than sighting the child), the information sought and received must be new information that informs the assessment about the safety of the child.

14 Two key safeguards were introduced with the new I&A commencement policy. First, a senior practitioner reviews all I&As proposed to be commenced by information to justify this avenue of commencement. Second, an I&A is not considered 'commenced,' in practice, until the child is sighted. **While the safeguards introduced by WDIA strengthen practice and reduce risk, they also create an aversion for child safety officers to commencing by information. They noted that it is simpler to commence by sighting, which must eventually occur anyway, and thus can avoid the extra steps required when commencing by information.**

15 The completion timeframe for I&A was extended from 60 to 100 days. **Child safety officers continue working to 60 day completion timeframes and aim to close cases as soon as possible, acknowledging they should be kept open if more work is required.**

16 Child Safety has a legislative responsibility to immediately notify QPS where it is reasonably believed that harm to a child may involve the commission of a criminal offence relating to the child. **The limited operational hours of the service centre (9 am to 5 pm) were seen as a barrier to jointly responding to notifications. When received after hours, QPS responds without a child safety officer. The information collected by QPS officers is made available to child safety officers.**

17 Agencies support the service centre by sharing information and facilitating engagement with children and their families. Formalised information sharing processes such as SCAN meetings involve a group of core government partners. **All child safety officers have regular contact with partnering agencies and spend a considerable amount of time gathering information from them, demonstrating why good working relationships are so important. Stakeholders reported a range of challenges with information sharing relationships, including risk averse sharing behaviour, repeat requests or lack of specificity with information requests, overly bureaucratised communication processes and lack of access to databases.**

# 5 References

1 Queensland Government 2019, Child Safety Practice Manual.

2 The Suspected Child Abuse and Neglect (SCAN) team enables a coordinated response by core team member agencies to the protection needs of children—Child Safety Practice Manual: Glossary.

3 Family-led decision making is an approach in which the family is supported in taking the lead in making decisions and plans and taking action to meet the safety, belonging and wellbeing needs of the child—Child Safety Practice Manual: Glossary.

4 A notification is recorded when child protection information received by a Child Safety regional intake service suggests a child may be in need of protection.

5 Department of Child Safety, Youth and Women 2019, Our performance: Notifications.

6 Ibid.

7 Significant harm is the threshold for harm that requires a statutory response from Child Safety. The level of significant harm may be:
- Serious—such as an injury requiring medical treatment
- Severe—such as an injury that is life-threatening or would cause permanent disfigurement or disability if untreated. Child Safety Practice Manual: Glossary.

8 Department of Child Safety, Youth and Women 2019, Our performance: Intake and assessment.

9 Queensland Parliament 2019, Record of proceedings (Hansard), 25 July 2019, 2019–2020 Budget Estimates—Health, Communities, Disability Services, and Domestic and Family Violence Prevention Committee—Health and Ambulance Services, 56th Parliament, p. 73.

10 Both sets of highlight reports were made available to the Minister for Child Safety, Youth and Women and Minister for the Prevention of Domestic and Family Violence and Child Safety leaders, including regional executive directors of the three service centre regions.

11 Comparison between timeframes: 01 January 2020 to 31 August 2020, compared to 01 September 2020 (the date on which the revised investigation and assessment policy came into effect) to 31 December 2020, the end of the quarter and latest data available at the time of writing. Change is reported in percentage points.

12 Department of Child Safety, Youth and Women 2020, Child Safety Practice Manual: Investigate and assess, page 32.

13 Queensland Parliament 2019, Record of proceedings (Hansard), 25 July 2019, 2019–2020 Budget Estimates—Health, Communities, Disability Services, and Domestic and Family Violence Prevention Committee—Health and Ambulance Services, 56th Parliament, p. 73.

14 Detailed findings about each service centre's strengths and areas for improvement are provided in the second set of highlight reports. These can be made available upon request (if not already received).

15 Department of Child Safety, Youth and Women 2019, Child Safety data provided to QFCC specifically for this project: Notifications with a commenced investigation and assessment, by whether the investigation and assessment commencement was within timeframe, by specific child safety service centre: Notifications received 1 September 2019 to 31 December 2019.

16 Department of Child Safety, Youth and Women 2019, Corporate data requested by Queensland Family and Child Commission under section 35 of the *Queensland Family and Child Commission Act 2014*. Child Safety corporate data on notifications was 'confidentialised' so all figures are approximate.

17 Australian Productivity Commission 2020, *Report on Government Services 2020*, Data tables—Table 16A.39, Population ages 0–17 years, by Indigenous status, as at 30 June 2019, accessed at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/community-services/child-protection

18 'Active efforts' can encompass a variety of strategies to ensure Aboriginal and Torres Strait Islander children's connection to family, culture, community and country is maintained. All practitioners are expected to make active efforts that are purposeful, thorough and timely. This is supported by legislation and policy.

19 The cultural practice advisor is a Child Safety Service Centre-based, Aboriginal and Torres Strait Islander (identified) position that provides individualised and culturally appropriate casework support to children and families, and cultural leadership in the service centre, to support culturally appropriate work with children and families.

20 Cultural safety is defined as an environment that is safe for people where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening (Williams, Robyn, 2008). Cultural safety: what does it mean for our work practice? Australian and New Zealand Journal of Public Health. 23(2): 213-214.

21 Description taken from Bundaberg service centre's Cultural Safety Audit Tool, provided to QFCC for this project.

22 The Child Placement Principle (*Child Protection Act 1999*, section 5C) is applied in administering the *Child Protection Act 1999* when working with Aboriginal or Torres Strait Islander children and families. Decisions about an Aboriginal or Torres Strait Islander child must be made in a way that upholds the five elements of the Child Placement Principle:

- Prevention—that a child has the right to be brought up within the child's own family and community
- Participation—that a child and the child's parents and family members have the right to participate in an administrative or judicial process
  for making a significant decision about a child.
- Partnership—that Aboriginal or Torres Strait islander peoples have the right to participate in significant decisions under the *Child Protection Act 1999* about Aboriginal or Torres Strait Islander children, including the design and delivery of programs and services
- Placement—that if a child is to be placed in care, the child has a right to be placed with a member of the child's family group
- Connection—that a child has a right to be supported to develop and maintain a connection with the child's family, community, culture, traditions and language.

23 The Child Protection and Investigation Unit is the Queensland Police Service unit responsible for the investigation of crimes committed against children.

24 Assessment and Service Connect is a partnership model of working with children subject to a notification of significant harm and their families. Child Safety works in partnership with Assessment and Service Connect-funded service providers to assess and respond to subject children and their families to increase safety. Source: *Child Safety Policy: Assessment and Service Connect*. Policy 636–1.

25 In July 2017, Child Safety and the Queensland Police Service (QPS) committed to undertake a trial of Child Protection Joint Response Teams (CPJRT) in three sites for matters where Child Safety had a reasonable suspicion a child was in need of protection and the QPS considered a related criminal offence may have occurred. On 2 April 2019, the Director-General of Child Safety, approved the state-wide implementation of CPJRT, following an evaluation by Griffith University.

26 Child Safety's regional intake services receive information and child protection concerns from community members and government and non-government agencies during business hours.

27 ICARE (Interviewing Children and Recording Evidence) provides skills and knowledge to conduct forensic interviews with child victims. In this context, forensic interviewing skills refer to the ability to obtain information from a child or about an event in a sensitive and legally defensible way.

28 Child Safety's practice advice suggests ICARE interviews should 'minimise further trauma to the child and collect credible evidence that meets both departmental and QPS legislative and procedural requirements'.

29 The QFCC notes neither the Child Safety Practice Manual nor the Child Safety's Assessment and Service Connect policy provides clear guidance on when to close a case involving Assessment and Service Connect. The Child Safety Practice Manual, page 143, states: The ASC provider is expected to finalise their involvement with the family within 60 days of receiving the request to participate in an ASC co-response. This excludes any period of 'active holding' by the ASC provider while waiting for another service to start working with the family. The active holding period should not extend beyond 60 days of the investigation and assessment being finalised.

30 Some stakeholders expect the Unify Program to deliver benefits and efficiencies, including 'increased ability to evaluate the effectiveness of services to improve service delivery to individual clients and inform future investment decisions', as noted at the Queensland Parliament 2019 Estimates pre-hearing (Question on Notice No. 4. Health, Communities, Disability Services, and Domestic and Family Violence Prevention Committee).

31 Queensland Government 2019, *Aboriginal and Torres Strait Islander Family Participation Program Guidelines*. Draft as at April 2019, page 5.

32 Queensland Government 2017, *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037*, page 8.

33 Department of Child Safety, Youth and Women (2020). Child Safety Practice Manual: Investigation and Assessment.

34 The HALT Collective group intervenes at the point of Child Safety intake to reduce the number of Aboriginal and Torres Strait Islander children and young people entering the tertiary child protection system. It has been operational since November 2018 and is governed by the Brisbane District First Nations Elders Advisory Group.

35 The QFCC notes the individual in this role is highly experienced and long tenured with the department. Both of these facts are deemed critical to the success of the differentiated child safety officer position given the core responsibilities of the role.

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