The Structured Decision Making® System
for Child Protective Services

Queensland
Child Protection Guide

July 2015

NCCD | Children’s Research Center
ACKNOWLEDGEMENTS

This Queensland Child Protection Guide represents the contributions of many individuals whose efforts to develop, review and refine the following decision trees and their definitions are greatly appreciated.

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PURPOSE

The Child Protection Guide (CPG) is an online decision-support tool designed to assist professionals with concerns about a child’s safety or well-being in making decisions regarding where to report or refer their concerns. The expanded use of the guide in Queensland is part of the government’s commitment to build stronger families and provide the right services at the right time to vulnerable families.

The decision to report child protection concerns is not an easy one and the consequences of the decision are considerable. The CPG was co-designed by multiple government departments and non-government agencies to ensure that reporting obligations are met and serious concerns are reported to child safety promptly, whilst also enabling families where less serious concerns exist to access support services without unnecessary statutory intervention.

The CPG supports professionals to make these decisions by:

- Focusing on the critical factors for decision making;
- Clearly identifying the threshold for concerns that require a report to Child Safety;
- Operationalising the legislation to ensure reporting obligations are met;
- Identifying alternative and additional ways to support a family where the concerns do not meet this threshold;
- Providing details of available local support services;
- Providing a consistent and objective framework for analysing concerns; and
- Promoting shared principles, language and thresholds across the system.

If a child has a serious illness or injury requiring immediate medical attention OR a crime has just been or is about to be committed OR a child has just caused or is about to cause serious harm to self or others, first call ‘triple 0’ and ask for the appropriate service to respond to the emergency.

The Queensland Police Service’s fundamental role in child protection is the investigation of criminal offences committed upon or by children. Child Safety is required to immediately advise the police if they reasonably believe alleged harm to a child may involve the commission of a criminal offence relating to the child.

This CPG is intended to complement, not replace, clinical judgement, expertise and critical thinking. The guide should be applied within the professional’s respective agency’s policies and procedures for managing child protection concerns where they exist. The outcome of the CPG does not prevent a professional reporter from any course of action he/she believes is appropriate. Finally, this guide is a dynamic document. Continual evaluation and feedback will be used to refine this manual over time.
PROCEDURES

Which Children
A child is defined under the *Child Protection Act 1999* as an individual under 18 years of age. Use the guide when you have concerns for a child who is accessing a service in Queensland, such as a health service or a school. It is not necessary for the reporter to determine whether the child is a resident of Queensland.

If the information available leads to a recommendation to report, the report may be made to Child Safety – Regional Intake Service (RIS). The child safety officer will be responsible for determining whether the report will be followed up by Queensland’s child protection agency, Child Safety, or reported to another jurisdiction.

When To Use This Guide
Use the guide when, in the course of your employment, you suspect on reasonable grounds that a child has been, is being or is at risk of being significantly harmed and there may not be a parent able and willing to protect the child.

Decision Points
Each path through a decision tree leads to a decision point as described below. After completion of the CPG, you may print the final summary report and save a copy, according to your agency procedures. Specific instructions will also be provided depending on the recommendation outcome.
1. **Report to Child Safety – Regional Intake Service**

   Child Safety – Regional Intake Service (RIS) receives information and child protection concerns from community members, government and non-government agencies during business hours (Monday to Friday, 9 a.m. – 5 p.m.).

   Outside of these hours, the Child Safety After Hours Service Centre (CSAHSC) can be contacted on 1800-177-135 or 07 3235 9999.


   To report child protection concerns, use the contact details below.

<table>
<thead>
<tr>
<th>Intake Service</th>
<th>General Line</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Safety After Hours Service Centre</td>
<td>1800 177 135</td>
<td>07 3235 9898</td>
</tr>
<tr>
<td>Brisbane RIS</td>
<td>1300 682 254</td>
<td>07 3259 8771</td>
</tr>
<tr>
<td>Central Qld RIS</td>
<td>1300 703 762</td>
<td>07 4938 4697</td>
</tr>
<tr>
<td>Far North Qld RIS</td>
<td>1300 684 062</td>
<td>07 4039 8320</td>
</tr>
<tr>
<td>North Coast RIS</td>
<td>1300 703 921</td>
<td>07 5420 9049</td>
</tr>
<tr>
<td>North Qld RIS</td>
<td>1300 706 147</td>
<td>07 4799 7273</td>
</tr>
<tr>
<td>South East RIS</td>
<td>1300 679 849</td>
<td>07 3884 8802</td>
</tr>
<tr>
<td>South West RIS</td>
<td>1300 683 390</td>
<td>07 4616 1796</td>
</tr>
</tbody>
</table>

   Direct lines to RIS are available for use by mandatory reporters including Queensland Health (QH), Department of Education, Training and Employment (DETE), Queensland Catholic Education Commission (QCEC), Independent Schools Queensland (ISQ) and Queensland Police Service.

<table>
<thead>
<tr>
<th>Intake Service</th>
<th>Direct Line</th>
<th>QPS After Hours Line</th>
<th>Fax</th>
<th>Email</th>
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</thead>
<tbody>
<tr>
<td>Child Safety After Hours Service Centre</td>
<td>1300 681 513</td>
<td>1300 682 724</td>
<td>07 3235 9898</td>
<td><a href="mailto:BrisbaneRISIntake@communities.qld.gov.au">BrisbaneRISIntake@communities.qld.gov.au</a></td>
</tr>
<tr>
<td></td>
<td>3235 9901</td>
<td>07 3235 9902</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brisbane RIS</td>
<td>1300 705 339</td>
<td>-</td>
<td>07 3259 8771</td>
<td><a href="mailto:BrisbaneRISIntake@communities.qld.gov.au">BrisbaneRISIntake@communities.qld.gov.au</a></td>
</tr>
<tr>
<td>Central Qld RIS</td>
<td>1300 683 042</td>
<td>-</td>
<td>07 4938 4697</td>
<td><a href="mailto:CQRISIntake@communities.qld.gov.au">CQRISIntake@communities.qld.gov.au</a></td>
</tr>
<tr>
<td>Far North Qld RIS</td>
<td>1300 683 596</td>
<td>-</td>
<td>07 4039 8320</td>
<td><a href="mailto:FNQRISIntake@communities.qld.gov.au">FNQRISIntake@communities.qld.gov.au</a></td>
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<tr>
<td>North Coast RIS</td>
<td>1300 705 201</td>
<td>-</td>
<td>07 5420 9049</td>
<td><a href="mailto:NCRISIntake@communities.qld.gov.au">NCRISIntake@communities.qld.gov.au</a></td>
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<tr>
<td>North Qld RIS</td>
<td>1300 704 514</td>
<td>-</td>
<td>07 4799 7273</td>
<td><a href="mailto:NQRISIntake@communities.qld.gov.au">NQRISIntake@communities.qld.gov.au</a></td>
</tr>
<tr>
<td>South East RIS</td>
<td>1300 678 801</td>
<td>-</td>
<td>07 3884 8802</td>
<td><a href="mailto:SERISIntake@communities.qld.gov.au">SERISIntake@communities.qld.gov.au</a></td>
</tr>
<tr>
<td>South West RIS</td>
<td>1300 683 259</td>
<td>-</td>
<td>07 4616 1796</td>
<td><a href="mailto:SWRISIntake@communities.qld.gov.au">SWRISIntake@communities.qld.gov.au</a></td>
</tr>
</tbody>
</table>

   You should make a report about your concerns to Child Safety – RIS as soon as possible, in accordance with your agency’s procedures. In some instances, you may also need to arrange medical care and/or inform QPS.
Include the following information, to the extent known, in your report and/or information as required by your agency’s policies and procedures:

- A description of the specific circumstances that supported your ‘YES’ or ‘NO’ responses on the decision trees.
- Child/ren’s details (name, DOB, sex, indigenous status/ethnicity, language).
- Parent/carer’s details (name, DOB, sex, indigenous status/ethnicity, language).
- Other household members’ details (name, DOB, sex, indigenous status/ethnicity, language).
- Address.
- Date the concerns were received.
- Concerns.
- Parent/carer’s protective actions or abilities, if known.
- History of previous relevant contact with service.
- Reporting officer’s details (name, position, contact details).

The child safety officer (CSO) will assess the information that you provide, along with information that may be known to Child Safety, to determine one of the following:

- The report does not meet the threshold for a notification; or
- The report is a notification and an investigation and assessment is required.

Irrespective of what Child Safety does, it is important to maintain your professional relationship with the family as far as appropriate and possible.

**ALERT:** When making a report to Child Safety – RIS, include any information you have about the impact of the report on the safety of the child, family or responding worker/officer (e.g. guns or weapons in the home, vicious dog in the home, threat to harm responding worker or officer, threat to retaliate).

2. **Refer to Family and Child Connect** to provide further identification of family needs, engage the family and provide referrals to the appropriate community-based services.

This decision point occurs when the identified concerns have not reached the reporting threshold under the *Child Protection Act 1999*, but children, young people and families are experiencing struggles. These families typically have complex needs requiring multiple, coordinated services in order to prevent problems from escalating and requiring statutory intervention. In these cases, the reporter believes it is
necessary to conduct further identification of family needs prior to determining the most appropriate support service(s) for the family.

Talk to the family about your concerns and seek their consent to provide a referral to a Family and Child Connect. Only reporters from particular prescribed entities may refer a family to Family and Child Connect without the consent of the family.

If the family does not consent to a referral and you are NOT from a particular prescribed entity, you cannot directly refer the family to an intensive family support service. Instead, you should document the decision and monitor and support child well-being as appropriate. You may also provide information regarding services and resources directly to the family.

If you have further concerns about the child, you could also contact Family and Child Connect for information and advice on how to move forward with the family.

3. **Refer to an intensive family support service** that provides case management and holistic supports and services, e.g. Intensive Family Support (IFS) services, Referral for Active Intervention (RAI), Aboriginal and Torres Strait Islander (ATSI) family support services.

This decision point occurs when the identified concerns have not reached the reporting threshold under the *Child Protection Act 1999*, but children, young people and families may be experiencing multiple and/or chronic problems. These families typically have complex and/or multiple needs requiring multiple, coordinated services in order to prevent problems from escalating and requiring statutory intervention.

**Talk to the family about your concerns and seek their consent to provide a referral to a family support service.** Only certain professionals from particular prescribed entities may refer a family to intensive family support services without the consent of the family.

If the family does not consent to a referral and you are not a particular prescribed entity, you can document the decision and monitor and support child well-being as appropriate. You may also provide information regarding services and resources directly to the family.

If the child or family identify as Aboriginal or Torres Strait Islander consult with the family to ascertain if they would prefer to be referred to an Aboriginal or Torres Strait Islander family support service.

4. **Direct referral to services to address the identified needs.**

This decision point occurs when the identified concerns are below the reporting threshold under the *Child Protection Act 1999*, but children, young people and families will benefit from a referral to a secondary service to address the particular identified need(s). These families have a specific need requiring support. However, they do not need an intensive case management approach to support.

Talk to the family about your concerns and seek their consent to provide a referral to the appropriate support service. Only certain professionals from particular prescribed entities may refer a family to a support service without the consent of the family.

If the family does not consent to a referral and you are NOT a particular prescribed entity, you cannot directly refer the family to a secondary service. Instead, you should
document the decision and monitor and support child well-being as appropriate. You may also provide information regarding services and resources directly to the family.

If you intend to refer the family to a secondary service and need assistance locating an appropriate service, you may also consult with Family and Child Connect. You do not need to complete a referral to Family and Child Connect or provide any identifying information to Family and Child Connect. Simply call to explain the type of secondary service you are seeking and any special considerations (i.e. cultural, transportation, language).

If you still have further concerns about the child you could also contact Family and Child Connect for information and advice on how to move forward with the family.

5. **Report not required.**

This decision point occurs when the concerns are substantially below the Child Safety – RIS screening threshold for reasonable suspicion that a child is in need of protection. Though no report is recommended, there may be alternative actions the reporter can take or initiate.

A. **Document decision.** Following your agency protocol, prepare a record of your concerns, including the information that led to your ‘yes’/’no’ answers on the decision tree. If concerns persist or worsen, the information you document can be included in a future consideration of making a report.

B. **Provide referrals as appropriate.** If your non-reportable concerns include an unmet family need, you can and should provide the family with information about local resources. You may respond in a number of ways depending on your knowledge of and relationships with family members. Talk to the family about your concerns and discuss options for support including referrals to appropriate support services. You may also provide information regarding services and resources directly to the family.

If you intend to refer the family to a secondary service and need assistance locating an appropriate service, you may also consult with Family and Child Connect. You do not need to complete a referral to Family and Child Connect or provide any identifying information to Family and Child Connect. Simply call to explain the type of secondary service you are seeking and any special considerations (i.e. cultural, transportation, language).

C. **Monitor and support child well-being as appropriate.** If your professional role includes an ongoing relationship with the child AND/OR parent, it is expected that such a relationship will continue regardless of the reporting decision. It is important to maintain a connection to the family so that if conditions change, you can reconsider your decision not to report. This relationship may include monitoring or creating and maintaining a safe space where the child or parent may make further disclosures about concerns that may exist or disclose new incidents.

If your professional role **does not** include an ongoing relationship with the child AND/OR parent, you are not required to maintain contact.

**NOTE:** Some circumstances are not reportable because they do not meet the threshold and yet the child may experience emotional or physical stress. You may be able to
assist the child in learning coping strategies or accessing suitable services, or to foster trust so that a child will alert you if conditions change.

Consider whether the child and family would benefit from access to other supports or services, provided through school, health, mental health, justice or housing services. The consent of the family should be sought when assistance through a referral is being made or information about a child or their family is being disclosed.

Legislative provisions in regard to information exchange are located in Chapter 5A of the 

RELEASE OF INFORMATION
Generally, if a situation is reportable to Child Safety – RIS, the information that you relied on to answer ‘yes’/’no’ to each question is information that can and should be provided to the Child Safety Officer (CSO). Seeking permission from the child or family to release information is not required as this indemnity is provided under the Child Protection Act 1999.

You can and should also provide any information affecting the safety of the child, other family members or the responding worker. You can and should provide identifying information as well.

If a report is not indicated, but a referral to a Family and Child Connect, intensive family support service or a direct referral to services to address the identified needs is recommended, then consent from the family is required before making these referrals. Certain professionals from particular prescribed entities under section 159M of the Child Protection Act 1999 do not require consent from the family for a referral where the child is likely to become a child in need of protection if no preventative support is provided. However, it is preferable to obtain consent, if possible. If the child has the capacity and is competent to consent to a referral for him/herself or the disclosure of his/her information, the child may do so.

PROCESS FOR COMPLETING THE QUEENSLAND CHILD PROTECTION GUIDE

NOTE: You are encouraged to consult with the child protection advice area within your agency (if you have access to one)—i.e. your Child Protection Liaison Officer (QH), your Child Protection Investigation Unit (CPIU) or your Guidance Officer/Senior Guidance Officer (DETE)—at any time during completion of a decision tree.

1. From the STARTING PAGE, select the decision tree that best represents your concern for the child. If you have more than one concern, start with the most serious concern.

   NOTE: If the decision is ‘report’, it is NOT NECESSARY to complete any additional decision trees. Contact the Department of Communities, Child Safety and Disability Services (Child Safety) and explain ALL of your concerns, even if you did not complete a decision tree for each one.

2. Start with the first question in the selected decision tree. Apply the definition to the information known to you and determine whether a ‘yes’ or ‘no’ answer fits best. Follow the arrow for either ‘yes’ or ‘no’ to the next question or to a decision point. In the online CPG, the definition appears on the right of the screen with every question.

3. Apply the definition provided to EVERY question you are asked.

4. If you arrive at a decision point, proceed to step 6.
5. If you are uncertain whether the best response is ‘yes’ or ‘no’, you should consider the following steps in the order outlined:

a. You may consult with a professional in your agency, e.g. Child Protection Liaison Officer/Child Protection Advisor (QH), Child Protection Investigation Unit (QPS) or Guidance Officer/Senior Guidance Officer (DETE). It is possible that there is another way to consider the answer or that you already have sufficient information that a supervisor/colleague could illuminate.

b. Are any other decision trees relevant? If so, complete those.

c. You (or someone from your agency) may attempt to obtain the information that would determine either a ‘yes’ or ‘no’ answer. This should not be construed as conducting an investigation, but simply as an effort to help make a reporting decision. Whether you do this depends on the piece of information that would help, how easy it would be to gather, your relationship with the child or parent, your comfort and skill in gathering this information, and your agency procedures. You may consult with Child Protection Liaison Officer (QH), Child Protection Investigation Unit (QPS), Guidance Officer/Senior Guidance Officer (DETE) or Child Safety before deciding whether to attempt this step. In some instances, the necessary information will not require talking to family members at all, just checking records or talking with a colleague who may know the family. If you need to speak with the family, limit this to the specific piece of information needed, asking the most open-ended question possible.

d. If, after following the above steps, you lack the information to answer in the direction that leads to a report (usually a ‘YES’ answer), answer in the direction less likely to lead to a report (usually a ‘NO’ answer). A report is required when you have reasonable suspicion a child may be in need of protection. The absence of enough information to answer the questions required is a basis for concluding your suspicion has not reached the level of ‘reasonable suspicion’.

6. The decision point at which you arrive will be one that best flows from your ‘yes’/‘no’ responses. Please treat this as a GUIDE, not a PRESCRIPTION. You may be aware of unique circumstances that were not considered during the course of completing the decision tree. You may:

a. Follow the recommendation;

b. Consider whether to complete an additional decision tree; or

c. Consult with a professional in your agency, e.g. Child Protection Liaison Officer (QH), Child Protection Investigation Unit (QPS) or Guidance Officer/Senior Guidance Officer (DETE).

d. State and non-state school staff should also consider mandatory reporting obligations in relation to sexual abuse or likely sexual abuse in accordance with ss. 364-366B of the Education (General Provisions) Act 2006.
NOTE: Nothing in this guide restricts a professional from contacting the Department of Communities, Child Safety and Disability Services (Child Safety). If you do report, and used the guide, tell the CSO worker about your actual path through the decision tree and the facts that supported your ‘yes’ and ‘no’, as well as any unique circumstances that led you to determine that a report was necessary.
Welcome to the online Queensland Child Protection Guide (CPG).

The Queensland Child Protection Guide (CPG) is a decision-support guide that has been collaboratively developed across both the government and non-government sector led by the Children’s Research Center, USA, to assist professionals to appropriately report or refer families to Department of Communities, Child Safety and Disability Services (Child Safety) or other service providers in a timely manner. The CPG was implemented on 23 January 2012 as a 12 month trial and was subsequently expanded across Queensland to support professionals with decisions around referral pathways for families.

The CPG is intended to complement rather than replace an individual professional’s critical thinking and does not prohibit a professional from any course of action he/she believes is appropriate.

If you become concerned that a child known to you in your professional working capacity is being abused or neglected, or is likely to be abused or neglected, and there may not be a parent able and willing to protect the child from harm, this CPG is a resource to help you make a decision about where and to whom to report or refer a child and his/her family to ensure they receive the supports and services they need in a timely manner.

1. Start on this page.

2. Select the main decision tree that most closely matches the concern(s) you have. If you have more than one concern, start with your most serious concern.

3. After selecting the applicable decision tree, you will be asked questions.

4. It is important to read the accompanying definitions to provide a ‘yes’ or ‘no’ answer until a final recommendation is reached.

5. A decision report can be generated with an explanation of the outcome based on your completion of the decision tree.

6. The decision report may be printed and/or saved for your records.

NOTE:

If a child has a serious illness or injury requiring immediate medical attention OR a crime has just been or is about to be committed OR a child has just caused or is about to cause serious harm to self or others, first call ‘triple 0’ and ask for the appropriate service to respond to the emergency and/or seek immediate medical or mental health care.

When the situation is under control, proceed to using this CPG to guide your
decision, if required.
DECISION TREES

Decision trees for selection include:

- Physical Harm
- Neglect
- Sexual Abuse
- Emotional/Psychological Harm
- Parent Concern
- Pregnant Woman—Unborn Child

If your concern does not fit any of the decision trees and you still have child protection concerns, it is strongly recommended that you seek advice from your supervisor and other internal agency resources.

This guide does not restrict a professional reporter from contacting the Department of Communities, Child Safety and Disability Services (Child Safety) with concerns regarding harm or suspected harm to a child or young person.

<table>
<thead>
<tr>
<th>Decision Tree</th>
<th>Use This When:</th>
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<tbody>
<tr>
<td>Physical Harm</td>
<td>You know of a non-accidental injury to a child that you suspect was caused by a parent or other adult household member.</td>
</tr>
<tr>
<td></td>
<td>You know of actions toward a child by a parent or other adult household member that may have caused or is likely to cause an injury.</td>
</tr>
<tr>
<td></td>
<td>Child was injured, or nearly injured, during a domestic violence incident involving adults.</td>
</tr>
<tr>
<td></td>
<td>NOTE: If any of the above are true, but the person causing harm is a child and/or young person living in the home, the decision to report should be guided by whether the incident was due to neglect: supervision. Please refer to that decision tree. If a child was injured by a non-household member, the issue may be a police matter.</td>
</tr>
<tr>
<td>Neglect</td>
<td>You suspect that a parent is not adequately meeting child needs.</td>
</tr>
<tr>
<td></td>
<td>A child appears neglected.</td>
</tr>
<tr>
<td></td>
<td>A child is a danger to self or others and parents are not supervising or providing care.</td>
</tr>
<tr>
<td>Decision Tree</td>
<td>Use This When:</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sexual Abuse        | • You learn about sexual abuse or have concerns about sexual contact involving a child.  
|                     | • A child has medical findings that indicate a suspicion of sexual abuse.     
|                     | • A child’s behaviour, including sexualised behaviour, makes you worry that he/she may be experiencing sexual abuse. 
|                     | • You are concerned that a child is at risk of sexual abuse.               
|                     | • You are concerned about a child’s problematic sexual behaviour.         |
| Emotional/Psychological Harm | • A child appears to be experiencing emotional/psychological distress that is a result of parental behaviour.  
|                     | • A child is a danger to self or others.                                  
|                     | • You are aware of parent behaviours that are likely to result in significant emotional/psychological harm. |
| Pregnant Woman—Unborn Child | Use this when you are concerned for the welfare of an unborn child after birth.     
|                     | NOTE: Reports related to an unborn child are not mandatory.            
|                     | Whilst reports relating to an unborn child are not mandatory, those with mandatory reporting responsibility should consider the benefits for the mother and unborn child of making a report to:  
|                     | • Enable Child Safety and other agencies to mobilise services for the potential benefit of the mother and unborn child; or  
|                     | • Enable Child Safety to prepare appropriate statutory/protective intervention following the birth of the child. |
| Parent Concern      | You have information that the child is, or is at risk of, being significantly affected by one of the following parent concerns; substance abuse, mental health, intellectual or cognitive disability, domestic violence.  
|                     | NOTE: If child has already experienced abuse or neglect, or is an unborn child, use the relevant abuse/neglect decision tree first. If a report to Child Safety is not indicated using any of those decision trees, you may consider a parent concern decision tree. |

These descriptions will appear if professional reporter selects ‘NEGLECT’.

<table>
<thead>
<tr>
<th>Decision Tree</th>
<th>Use This When:</th>
</tr>
</thead>
</table>
| Supervision         | • A child has been or is going to be alone and is not able to self-care.     
|                     | • A child has been abandoned by his/her parent.                            
|                     | • A child is in a dangerous care arrangement.                              
|                     | • A child is at risk of harm due to inadequate supervision by the parent.  
|                     | • A child is a danger to self or others and parent is not providing supervision. |
| Physical Shelter/Environment | • A child or family is homeless or is at imminent risk of homelessness.     
|                     | • A child is living in or exposed to a dangerous environment.               
|                     | • A child or family is refusing to stay in an available safe place.        
|                     | • A parent is refusing to provide shelter for a child due to child’s disruptive behaviour, including upon release from remand. |
| Nutrition           | • A child is not receiving appropriate nutrition.                           |
| Medical Care – Medical Professionals | • A child has an untreated/inappropriately treated medical condition. There are two trees: one for medical professionals and one for non-medical professionals. |
|                     | • A child has an untreated/inappropriately treated mental health condition. 
|                     | • A child is a danger to self or others and parent is not providing intervention. |
| Mental Health       | • A child appears extremely dirty.                                         
| Hygiene/Clothing    | • A child is wearing clothing that is not adequate for conditions.         
|                     | • A parent is not attending to the child’s need for personal hygiene and/or clothing. |
These descriptions will be displayed if professional reporter selects ‘SEXUAL ABUSE’.

<table>
<thead>
<tr>
<th>Use This When:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Abuse (Age 0&lt;16 years)</td>
</tr>
<tr>
<td>• The child is age 0&lt;16. (Has not reached 16th birthday.)</td>
</tr>
<tr>
<td>Sexual Abuse (Age 16–17 years)</td>
</tr>
<tr>
<td>• The young person is age 16 or 17. (Has not reached 18th birthday.)</td>
</tr>
<tr>
<td>Child Problematic Sexual Behaviour – Self-Directed/Toward Others</td>
</tr>
<tr>
<td>• You are concerned that a child is exhibiting or has exhibited sexual behaviours that are interfering with his/her and/or other children’s sense of safety (physical and psychological), social, emotional and/or academic development.</td>
</tr>
</tbody>
</table>

These descriptions will be displayed if professional reporter selects ‘PARENT CONCERN’.

<table>
<thead>
<tr>
<th>Use this when you do not have information that a child has been injured, neglected or psychologically harmed, however:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
</tr>
<tr>
<td>• A child discloses significant substance use by a parent.</td>
</tr>
<tr>
<td>• You observe a parent to be significantly impaired by substance use.</td>
</tr>
<tr>
<td>• Inappropriate parent substance use is reported to you by a third party.</td>
</tr>
<tr>
<td>• A child is born and there is evidence that the child was exposed to alcohol or drugs.</td>
</tr>
<tr>
<td>• The parent discloses substance use.</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>• A child discloses significant parent mental health concerns.</td>
</tr>
<tr>
<td>• You observe a parent displaying behaviours that may indicate mental health concerns.</td>
</tr>
<tr>
<td>• Parent mental health concerns are reported to you by the parent or a third party.</td>
</tr>
<tr>
<td>Intellectual and Cognitive Disability</td>
</tr>
<tr>
<td>• A child discloses significant parent intellectual or cognitive disability concerns.</td>
</tr>
<tr>
<td>• You observe a parent displaying behaviours that may indicate intellectual or cognitive disability concerns.</td>
</tr>
<tr>
<td>• Parent intellectual or cognitive disability concerns are reported to you by the parent or a third party.</td>
</tr>
<tr>
<td>Domestic Violence</td>
</tr>
<tr>
<td>• You are aware of an incident of domestic violence (observed by you or reported to you) that did not result in injury to a child or psychological harm to a child or relates to an unborn child.</td>
</tr>
<tr>
<td>• You suspect domestic violence, e.g. observations of power/control dynamics or threats of harm to adults in household.</td>
</tr>
</tbody>
</table>
**PHYSICAL HARM**

Are you aware or reasonably suspicious of a current injury? (p. 33)

- Yes
  - Does child or another person (including reporter) say that the injury was caused by parent or other adult household member AND it was not accidental? (p. 34)
    - Yes
      - Are you aware or reasonably suspicious that parent or other adult household member has done any of the following?
        - Used a form of discipline that often results in significant harm;
        - Acted in a dangerous way toward child that is likely to result in significant injury, including during a domestic violence incident;
        - Threatened to kill or cause significant injury to child; and/or
        - Planned a genital mutilation. (p. 40)
    - No
      - Are you aware of or reasonably suspicious that parent or other adult household member has one or more of the following?
        - Chronic or escalating pattern of discipline that results in non-significant injury;
        - Known history of abuse or neglect; and/or
        - Significant circumstances that create volatile behaviour in parent or other adult household member. (p. 42)
  - No
    - Is the injury significant? (p. 35)
      - Yes
        - Seek immediate medical treatment as required. Report to Child Safety – RIS.
      - No
        - Is the injury suspicious OR is the explanation inconsistent OR are there injuries of various ages? (p. 36)
          - Yes
            - Report to Child Safety – RIS.
          - No
            - Report not required. Document decision. Provide referrals as appropriate. Monitor and support child well-being if appropriate.
  - No
    - Are you aware of a pattern of multiple injuries OR is child under age 5 or with a disability OR is child refusing/afraid to go home? (p. 38)
      - Yes
        - Report to Child Safety – RIS.
      - No
        - Does the family have complex and/or multiple needs? (p. 39)
          - Yes
            - Direct referral to services to address the identified needs.
            - Is the family willing to engage in services? (p. 44)
              - Yes
                - Report to Child Safety – RIS.
              - No
                - Go to intensive family support services/Family and Child Connect tree.
          - No
            - Are you aware that family is currently benefiting from services or assistance to address problem? (p. 44)
              - Yes
                - Direct referral to services to address the identified needs.
                - Is the family willing to engage in services? (p. 44)
                  - Yes
                    - Report to Child Safety – RIS.
                  - No
                    - Go to intensive family support services/Family and Child Connect tree.
              - No
                - Report not required. Document decision. Provide referrals as appropriate. Monitor and support child well-being if appropriate.

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NEGLECT: SUPERVISION

Are you aware that the child is currently alone in circumstances that create danger, or is in a dangerous care arrangement or will be in the next few days? (p. 46)

- yes
  - Report to Child Safety – RIS.

- no
  - Are you aware of incidents in which the child has been/is being significantly injured/harmed OR narrowly escaped significant injury because parent was absent or not paying attention to child? (p. 48)
    - yes
      - During the incident(s), did the time the child was alone or the level of inattentiveness exceed reasonable standards given child’s age/development or the conditions? (p. 48)
        - no
          - Does child appear to be significantly affected by:
            - Chronic parent absence or inattentiveness; or
            - Inappropriate care arrangements? (p. 50)
              - yes
                - Does the family have complex and/or multiple needs? (p. 52)
                  - yes
                    - Report not required.
                      - Document decision.
                      - Provide referrals as appropriate.
                      - Monitor and support child wellbeing as appropriate.

                  - no
                    - Go to intensive family support services/ Family and Child Connect tree.

              - no
                - Are you aware that family is refusing or avoiding services OR are you aware of reasons parent would be unable to remedy situation with assistance? (p. 51)
                  - yes
                    - Report to Child Safety – RIS.

                  - no
                    - Go to intensive family support services/ Family and Child Connect tree.

Are you aware of incidents in which the child has been/is being significantly injured/harmed OR narrowly escaped significant injury because parent was absent or not paying attention to child? (p. 48)

- yes
  - During the incident(s), did the time the child was alone or the level of inattentiveness exceed reasonable standards given child’s age/development or the conditions? (p. 48)
    - no
      - Does child appear to be significantly affected by:
        - Chronic parent absence or inattentiveness; or
        - Inappropriate care arrangements? (p. 50)
          - yes
            - Does the family have complex and/or multiple needs? (p. 52)
              - yes
                - Report not required.
                  - Document decision.
                  - Provide referrals as appropriate.
                  - Monitor and support child wellbeing as appropriate.

              - no
                - Go to intensive family support services/ Family and Child Connect tree.

          - no
            - Are you aware that family is currently benefiting from services or assistance to address problem? (p. 51)
              - yes
                - Report not required.
                  - Document decision.
                  - Provide referrals as appropriate.
                  - Monitor and support child wellbeing as appropriate.

              - no
                - Direct referral to services to address the identified needs.
NEGLECT: PHYSICAL SHELTER/ENVIRONMENT

Do you have significant safety concerns for the family/child due to homelessness or risk of homelessness?
OR
Is there imminent danger of serious harm in the current residence? (p. 53)

Are you aware that a child or parent refused or avoided opportunity for any assistance? (p. 54)

Have appropriate accommodations been secured? (p. 54)

Does the family have complex and/or multiple needs? (p. 54)

Are you aware that family is currently benefiting from services or assistance to address problem? (p. 56)

Are you aware that a child OR parent refused or avoided opportunity for any assistance? (p. 57)

Does the family have complex and/or multiple needs? (p. 54)

Does the family have complex and/or multiple needs? (p. 54)

Report to Child Safety – RIS.

Direct referral to services to address the identified needs.

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Go to intensive family support services/ Family and Child Connect tree.

Go to intensive family support services/ Family and Child Connect tree.

Direct referral to services to address the identified needs.

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NEGLECT: NUTRITION

Does child:
- Report persistent hunger;
- Report persistent withholding of food or fluids as a deliberate act;
- Appear thin, frail or listless, or has lost significant weight; or
- Frequently beg/steal/hoard food? (p. 58)

Are you aware that the family is refusing or avoiding services OR are you aware of reasons parent would be unable to remedy situation with assistance? (p. 59)

Are you aware that child:
- Occasionally talks about going without food;
- Occasionally arrives at school without food;
- Presents with stale or inedible food;
- Has difficulty concentrating at school; and/or
- Reports hunger? (p. 59)

Report to Child Safety – RIS.

Go to intensive family support services/ Family and Child Connect tree.

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Are you aware that family is currently benefiting from services or assistance to address problem? (p. 60)

Does the family have complex and/or multiple needs? (p. 61)

Direct referral to services to address the identified needs.

Go to intensive family support services/ Family and Child Connect tree.

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NEGLECT: MEDICAL CARE—MEDICAL PROFESSIONALS

(A medical professional is a person qualified to make a diagnosis and/or treat the condition being reported.)

Does child require medical care for an ACUTE condition for which parents did not provide necessary medical treatment?

OR

Does child have a CHRONIC condition requiring ongoing treatment plan AND the plan is not being followed AND this is likely to result in significant harm?

OR

Does the child have a disability and high medical support needs that are not being met? (p. 62)

Report not required.
• Document decision.
• Provide referrals as appropriate.
• Monitor and support child well-being as appropriate.

Report to Child Safety – RIS.

Does the family have complex and/or multiple needs? (p. 65)

Go to intensive family support services/Family and Child Connect tree.

Is parent’s decision based on conscientious or ideological grounds? (p. 64)

Provide emergency medical care and/or consider any necessary legal action for continuing care/treatment.

Is parent making reasonable effort to address child’s needs? (p. 66)

Have child’s medical needs now been met? (p. 65)

Does the family have complex and/or multiple needs? (p. 65)

Report to Child Safety – RIS.

Go to intensive family support services/Family and Child Connect tree.

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NEGLECT: MEDICAL CARE—NON-MEDICAL PROFESSIONALS

Does child have a physical health condition that appears to require immediate attention but care is not being provided? (p. 67)

yes

Provide first aid and/or seek emergency medical care and advise parent.
Is parent refusing to provide any ongoing medical care? (p. 67)

yes

Report to Child Safety – RIS.

no

Report not required.
- Document decision.
- Inform responding medical staff of parent actions or inactions to this point.

no

Does child have a medical condition or disability that requires an ongoing medical treatment plan that is not being followed? (p. 67)

yes

Is parent making reasonable effort to address child’s needs? (p. 68)

no

Go to intensive family support services/ Family and Child Connect tree.

yes

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

no

Direct referral to services to address the identified needs.

no

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.
NEGLECT: MENTAL HEALTH

Is child/young person suicidal OR has committed or is threatening serious violence OR is causing significant self-harm? (p. 70)

If appropriate, seek emergency services assistance (police/ambulance/mental health), do not leave child unattended and ensure safety of others.

Are child’s mental health symptoms interfering with his/her daily activities, performance, relationships or development? (p. 73)

Are you aware that parents are refusing to provide or access mental health care that the child requires? (p. 71)

Are you aware that lack of required mental health care is due to reluctance, a lack of capacity to participate or unavailability of services? (p. 72)

Are you professionally competent to form an opinion that, if untreated, child’s mental health symptoms will worsen in the next several months? (p. 74)

Does the family have complex and/or multiple needs? (p. 72)

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor child well-being as appropriate.

Go to intensive family support services/Family and Child Connect tree.

Direct referral to services to address the identified needs.
NEGLIGENCE: HYGIENE/CLOTHING

**MEDICAL ONLY**: Does the child have a medical condition caused or exacerbated by inadequate hygiene or clothing? (p. 75)

- yes → Report to Child Safety – RIS.
- no → **NON-MEDICAL STARTS HERE:**

  Is there a pattern or a significant incident where the child is:
  - Filthy/unhygienic; or
  - Inadequately clothed; AND
  - Child is at considerable risk of needing medical care; or
  - Child is significantly affected emotionally and/or behaviourally? (p. 75)

  - yes → Are you aware that the family is refusing or avoiding services OR are you aware of reasons family would be unable to remedy situation with assistance? (p. 77)
    - yes → Report to Child Safety – RIS.
    - no → Go to intensive family support services/Family and Child Connect tree.
  - no → Are you aware that family is currently benefiting from services or assistance to address problem? (p. 79)
    - yes → Go to intensive family support services/Family and Child Connect tree.
    - no → Direct referral to services to address the identified needs.

- no → Is the child filthy or unhygienic or especially inadequately clothed? OR Have you observed that the child’s clothing and/or hygiene needs are frequently not being attended to? OR Does the child exhibit emotions and/or behaviours that indicate he/she is upset, embarrassed or otherwise affected? (p. 78)

  - yes → Report not required.
    - Document decision.
    - Provide referrals as appropriate.
    - Monitor and support child well-being as appropriate.
  - no → Go to intensive family support services/Family and Child Connect tree.

- no → Report not required.
  - Document decision.
  - Provide referrals as appropriate.
  - Monitor and support child well-being as appropriate.

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SEXUAL ABUSE OF A CHILD (AGE 0<16 YEARS)

Has child made a reasonably clear statement of sexual abuse? (p. 81)

OR

Do you have information that child has a sexually transmitted infection or is pregnant and has experienced significant harm? (p. 81)

OR

Have you or someone else witnessed sexual abuse of the child, including photos/videos? (p. 82)

OR

Is there someone with access to the child who is a known sex offender or who appears to be ‘grooming’ the child? (p. 82)

Does the concerning behaviour involve a household member or is there reason to suspect a household member? (p. 82)

Is there a parent who may be able and willing to protect the child from further harm? (p. 83)

Is the child displaying behaviours that are:
- Excessive, secretive, compulsive, coercive, degrading or threatening?
- Characterised by significant age, developmental and/or power differences between the children involved?
- Of concern because of the nature of the activities and the manner in which they occur?
- OR has the child made an indirect statement of sexual abuse? (p. 83)

Report to Child Safety – RIS.*

Would the child or family benefit from support services? (p. 83)

Report to Child Safety – RIS.*

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Go to intensive family support services/ Family and Child Connect tree.

Is the parent currently engaged with support services? (p. 86)

Does the family have complex and/or multiple needs? (p. 87)

Direct referral to services to address the identified needs.

*State and non-state school staff should also consider mandatory reporting obligations in relation to sexual abuse or likely sexual abuse in accordance with ss. 364-366B of the Education (General Provisions) Act 2006.

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SEXUAL ABUSE OF YOUNG PERSON (AGE 16–17 YEARS)

Has young person made a reasonably clear statement of sexual abuse? (p. 88)

OR

Have you or someone else witnessed sexual abuse of the young person, including photos/videos? (p. 88)

OR

Is there someone with access to the young person who is a known sex offender or who appears to be ‘grooming’ the young person? (p. 89)

OR

Is young person engaged in a sexual relationship that is not consensual, is not fully comprehended or suggests an inappropriate power differential or age gap? (p. 89)

OR

Is young person engaged in prostitution or pornography? (p. 90)

Does the concerning behaviour involve a household member or is there reason to suspect a household member? (p. 90)

Is there a parent who may be able and willing to protect the young person from further harm? (p. 90)

Report to Child Safety – RIS.*

Would the young or family benefit from support services? (p. 91)

Yes

Direct referral to services to address the identified needs.*

No

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Report to Child Safety – RIS.*

*State and non-state school staff should also consider mandatory reporting obligations in relation to sexual abuse or likely sexual abuse in accordance with ss. 364-366B of the Education (General Provisions) Act 2006.
CHILD PROBLEMATIC SEXUAL BEHAVIOUR—SELF-DIRECTED/ Toward Others

Is the child behaving in sexual ways that are:
- Excessive, secretive, compulsive, coercive, degrading or threatening?
- Characterised by significant age, developmental and/or power differences between the children involved?
- Of concern because of the nature of the activities and the manner in which they occur? (p. 92)

no

Is the parent able and willing to take appropriate action? (p. 93)

yes

Is the child behaving in sexual ways that are:
- Outside ‘normal’ sexual behaviour in terms of persistence, frequency or inequality in age or developmental abilities?
- Unusual or different for a particular child? (p. 94)

no

Is there information that the parent has taken protective action? (p. 96)

yes

yes

Report not required.*

- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

no

Is the parent able and willing to take appropriate action? (p. 93)

no

yes

Does the family have complex and/or multiple needs? (p. 94)

yes

Report to Child Safety – RIS*.

no

Go to intensive family support services/ Family and Child Connect tree.

no

Direct referral to services to address the identified needs.

*State and non-state school staff should also consider mandatory reporting obligations in relation to sexual abuse or likely sexual abuse in accordance with ss. 364-366B of the Education (General Provisions) Act 2006
EMOTIONAL/PSYCHOLOGICAL HARM

Do you have reason to believe that the child experiences or is exposed to any of the following?
- Chronic/severe domestic and family violence;
- Significant parental mental health and/or substance abuse concerns;
- Parental behaviours that are persistent and/or repetitive and have a significant negative impact on a child’s development, social needs, self-worth or self-esteem;
- Parental criminal and/or corrupting behaviour; and/or
- Parental behaviour that deliberately exposes a child to traumatic events. (p. 97)

Yes

Does the child exhibit emotions and/or behaviours that indicate the child is significantly affected? (p. 98)

Yes

Report to Child Safety – RIS.

No

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

No

Does the child exhibit emotions and/or behaviours that indicate the child is moderately affected? (p. 100)

Yes

Is the child afraid to go/remain home OR are you concerned for the child’s safety at home? (p. 100)

Yes

Report to Child Safety – RIS.

No

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

No

Are the parents willing or do they have the capacity to engage with services/other supports to assist the child and family? (p. 101)

Yes

Go to intensive family support services/
Family and Child Connect tree.

No

Report to Child Safety – RIS.
PREGNANT WOMAN—UNBORN CHILD

Are you aware of a history of significant abuse or neglect of siblings of the unborn child OR have siblings been removed or died in circumstances of abuse or neglect OR does any household member have a history of significant abuse against children? (p. 102)

Are you aware of circumstances that suggest that either parent may be unable to care for baby upon birth?
- Suicidal;
- Self-harming;
- Substance abuse/misuse;
- Mental illness;
- Domestic/family violence;
- Cognitive or intellectual impairment;
- Significant medical condition; and/or
- Homeless. (p. 102)

Are you aware that the pregnant woman has accepted referrals to services to address concerns OR that other family members will provide for child’s safety and care upon birth? (p. 104)

Are you aware of reasons parent would be unable to remedy situation with assistance? (p. 104)

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Report to Child Safety – RIS.
PARENT CONCERN: SUBSTANCE ABUSE

Does the parent’s substance abuse impact, or is it likely to impact, his/her ability to meet the child’s needs and/or does the child’s behaviour indicate a significant impact of parent’s substance abuse concern? (p. 105)

Is there another parent who cares for and protects the child? (p. 107)

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

Are you aware that the family is currently benefiting from services or assistance to address the substance abuse? (p. 108)

Has parent refused or avoided services that reduce risk? (p. 108)

Report to Child Safety – RIS.

Does the family have complex and/or multiple needs? (p. 108)

Direct referral to services to address the identified needs.

Go to intensive family support services/ Family and Child Connect tree.

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PARENT CONCERN: MENTAL HEALTH

Does the parent’s mental health concern impact, or is it likely to impact, his/her ability to meet the child’s needs or does the child’s behaviour indicate the significant impact of parent’s mental health concern? (p. 110)

- yes
  - Is there another parent/caregiver who cares for and protects the child? (p. 112)
    - yes
      - Report not required.
      - • Document decision.
      - • Provide referrals as appropriate.
      - • Monitor and support child well-being as appropriate.
    - no
      - Are you aware that the family is currently benefiting from services or assistance to address the mental illness? (p. 113)
        - yes
          - Report not required.
          - • Document decision.
          - • Provide referrals as appropriate.
          - • Monitor and support child well-being as appropriate.
        - no
          - Has parent refused or avoided services? (p. 113)
            - yes
              - Report to Child Safety – RIS.
            - no
              - Does the family have complex and/or multiple needs? (p. 114)
                - no
                  - Direct referral to services to address the identified needs.
                - yes
                  - Go to intensive family support services / Family and Child Connect tree.

PARENT CONCERN: INTELLECTUAL OR COGNITIVE DISABILITY

Does the parent’s intellectual or cognitive disability impact, or is it likely to impact, his/her ability to meet the child’s needs or does the child’s behaviour indicate the significant impact of parent’s intellectual or cognitive disability? (p. 115)

Are there indicators that another parent can support the parent with an intellectual or cognitive disability to care for and protect the child? (p. 116)

- yes
- no

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child’s well-being as appropriate.

Are you aware that the parent with an intellectual or cognitive disability is currently benefiting from appropriate supports and services? (p. 117)

- yes
- no

Report to Child Safety – RIS.

Has the parent been unable to access appropriate supports and services? (p. 117)

- yes
- no

Report to Child Safety – RIS.

Does the family have complex and/or multiple needs? (p. 118)

- no
- yes

Direct referral to services to address the identified needs.

Go to intensive family support services/ Family and Child Connect tree.
PARENT CONCERN: DOMESTIC VIOLENCE

Has there been an incident of domestic violence where one or more of the following occurred AND a child normally resides in the home?
- Use of weapon (gun, knife, etc.);
- Attempt to strangle/suffocate/kill;
- Serious injury to adult;
- Physical injury to a child;
- Serious threat to harm child/adult/self; and/or
- Significant escalation in pattern of violence. (p. 119)

yes

If appropriate, ensure that police are called and incident is reported.

no

Was a child:
- Attempting to intervene;
- In parent’s arms or close enough proximity to be hurt;
- Significantly emotionally/psychologically distressed by incident(s); and/or
- The subject of a previous unborn child report related to domestic violence? (p. 120)

yes

Report to Child Safety – RIS.

no

Are you aware of the presence of risk factors including:
- Current DVO or family law contact orders;
- Recent/imminent divorce or separation;
- Stalking, extremely controlling behaviour or sexual assault of a parent;
- Aggressor has significant mental health issues or severe alcohol or drug abuse; or
- One or a combination of additional risk factors? (p. 121)

yes

Are you aware that the family is currently benefiting from services or assistance to address domestic violence? (p. 122)

yes

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

no

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.

no

Go to intensive family support services/Family and Child Connect tree.

Does the family have complex and/or multiple needs? (p. 122)

yes

Direct referral to domestic and family violence services.

no

Report not required.
- Document decision.
- Provide referrals as appropriate.
- Monitor and support child well-being as appropriate.
FAMILY AND CHILD CONNECT OR INTENSIVE FAMILY SUPPORT SERVICES

Have you obtained consent from the family to refer directly to services? (p. 124)

- yes
- no

- Is it necessary to conduct further identification of family needs prior to determining the most appropriate support service for the family? (p. 125)

- no
- yes

- Are you from a particular prescribed entity? (p. 124)

- yes
- no

- Family consent is required to refer the family for support. Document your concerns. Also consider:
  - Seeking consent from the family or
  - Providing information to the family about available resources or
  - Monitoring the family.

- Refer to an intensive family support service.
- Refer to Family and Child Connect.
DEFINITIONS

PHYSICAL HARM

Are you aware or reasonably suspicious of a *current* injury?

**ANSWER ‘YES’ IF:**

- You see that a child has an injury ranging from a significant bruise (for example, on torso or head), cut or burn, to a severe injury (including female genital mutilation).

  OR

- You see that a child under age 2 or a child of any age who cannot talk or walk has any injury.

  OR

- You suspect that a child has an injury even if you cannot see it. For example:
  
  » The child is acting as if he/she may have head injuries, such as losing consciousness, blurred vision or stopped breathing.

  » The child is acting as if he/she may have injuries to joints, bones or muscles, such as limping, holding an arm or leg in an awkward position or not bearing weight.

  » The child tells you he/she has an injury that you are unable to see because it is covered by clothing.

  » The child is acting as if he/she may have internal injuries, such as being in pain, vomiting, becoming pale or losing consciousness.

  » The child is acting as if she may have experienced genital mutilation, such as being reluctant to be involved in sports/activities she previously enjoyed, has difficulty toileting or difficulty with menstruation.

  **AND**

- The injury is *current*. Include injuries that are present at this time, including any bruises, regardless of colour. If you are just learning of a prior injury that has already healed, answer ‘no’.

**ANSWER ‘NO’ IF:**

- The child does not appear to have a current injury.

  OR
The child has very minor injuries. Very minor injuries are defined as those that involve only mild redness, minor welts/scratches/abrasions/bruises to arms or legs or brief and minor pain. HOWEVER, any injury to a child under age 2 or a child of any age who is not able to talk or walk should be considered non-minor and result in a ‘YES’ answer to this question.

OR

You are just learning of a prior injury that has already healed.

Does child or another person (including reporter) say that the injury was caused by parent or other adult household member AND it was not accidental?

ANSWER ‘YES’ IF:

- The child has provided an account of the injury. The child’s account is that a parent or other adult household member acted deliberately to cause the injury, or acted in a way that was likely to cause injury even if he/she had not planned in advance to cause injury. If the child states that the injury was accidental, answer ‘no’ even if you remain concerned.

OR

- The child has not provided an account of the injury. The child is nonverbal (too young, developmentally delayed or, for any reason, is not explaining how the injury was caused); however, another person (including the reporter) saw the incident leading to the injury and states that the injury was caused by a parent or other adult household member acting deliberately or recklessly.

EXAMPLES

<table>
<thead>
<tr>
<th>Non-Accidental</th>
<th>Accidental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or other adult household member said he/she was going to hurt child.</td>
<td>Parent or other adult household member injured child while attempting to prevent child from greater danger (bruise on arm from grabbing child to prevent child from running into traffic; grabbing child by the arm whilst bathing or changing nappy to stop child from falling to the floor).</td>
</tr>
<tr>
<td>Parent or other adult household member said he/she was going to teach child a lesson.</td>
<td>Parent or other adult household member inadvertently injured child in the course of routine care.</td>
</tr>
<tr>
<td>Parent or other adult household member hit or shook child hard enough to cause injury even though he/she later said he/she did not mean it and/or was sorry about it.</td>
<td></td>
</tr>
<tr>
<td>Female genital mutilation.</td>
<td></td>
</tr>
<tr>
<td>Injuries are inconsistent with explanation provided.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Adult Household Member</th>
<th>Adult Household Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sibling or other child in the home caused injury.</td>
<td>A legal parent or guardian caused the injury.</td>
</tr>
<tr>
<td>A child outside of the home caused injury.</td>
<td>An adult who lives in the child’s home caused the injury.</td>
</tr>
<tr>
<td>A stranger, teacher, coach, neighbour, relative who does not live with the child or any other adult caused injury.</td>
<td>An adult who lives in the home with a child’s parent with whom child visits caused the injury.</td>
</tr>
</tbody>
</table>

NOTE: If injury is caused by a non-adult household member, consider whether adequate supervision is being provided.
ANSWER ‘NO’ IF:

- Child reports that injury was caused by someone other than parent/other adult household member OR if the injury was caused by a parent or other household member, you have no information that it was intentional.

Is the injury significant?

ANSWER ‘YES’ IF:

- The injury, if untreated, would likely result in death, disfigurement or temporary or permanent loss or impairment of normal functioning. *NOTE: If you are at this question because you answered ‘yes’ to injuries of various ages, this question applies to any of the injuries, not just the current injury.*

  OR

- Child less than 2 years of age has any non-accidental injury.

  OR

- Child has injuries requiring assessment/treatment, but injuries are not life-threatening and not likely to result in temporary or permanent disability or disfigurement.

  OR

- Child has injuries that do not require assessment/treatment; however, do not include very minor injuries. Very minor injuries are defined as those that involve only mild redness or swelling, minor welts/scratches/abrasions or brief and minor pain.

Refer to the following table for examples of significant injuries.

<table>
<thead>
<tr>
<th>Area of Injury</th>
<th>Physician Determined</th>
<th>Non-Physician/Others</th>
</tr>
</thead>
</table>
| Head           | • Skull or facial fractures.  
• Intra-cranial and retinal haemorrhage.  
• Brain oedema.  
• Injuries to eyes/teeth.  
• Anoxic brain injury.  
• Bruises to the pinna. | • Child lost consciousness.  
• Obviously disfigured nose/jaw.  
• Injury to eyes or teeth. For example, eye is swollen shut, child has been blinded, teeth have been broken or knocked out.  
• Bruises or swelling to head, face or ear that require medical assessment or treatment. |
| Neck           | • Cervical fracture.  
• Injury to pharynx/larynx.  
• Ligature marks. | • Bruise or redness that goes around neck.  
• Child is unable to talk normally. |
**Area of Injury** | **Physician Determined** | **Non-Physician/Others**—In most instances a significant injury will require medical assessment and/or treatment, and a physician will determine whether or not the injury is significant. However, a layperson can reasonably conclude that an injury is significant if the following circumstances exist
---|---|---
**Torso** | • Rib or spinal fractures. • Internal organ injuries. • Investigation suggests abdominal trauma. • Bruises: Deep bruises that are consistent with internal injuries even if no internal injuries are present at this time. | • Child is coughing/spitting blood. • Child is in significant back or abdominal pain. • Child is throwing up, or becoming pale or faint. • Bruises to back, sternum or stomach.
**Arms/Legs** | • Broken bones, sprains, dislocations. • Ligature marks. | • Child is holding an arm or leg in an odd position. • Child cannot bear weight.
**Skin** | • Burns: All second- and third-degree. • Lacerations: All lacerations requiring sutures. • Bruises: Deep bruises that are consistent with underlying haematoma. | • Burns that require medical care, including cigarette burns. • Cuts that require stitches. • Bruises to stomach, back or head. • Bruising in non-mobile child, e.g. infant under 6 months or immobile child with a disability. • Bruises or welts that are in the shape of a hand or fist or another object.
**Other** | • Genital damage consistent with female genital mutilation. • Serious damage resulting from circumcision of a boy by an unqualified practitioner. | Female genital mutilation is suspected for a girl who: • Is reluctant to be involved in sports or other physical activities when previously interested; • Has difficulties with toileting or menstruation; and/or • Has long periods of sickness.

ANSWER ‘NO’ IF:
- The child’s injury is less severe than those listed in the table. For example, bruises on an arm or leg that did not require medical treatment.

**Is injury suspicious?**

OR

**Is explanation inconsistent?**

OR

**Are there injuries of various ages?**

ANSWER ‘YES’ IF:
- Injury is suspicious. Suspicious injuries are those that are highly correlated with abuse. In most instances a physician will determine whether or not the injury is suspicious. However, a layperson can reasonably conclude that an injury is suspicious, depending on the symptoms.

Refer to the following table for examples of suspicious injuries.
Area of Injury | Physician | Non-Physician/Others
--- | --- | ---
Head | • Torn frenulum in infant.  
• Bruising to earlobe on both surfaces and underlying scalp.  
• Constellation of injuries consistent with sudden impact.  
• Scalp haematoma. | • Facial bruising to soft tissue of cheek.  
• Two blackened eyes.  
• Cuts to face.  
• Bruising to scalp.  
• Bruise to earlobe. |
Neck | • Bruising to neck. |  
• Multiple bruising/lacerations. |
Torso | • Multiple rib fractures (especially posterior).  
• Fractures to spine. |  
• Spiral/oblique fracture.  
• Corner fractures.  
• Bucket handle tears.  
• Multiple fractures of different ages. |
Arms/Legs |  
• Human bite marks.  
• Loop marks.  
• Multiple linear marks.  
• Marks in the shape of another object.  
• Cigarette or other contact burns in the shape of an object.  
• Stocking pattern burns,*  
• Marks that cover circumference (or nearly so) of a limb or neck.  
• Multiple bruising of different colours (fresh and fading to yellow) that is not on knees, shins, elbows or other common areas for accidental bruising. |
Skin |  
• Actual damage is rarely caused by amount of force reported (e.g. child has sheared cranial blood vessels and report is ‘I just jiggled baby’, or child has skull fracture crossing suture lines and report is child fell off of couch).  
• Report is of single impact but actual damage suggests multiple impacts. |  
• Report is of a fall but visible injuries are to non-prominent soft tissue (e.g. report is that child fell forward, but rather than injury to nose, chin or forehead, injury is to cheek).  
• Report is of single impact (e.g. a fall) but injuries are on two or more surfaces that could not have been injured in single contact (e.g. marks on both left and right jaw). NOTE: A direct blow to nose could cause blackening of both eyes. |

*Stocking pattern burns are those in which the foot or hand is burned, and the line separating burned from non-burned skin is relatively consistent. The burned area looks as if there is a stocking or mitten on the foot or hand. Non-stocking pattern burns have an irregular line separating burned from non-burned skin.

- **Explanation is inconsistent.** The injury is a type that could be accidental or purposely inflicted but the explanation given suggests that the injury was not caused in the manner reported. For example, the developmental age of the child does not match the explanation of the injury, as in the case of an infant who is not able to turn over being reported to have been injured whilst moving about.

Refer to the following table for examples of inconsistent explanations.
Injuries of various ages: There are multiple injuries that appear to have been caused at different times. Timing of injuries is complicated and is primarily a determination made by a physician. Many children/young people experience accidental injuries at different times in their lives, so the mere presence of injuries or healed injuries of different ages is not, in and of itself, sufficient to answer ‘yes’.

ANSWER ‘YES’ IF:

- Skeletal survey shows at least one prior broken bone for which there is no known medical history.
- Skeletal survey shows at least one prior broken bone for which there was a medical history, and in isolation both the current and prior injuries could be considered accidental. However, the chances of each injury being accidental are decreased.

AND/OR

- Child/young person has scars in the shape of loop marks, multiple linear marks, cigarette burns, scars bearing the shape of objects, burn scars in stocking pattern or bearing the shape of objects AND there is no confirmation that prior injuries have been reported to Child Safety. (NOTE: Child Safety will not investigate further if it is confirmed that prior injuries have already been investigated, unless you have new information about the cause of the injuries).

ANSWER ‘NO’ IF:

- Injury is not inherently suspicious OR the history provided by the child/young person and/or others leads to a reasonable conclusion that the cause was accidental, and there are no concerning prior injuries.

Are you aware of a pattern of multiple injuries?

OR

Is child under age five or with a disability?

OR

Is child refusing/afraid to go home?

ANSWER ‘YES’ IF:
• **You are aware of a pattern of multiple injuries.** While the current injury is not significant, the child has had multiple prior injuries.

**FOR EXAMPLE:**

» Medical history showing a pattern of treatment for injuries that were reported to Child Safety.

» Medical history showing a pattern of injuries that, considered individually, were not suspicious, but in combination led the treating physician to suspect abuse.

» On at least one prior occasion, the reporter questioned child about an injury, and while child has consistently denied abuse, one of the following conditions is present:
  - Prior injuries have been suspicious.
  - Child shows other signs of abuse, such as deterioration in school performance, withdrawing or aggressive behaviour.
  - Reporter is aware of a pattern of domestic violence among adults in the home including physical and non-physical violence, or violent criminal and non-criminal acts.

• **Child is under age 5 or has a disability.** Child has not reached his/her 5th birthday OR child is over age 5 but has a developmental disability to the extent that he/she functions below the average for that age range OR child has a disability to the extent that he/she is unable to initiate self-protective behaviours.

• **Child is refusing/afraid to go home.** Child is stating that he/she is afraid to go home at this time. This may be fear of being harmed again or fear of retribution for disclosing abuse. It is not necessary that child specifically states he/she is afraid or refusing to go home if he/she appears extremely anxious (e.g. tearful, shaking, upset stomach). NOTE: If appropriate, child should be kept with reporter until Child Safety is able to respond.

**ANSWER ‘NO’ IF:**

• You have no information about previous injuries, the child is over age 5, has no known disability and the child is not expressing concerns that if he/she goes home he/she will be injured.

**Does the family have complex and/or multiple needs?**

**ANSWER ‘YES’ IF:**

• There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family
violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

**ANSWER ‘NO’ IF:**

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.

**Are you aware of or reasonably suspicious that parent or other adult household member has done any of the following?**

- Used a form of discipline that often results in significant harm.
- Acted in a dangerous way toward child that is likely to result in significant injury, including during a domestic violence incident.
- Threatened to kill or cause significant injury to a child.
- Planned a genital mutilation.

**ANSWER ‘YES’ IF:**

- Parent or other adult household member used a form of discipline that can often result in significant harm. Based on what child states happened, or what reporter or another person saw happen, the parent or other adult household member’s action was likely to cause a significant injury. Include the following:
  - Child was significantly injured but the injury is healed.
  - Reporter does not know whether child was injured.
  - Child escaped significant injury through the child’s own evasive or self-protective actions, the intervention of a third party or chance.

**AND**

- This, in combination with any of the following, was likely to result in significant physical injury:
  - Parent or other adult household member used a *disproportionate degree of force* relative to the child’s age/physical size/physical vulnerability (with or without use of an object).
» Parent or other adult household member hit child in *sensitive areas* such as eyes, head, chest/abdomen.

» Parent or other adult household member was out of control while disciplining child.

» Parent or other adult household member exposed child to extreme heat/cold for sufficient duration to result in serious harm.

**EXAMPLES**

<table>
<thead>
<tr>
<th>Include:</th>
<th>Exclude:</th>
</tr>
</thead>
<tbody>
<tr>
<td>While corporal punishment is not endorsed, it is not prohibited as long as physical force is not applied to any part of the head or neck of a child or any other part of a child’s body in a way that is likely to cause harm to the child that lasts for more than a short period.</td>
<td></td>
</tr>
<tr>
<td>Hit child repeatedly with buckle end of belt that landed on buttock, upper thighs, lower back.</td>
<td>Stinging, but otherwise not injuring, strikes with non-buckle end of belt on buttock.</td>
</tr>
<tr>
<td>Parent or other adult household member was holding child in extremely hot water, but another person intervened within seconds and got child out before child sustained burns.</td>
<td>Parent or other adult household member instantly realised water was too hot and removed child immediately.</td>
</tr>
</tbody>
</table>

- Parent or other adult household member acted in a dangerous way toward child that is likely to result in significant injury, including domestic violence. While parent or other adult household member did not intend to harm child, his/her dangerous behaviour in the child’s presence showed reckless disregard for the child’s safety and it was only due to the child’s protective/evasive behaviour, intervention by a third party or chance that the child was not significantly injured.

**FOR EXAMPLE:**

» Domestic/family violence incidents involving at least one parent or other household member in which child attempts to intervene, is being held by one parent/other adult household member or is close enough to be accidentally injured. Consider the range of potential harm created by parent/other adult household member’s actions. For example, use of a gun means that a child anywhere in the home could have been injured; throwing objects means that a child anywhere in the room could have been injured; a single slap means that a child within arm’s reach could have been injured. Keeping unsecured weapons increases danger.

» Parent or other adult household member was driving under the influence of alcohol or other drugs (and caused or nearly caused an accident) and children/young people were in the car.

- Parent or other adult household member threatened to kill or cause significant injury to child. Parent/other adult household member has stated an intent to kill or cause significant injury to the child in the near future and the reporter
has reasonable belief that without intervention, the child will be significantly harmed. Reasonable belief may be based on any of the following.

» Known history of confirmed or reported abuse by parent or other adult household member.

» Reporter personally knows or has been informed that parent or other adult household member has a history of violent behaviour, substance abuse or mental illness.

» Child exhibits significant fear of parent/other adult household member and/or reports prior instances of being injured by parent/other adult household member.

AND

» Threat is to cause a significant injury and/or use a form of discipline that often results in significant harm.

• Circumstances suggest that genital mutilation is planned.

ANSWER ‘YES’ FOR A GIRL IF:

• She is having a special operation associated with celebrations.

• She is anxious about forthcoming school holidays or a trip to a country that practices female genital mutilation (FGM).

OR

• Older siblings are worried about their sister visiting their country of origin.

ANSWER ‘YES’ FOR A BOY IF:

• A circumcision is planned using an unqualified practitioner.

Does parent/other adult household member have one or more of the following?

• Chronic or escalating pattern of discipline that results in non-significant injury

OR

• Known history of abuse or neglect

OR

• Significant circumstances that create volatile behaviour in parent or other adult household member.

ANSWER ‘YES’ IF:
• Parent or other adult household member has chronic or escalating pattern of discipline that results in minor injury. Though child does not have a current or past significant injury that reached the threshold of concern, the parent or other adult household member regularly uses discipline that causes minor injuries such as redness or swelling to child’s torso, buttocks, arms or legs. Include longer (six months or more) consistent patterns of minor injury as well as patterns of any period where the frequency or severity is increasing. Also include single incidents involving children under the age of 2.

NOTE: In isolation, one incident may not be enough to be a concern, but taken together, they may reach the threshold.

• Known history of abuse/neglect. Reporter knows that a current parent or other adult who is a current household member has abused or neglected a child prior to the current concern. This may be based on knowledge of a confirmed prior report, or knowledge that services were initiated in response to abuse or neglect (for example, family support or other service intervention).

• Significant circumstances that create volatile behaviour in parent or other adult household member.

  » Parent or other adult household member has significant:

    ▪ Alcohol or other drug use. Reporter has information that parent or other adult household member uses alcohol or other drugs to an extent that he/she becomes agitated, volatile, violent;

    ▪ Mental health concerns. Reporter has information that parent or other adult household member is diagnosed with or has symptoms of mental illness that have already increased or are likely to increase aggressive/violent behaviour; or

    ▪ Domestic/family violence. Reporter has information that parent or other adult household member is an aggressor in a violent relationship with another adult.

  » Child has significant behavioural issues. The child persistently acts in ways that escalate parent/other adult household member violence.

NOTE: This does not mean that abuse is the child’s fault. This is simply identifying a behaviour pattern that increases the risk of significant harm.

ANSWER ‘NO’ IF:

• There has been a single incident resulting in minor injury or multiple incidents that never result in any injury.

OR

• There are no circumstances that give risk to volatile behaviour by parent/other adult household member (that is, no known history of abuse/neglect, parent
alcohol or drug abuse, mental health or domestic violence issues) and no significant behavioural issues in child.

Are you aware that family is currently benefiting from services or assistance to address problem?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with parent or other adult household member about your concerns and have provided resources for effective services/interventions, or the family has sought services on their own. This may include parenting classes that focus on discipline, anger management or consultation with relative or mentor about effective parenting.

AND

- Parent/other adult household member has agreed to services or assistance, and based on time elapsed, is making progress toward reducing risk of harm to child. For example, parent/other adult household member is instituting alternative forms of discipline, working on alternatives to violence or addressing contributing factors such as substance abuse, mental health or domestic violence.

ANSWER ‘NO’ IF:

- Parent/other adult household member has refused services, indicated acceptance of services but after a reasonable period of time has not engaged in services or, having engaged in services, is not effectively using services to reduce risk of harm to child.

OR

- You have no information about whether parent/other adult household member has been offered or engaged in services.

Is the family willing to engage in services?

ANSWER ‘YES’ IF:

- You or another person have had a conversation with the parent or other adult household member about your concerns and he/she indicated his/her willingness to engage with a support service.

ANSWER ‘NO’ IF:

- You or another person have had a conversation with the parent or other adult household member about your concerns and the parent/other adult household member has declined the offer of support services.
NEGLECT: SUPERVISION

Are you aware that the child is currently alone in circumstances that create danger, or is in a dangerous care arrangement or will be in the next few days?

ANSWER ‘YES’ IF:

You have information that the child is currently alone or will be alone at some point over the next few days AND, based on the child’s age/developmental level, length of time expected to be alone and circumstances, the child will be in danger. Consider the individual child and ways the parent may have prepared the child to manage independently. Consider the availability of other responsible adults in the community to assist the child if needed.

EXAMPLES:

- A young and/or vulnerable child is found alone on street and cannot provide directions to his/her residence.

- The young and/or vulnerable child is without supervision due to the parent’s refusal to provide supervision OR the parent has stated a clear intention not to provide the child with supervision effective immediately.

- Child is alone in a car in temperatures that create danger. (NOTE: A child may be at risk of significant harm if left in a car during warm or cool temperatures even if windows are left partially open).

- Parent made arrangements for another person who poses a danger to the child to supervise or provide care for the child. For example, someone who is currently under the influence of alcohol or other drugs, mentally ill, intellectually impaired or physically impaired to the extent that he/she cannot meet child’s basic needs or keep child safe; someone who is a known or highly suspected perpetrator of sexual abuse; or someone who has previously caused serious physical harm to children in his/her care.

- A sibling who is present is physically or emotionally abusive to child to the extent that the child has been significantly harmed by the sibling.

- Parent has failed to collect child from agreed upon care arrangements or health/education facility and multiple attempts to contact him/her or nominated/alternative contacts have been unsuccessful OR parent is unwilling to collect child and no alternative arrangement has been/can be made.

Child MAY be considered in danger if left alone in dangerous circumstances dependent on the environmental context, the age and the individual characteristics of the child. For example, a toddler who is unable to swim should not be unattended near water. The greater the environmental risk, the shorter the time a child should be unattended. The circumstances listed provide examples of conditions that, if present, may mitigate risk.

In Queensland, it is a criminal offence to leave a child under 12 unattended for an unreasonable period of time without arranging for the child’s reasonable supervision. However, what is an ‘unreasonable amount of time’ and what is ‘reasonable supervision’
neglect

Supervision

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needs to be considered in each case individually and would depend upon circumstances including the child’s age, level of maturity, the environment the child is in and the circumstances in which the child is left.

This does not mean that a child under 12 must be constantly within sight and hearing of an adult supervisor. The below table provides some guidance about what may generally be considered age- and developmentally-appropriate circumstances and supervision levels.

<table>
<thead>
<tr>
<th>Examples of Circumstances and Appropriate Supervision Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Developmental Age of Oldest Child</td>
</tr>
</tbody>
</table>
| Infant/Toddler | • Parent may leave child briefly unattended when another responsible adult is present.  
• Child is asleep or in safe setting generally within hearing or sight of an adult (e.g. play pen, child seat, protected area) while parent attends to other responsibilities, including self-care.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Preschool | • Parent attends to other responsibilities, including self-care, for periods of time up to approximately 15 minutes as child is asleep or quietly playing in safe circumstances.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 5–7 | • Child is in safe circumstances with an adult present in the household and has been given instructions child is capable of following including remaining where he/she is while parent attends to other responsibilities, including self-care for periods up to one hour.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 8–9 | • There is a back-up responsible adult available to child who is accessible, on call and able to give assistance for periods up to two hours.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 10–13 | • There is a back-up responsible adult available to child.  
• Child has demonstrated ability to self-supervise for periods of time up to 24 hours. |
| Ages 14–15 | • Assess safety based on young person’s capacity to live independently. Refer to ‘Lack of Shelter’ decision tree if needed for periods of time more than 24 hours. |
| Ages 16–17 | • Assess safety based on the level of disability and the nature of the child’s care needs. |

ANSWER ‘NO’ IF:

• Child is not alone or unattended CURRENTLY and there is no known plan for the child to be alone in the next few days.

OR

• Child is, or will be, alone; however, based on child age/developmental status, amount of time and circumstances, the situation (even if undesirable) is not imminently dangerous.
Are you aware of incidents in which the child has been/is being significantly injured/harmed or narrowly escaped significant injury because parent was absent or not paying attention to child?

ANSWER ‘YES’ IF:

Either of the following is true:

- Parent was not present at time of injury/incident.
- Parent was present, but not paying attention to impending danger such as a child walking toward a street, ledge or body of water; a child playing with or near fire or dangerous objects/chemicals/drugs (prescribed or not). Parent’s inattention may be related to being under the influence of legal or illegal substances; depression; or may be due to distraction by television, Internet, reading, conversation, texting, household chores or any other distraction.

AND

Either of the following is true:

- Child was significantly injured/harmed. This includes any injury that required professional medical treatment (or should have received medical treatment, even if treatment was not given or is pending).
  
  Include near drowning, ingestions and injury/harm inflicted by sibling or other child in household.

OR

- An incident occurred that would often result in significant injury/harm, but child escaped harm through intervention by a third party or chance.
  
  The slightest possibility of harm is not sufficient to answer ‘yes’, but answering ‘yes’ does not require certainty. If it is more likely than not that a significant injury would occur, answer ‘yes’. Probability increases with frequency, so that a single, brief episode may have a low chance of injury, but the chances go up as child is left alone/unattended longer/more often.

During the incident(s), did the time the child was alone or the level of inattentiveness exceed reasonable standards given child’s age/development or the conditions?

NOTE: It is understood that no parent has direct attention with a child, even an infant, every minute of the day, and that sometimes tragic accidents happen in brief periods during which attention is directed elsewhere. The fact that an accident occurred while a parent was not looking does not necessarily constitute neglect.

ANSWER ‘YES’ IF:

- Parent was present but did not pay direct attention to child, meaning parent did not look at, interact with or have contact with the child for a period of time
that is unreasonable for child’s age/development and the conditions based on the table below.

OR

- Child was alone for length of time/conditions exceeding guidelines based on the table below. Based on the child’s age/developmental level, length of time expected to be alone and circumstances, the child was in danger.

Child MAY be considered in danger if left alone in dangerous circumstances dependent on the environmental context, the age and the individual characteristics of the child. For example, a toddler who is unable to swim should not be unattended near water. The greater the environmental risk, the shorter the time a child should be unattended. The circumstances listed provide examples of conditions that, if present, may mitigate risk.

In Queensland, it is a criminal offence to leave a child under 12 unattended for an unreasonable period of time without arranging for the child’s reasonable supervision. However, what is an ‘unreasonable amount of time’ and what is ‘reasonable supervision’ needs to be considered in each case individually and would depend upon circumstances including the child’s age, level of maturity, the environment the child is in and the circumstances in which the child is left.

This does not mean that a child under 12 must be constantly within sight and hearing of an adult supervisor. The below table provides some guidance about what may generally be considered age- and developmentally-appropriate circumstances and supervision levels.

<table>
<thead>
<tr>
<th>Age/Developmental Age of Oldest Child</th>
<th>Safe Circumstances</th>
</tr>
</thead>
</table>
| Infant/Toddler                        | • Parent may leave child briefly unattended when another responsible adult is present.  
• Child is asleep or in safe setting generally within hearing or sight of an adult (e.g. play pen, child seat, protected area) while parent attends to other responsibilities, including self-care.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Preschool                             | • Parent attends to other responsibilities, including self-care, for periods of time up to approximately 15 minutes as child is asleep or quietly playing in safe circumstances.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 5–7                              | • Child is in safe circumstances with an adult present in the household and has been given instructions child is capable of following including remaining where he/she is while parent attends to other responsibilities, including self-care, for periods up to one hour.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 8–9                              | • There is a back-up responsible adult available to child who is accessible, on call and able to give assistance for periods up to two hours.  
• Child is left with appropriate adult supervision during the evening while parents are not at home. |
| Ages 10–13                            | • There is a back-up responsible adult available to child.  
• Child has demonstrated ability to self-supervise for periods of time up to 24 hours. |
| Ages 14–15                            | |

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Examples of Circumstances and Appropriate Supervision Levels

<table>
<thead>
<tr>
<th>Age/Developmental Age of Oldest Child</th>
<th>Safe Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 16–17</td>
<td>• Assess safety based on young person’s capacity to live independently. Refer to ‘Lack of Shelter’ decision tree if needed for periods of time more than 24 hours.</td>
</tr>
<tr>
<td>Child with a disability</td>
<td>• Assess safety based on the level of disability and the nature of the child’s care needs.</td>
</tr>
</tbody>
</table>

Does child appear to be significantly affected by chronic parent absence or inattentiveness or inappropriate care arrangements?

ANSWER ‘YES’ IF:

- Child shows significant adverse effects such as the following:

<table>
<thead>
<tr>
<th>Age/Developmental Age of Child</th>
<th>Significant Adverse Effects (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>Recurrent episodes of serious, unintentional injury/harm in circumstances where supervision has been an issue.</td>
</tr>
</tbody>
</table>
| Infant/Toddler                  | • Symptoms of non-organic failure to thrive.  
                                        • Delays reaching developmental milestone and no medical reasons for delay are identified.  
                                        • Child does not seem attached to caregiver.  
                                        • Injuries and accidents related to lack of appropriate supervision. |
| Preschool                       | • Language delays with no other explanation.  
                                        • Child is not learning age-appropriate self-care such as brushing teeth; cannot assist in dressing self. |
| Ages 5–9                        | • Child is not developing social skills.  
                                        • Child is frequently out of control.  
                                        • Child is extremely clingy with other adults. |
| Ages 10–13                      | • Child is getting involved in dangerous, risky and/or illegal behaviours.  
                                        • School refusal. |
| Ages 14–17                      | • Illegal behaviour, high risk sexual activity, alcohol/drug abuse and self-harm.  
                                        • Disengagement from education/training. |

AND

- There is a pattern of parent being persistently inattentive or leaving child alone or in dangerous company. Length of time a child is alone or unattended may be less than timeframes in above tables, but child has been alone/unattended on multiple occasions. This includes a child who is unattended by a parent and creates companionship with others who are having significant and prolonged negative effects on the child (i.e. involving child in significant alcohol or drug use, offending behaviour).

ANSWER ‘NO’ IF:

- Child is not showing significant adverse effects despite periods of parent absence or inattentiveness. Child may express hopes or wishes for increased parent availability; however, child is coping with minimal impact.
Are you aware that the family is refusing or avoiding services OR are you aware of reasons parent would be unable to remedy situation with assistance?

ANSWER ‘YES’ IF:

- You or another person has had a conversation with the parent about the way lack of supervision is adversely affecting child.

AND

- Parent states he/she will not increase the level of supervision.

OR

- After a reasonable period of time parent has continued to provide inadequate supervision.

OR

- You are aware that the parent has substance abuse, mental health or domestic violence issues to the extent that it is unsafe for reporter to have conversation with parent, or after having a conversation with the parent, you become aware that these or other issues exist to an extent that the family is unlikely to engage in non-statutory services.

Are you aware that family is currently benefiting from services or assistance to address problem?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with parent about your concerns and have provided resources for effective services/solutions, or the family has sought services/solutions on their own. This may include child care (formal or informal), solutions to reduce the time parent needs to be away or ways to increase the capability of child for self-care.

AND

- Parent has agreed to services or assistance, and based on time elapsed since services were recommended, is making progress toward reducing risk of harm to child.

ANSWER ‘NO’ IF:

- Parent has indicated acceptance of resources/services but after a reasonable period of time has not engaged in services; or, having engaged in services, is not effectively using services to reduce risk of harm to child.

OR
• You have no information about whether parent has been offered or engaged in resources/services or has attempted solutions.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

• There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

• More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

• The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
NEGLECT: PHYSICAL SHELTER/ENVIRONMENT

Do you have significant safety concerns for the family/child due to homelessness or risk of homelessness?

OR

Is there imminent danger of serious harm in the current residence?

ANSWER ‘YES’ IF:

- The child/family has no residence, or is about to lose their residence AND:
  - The child/family cannot protect child from danger from violent or sexual crime or current harsh weather, or child needs medicine or medical devices that require refrigeration or electricity.
  - The child/family is staying in temporary shelter or housing (e.g. car, boarding house) that exposes them to danger from violent or sexual crime.
  - A child or family who has access to a safe place to stay but who refuses to stay there is considered to have no safe place to stay.

- The physical structure is likely to result in a serious injury or illness to the child in the near future. For example:
  - Exposed electrical wiring;
  - Extremely dangerous objects/materials accessible to the child (e.g. chemicals, power equipment, guns, knives, medication, illegal substances);
  - House has been condemned by an engineer or other appropriate authority;
  - Significant amounts of animal/human faeces litter the premises;
  - Biohazard is present;
  - Child needs medical devices or refrigerated medicine and has no access to electricity; and/or
  - The physical environment exacerbates the child’s existing serious medical conditions.

- NOTE: Families may stay in residences such as caravan parks, shelters, hotels or other atypical environments. Answer ‘yes’ only if these residences create imminent danger according to the definition above.
ANSWER ‘NO’ IF:

- Child/family is sharing a residence with others by mutual agreement and this arrangement is stable.
- Child/family’s current residence does not pose imminent danger of serious harm.

Are you aware that a child or parent refused or avoided opportunity for any assistance?

ANSWER ‘YES’ IF:

- You are aware that the child/family has refused to accept or engage with a service provider to address the concerns about the physical shelter/living conditions.

ANSWER ‘NO’ IF:

- Child/family is engaged with services, even if the family’s choice of service provider is different from what was recommended.

Have appropriate accommodations been secured?

ANSWER ‘YES’ IF:

- Appropriate shelter that will keep the child/family safe has been secured, for at least the next several days whilst longer-term solutions can be found.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;
- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:
Neglect: Physical Shelter/Environment

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.

Has child/family or other household members become significantly ill or injured from structural, or environmental concerns or living conditions?

OR

Are there structural or environmental concerns or living conditions that are likely to cause child significant illness or injury if not resolved?

OR

Is child or family in temporary shelter that is not stable?

ANSWER ‘YES’ IF:

Significant illness or injury:

- You are aware that a child is receiving or has previously received medical treatment for a significant illness or injury that was caused by conditions in the home such as exposure to faecal material, rotting food, insect/rodent infestation or dangerous objects/materials (e.g. poisons, medications, exposure to chemicals).

*NOTE: If you are uncertain whether an illness or injury was CAUSED by conditions in the home, consult with a supervisor or a medical professional.*

- You are aware that an adult is receiving or has previously received medical treatment for any of the above and you know that a child in the household is exposed to the same conditions.

Structural or environmental concerns. The child lives in a residence that is likely to cause significant illness or injury to the child because of any of the following:

- Hygiene is significantly compromised. For example, human or animal faeces/urine is not routinely eliminated; there is insect/rodent infestation; no access to facilities to bathe; no access to facilities to launder.

- Objects/clutter create significant danger. For example, significant fire hazard exists, or child has easy access to dangerous objects/materials such as medications, poisons, rotten food, guns, illicit drugs/alcohol or matches/lighters.

- Sleeping arrangements create serious danger. For example, a newborn baby sleeps on the couch.

Base answer on your direct observations of the residence or credible statements by the child or another person who has seen the residence, or in some instances, on your observations of the RESULTS of exposure to the following. Consider child’s vulnerability (age, development, medical issues). For example, older children can make decisions to avoid
isolated dangers; infants are not expected to crawl or walk; mobile toddlers are exploratory and not aware of danger; children with asthma are more vulnerable to air quality issues.

Homeless/temporary shelter. The child/family does not have a permanent residence and:

- The accommodation places the child in circumstances that are likely to damage the child’s physical/psychological health or threaten safety. Consider:
  - Vulnerability of child (age, development, medical needs);
  - Capability of parent to access resources and protect child; or
  - Environmental safety (physical hazards, exposure to violent and/or sexual crime, climate extremes).

- The accommodation is temporary and not sustainable.

Are you aware that family is currently benefiting from services or assistance to address problem?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with child and/or parent about your concerns and have provided resources for effective services/interventions, or they have sought services on their own. This may include help clearing the residence of dangers, or a relative providing adequate housing.

AND

- Child and/or parent has agreed to services or assistance, and based on time elapsed since services were recommended, is making progress toward reducing risk of harm to child.

ANSWER ‘NO’ IF:

Child and/or parent has refused services; indicated acceptance but after a reasonable period of time has not engaged in services; or having engaged in services, is not effectively using services to reduce risk of harm to child. This may be evidenced by the following:

- Conditions in the residence are not improving.
- Child/family is not in a stable living situation.

Are you aware that a child or parent refused or avoided opportunity for any assistance?

ANSWER ‘YES’ IF:

- You are aware that the child/family has refused to accept or engage with a service provider to address the concerns regarding physical shelter/living conditions.
ANSWER ‘NO’ IF:

- Child/family is engaged with services.
NEGLECT: NUTRITION

Does the child:

- Report persistent hunger;
- Report persistent withholding of food or fluids as a deliberate act;
- Appear thin, frail or listless or has lost significant weight; or
- Frequently beg/steal/hoard food?

ANSWER ‘YES’ IF:

- **Child reports persistent hunger.** Reporter has had contact with or knowledge of child who frequently mentions hunger, appears hungry, or describes routinely inadequate food intake. Children with complex communication needs may have difficulty expressing hunger. Be aware that severe dehydration and malnutrition can inhibit crying.

  **DO NOT REPORT:** A child who is reporting feeling hungry between adequate meals or a child who mentions being hungry but shows no signs of effects of inadequate diet.

- **Child reports persistent withholding of food or fluids as a deliberate act.** Child mentions or reporter otherwise learns that parent routinely withholds meals or limits meals to nutritionally inadequate amounts/types of food for example, only bread and water. ‘Routinely’ suggests that this has happened more than a single incident and is a standard form of discipline or feeding in the household.

  **DO NOT REPORT:** Withholding snacks, sweets or desserts as discipline, or a one-off decision to withhold a meal in a child over the age of 5 who is otherwise healthy.

- **Child appears thin, frail, listless or has lost significant weight.** A child appears to be unusually thin, less energetic than is typical or shows other symptoms of malnutrition including but not limited to thinning hair, bloating abdomen, or bleeding gums, and you are not aware of any known medical condition that could be causing this.

- **Child frequently begs/steals/hoards food.** Child engages in unusual food-seeking behaviours that may include frequently going to others to beg for food; stealing food from classmates or stores; and/or creating caches of food in hiding places that he/she may eat later or may forget.

  **DO NOT REPORT:** Asking for or stealing food where the purpose appears to be unrelated to alleviating unremitting hunger; child keeping some secret snacks or treats.

**NOTE:** If your concern is related to a child who is extremely overweight, answer ‘no’, but encourage family to obtain a medical evaluation. Medical staff will determine whether a report is indicated. If the family will not seek medical evaluation, unless there is a medical condition, even extreme obesity is not likely reportable. You may discuss with your supervisor or consult with Child Safety – RIS.
Are you aware that the family is refusing or avoiding services?

OR

Are you aware of reasons parent(s) would be unable to remedy situation with assistance?

ANSWER ‘YES’ IF:

- You have discussed your concerns about the child with his/her parent and the parent refuses to pursue a medical evaluation or other resources/services;
- Despite reasonable efforts, parent has not engaged in conversation with you about your concerns;
- Parent has agreed to medical evaluation or other resources/services but has not followed through within a reasonable timeframe;
- You have discussed your concerns with the parent and, in the course of the discussion or from any other source, have learned that the parent has significant barriers to accepting available voluntary supports. For example, the parent’s current substance abuse or mental health issues are so severe that he/she will be unable to follow through with provided resources; or
- Based on information available to you, you consider it unsafe for you or for the child to initiate a conversation with the parent about your concerns.

ANSWER ‘NO’ IF:

- You have no information about potential barriers to parent participation in service referrals or the information you have suggests that voluntary remedies are likely to resolve the concern.

OR

- Parent provides plausible explanation for child’s appearance/actions and parent is providing appropriate intervention. For example, child’s appearance is explained as due to underlying disease, or lack of food is due to poverty alone.

OR

- There are barriers such as transportation, language or financial resources that can be addressed with community supports and the parent is willing to accept these supports.

Are you aware that the child:

- Occasionally talks about going without food;
- Occasionally arrives at school without food;
- Presents with stale or inedible food;
• Has difficulty concentrating at school; and/or
• Reports hunger?

ANSWER ‘YES’ IF:

Without a plausible explanation:\

• Child arrives at school with no breakfast, or without lunch and has no means to secure lunch more than just a few times, but shows no other signs of malnutrition;
• Child is provided food, but it is stale or inedible; and/or
• Child is struggling to concentrate or take in new information and there is no reason to believe this is caused by learning disability, attention deficit disorder, emotional distress or other social or environmental causes.

ANSWER ‘NO’ IF:

• There has been a single incident of child going without eating, no more than a few incidents of child arriving at school without lunch, or child’s lack of concentration is likely related to reasons other than lack of nutrition.

\(^{1}\)For example, child is prone to losing his/her lunch money, or is being bullied by theft of lunch or lunch money; family's cultural practice does not include typical 'lunch' but child's nutritional needs are being met.

Are you aware that the family is currently benefiting from services or assistance to address problem?

ANSWER ‘YES’ IF:

• You or another person have already had a conversation with parent about your concerns and have provided resources for effective services/solutions or the family has sought services/solutions on their own. This may include referral to an agency that provides emergency relief funds or food vouchers, advice on child’s nutritional needs, etc.

AND

• Parent has agreed to services or initiated solutions, and based on time elapsed since services were recommended, has engaged in services and is making progress toward improving the child’s nutrition.

ANSWER ‘NO’ IF:

• Parent has indicated acceptance of resources/services but after a reasonable period of time has not engaged in services; or, having engaged in services, is not effectively using services to reduce risk of harm to child.

\(^{1}\)For example, child is prone to losing his/her lunch or lunch money, or is being bullied by theft of lunch or lunch money; family’s cultural practice does not include typical 'lunch' but child’s nutritional needs are being met.
OR

- You have no information about whether parent has been offered or engaged in resources/services or has attempted solutions.

**Does the family have complex and/or multiple needs?**

**ANSWER ‘YES’ IF:**

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

**ANSWER ‘NO’ IF:**

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
NEGLECT: MEDICAL CARE—MEDICAL PROFESSIONALS

Medical professional is someone qualified to diagnose and/or treat the condition being reported.

Does child require medical care for an ACUTE condition for which parents/carers did not provide necessary medical treatment?

OR

Does child have a CHRONIC condition that requires an ongoing treatment plan AND the plan is not being followed (OVER-treating or UNDER-treating, including not keeping medical appointments) AND this is likely to result in significant harm?

OR

Does the child have a disability and high medical support needs that are not being met?

ANSWER ‘YES’ IF:

- The child has an illness or injury.

AND

- If this illness or injury goes untreated, the result will likely be death, disfigurement, loss of bodily function or prolonged significant pain and suffering.

AND

- The parents/carers are providing no care, insufficient care, a lack of timely care or inappropriate care even though the medical professional has explained the concerns to the family, discussed the options, including any religious or ideological grounds for refusal, and the consequences of inaction.

» No care. Parents/carers may or may not be providing home care, but the child’s condition requires immediate professional medical care. Consider whether most parents/carers would seek professional medical care for the same condition and/or whether most physicians would recommend immediate professional medical care. An indicator that home care is inadequate would be that the child’s condition is worsening.

DO NOT REPORT: Illness or injury that would commonly be treated at home even if medical intervention may be helpful (e.g. minor cuts, small first- or second-degree burns, colds and brief episodes of flu or fever in an otherwise healthy child).

» Insufficient care. Parents/carers have sought medical evaluation and care and a physician or other qualified medical professional has
prescribed a treatment plan, but the parents/carers are not following the plan to the extent that the child’s recovery is compromised.

DO NOT REPORT: Deviations from plan that, while not desirable, cannot be demonstrated to have significantly compromised or be likely to significantly compromise child’s recovery. For example, missing a dose of medication with no negative results or missing a follow-up or final check-up when all indications are child was progressing satisfactorily.

- **Inappropriate care.** Parents/carers may have sought medical evaluation and care, but
  - Delayed care to the extent that child’s condition is now critical or child is more likely to have increased suffering or lasting harm, OR;
  - Are adding or substituting alternative treatments that are having or are likely to have a significant and imminent adverse effect on child’s health. Inappropriate health-seeking behaviours may involve unnecessary, invasive medical procedures.

OR

- Child has a medical condition that requires ongoing treatment (e.g. diabetes, asthma, Crohn’s disease, cystic fibrosis, or child requires feeding tube, ventilation or other medical devices).

AND

- Parents/carers are providing no care, inadequate care or inappropriate care.

  - **No care.** Parents/carers are completely disregarding recommended medical treatment plan. They may be providing home or alternative care.

  - **Inadequate care.** Parents/carers are following parts of the medical treatment plan, but are not following substantial portions of the plan.

  - **Inappropriate care.** Parents/carers may be following the medical treatment plan, but are also providing additional interventions that are detrimental to the child. Include parent who seeks repetitive invasive procedures or seeks invasive treatments that are harming rather than helping child who may have no underlying condition.

AND

- As a result, child is experiencing increased pain/suffering OR is at increased risk of acute complications OR ultimate lifespan of child will likely be shortened.

OR
• Child has complex health needs and/or a disability that requires ongoing care including medical care, occupational therapy, physiotherapy, speech therapy, ventilation, or supplemental nutritional feeding that is not being provided to the extent that the child's ability to develop to the best of his/her capacity is being significantly limited.

ANSWER ‘NO’ IF:

• Child’s condition is such that with or without treatment, the outcomes will be similar.

OR

• The proposed treatment is experimental or is not considered to be standard of care.

OR

• While child may fare marginally better with treatment, the burden of treatment is substantial and many parents/carers would opt out of treatment in similar circumstances.

NOTE: Before proceeding to the next question, it is essential to make reasonable efforts to ensure that the parent understands available options and consequences.

Is parent’s decision based on conscientious or ideological grounds?

ANSWER ‘YES’ IF:

• The parent is able to clearly express understanding of the child’s condition, treatment options and consequences of treating vs. not treating AND the parent states that the reason he/she is choosing to not follow the plan is based on religious beliefs or other ideological grounds AND there are no other child protection concerns.

ANSWER ‘NO’ IF:

• Parents are unable and/or unwilling to meet the child’s medical needs and make no claim of religious or ideological basis for their decision.

OR

• Parents profess a conscientious or ideological basis for the decision to not follow the treatment plan, however, medical professional has additional child protection concerns.

NOTE: Provide emergency medical care and/or consider any necessary legal action for continuing care/treatment.
Have child’s medical needs now been met?

ANSWER ‘YES’ IF:

- After providing emergency medical care and/or legal action, all medical needs of the child are met and there are no additional child protection concerns.

ANSWER ‘NO’ IF:

- Emergency care and/or legal remedies have not resolved the child’s ongoing need for medical care, which parents continue to refuse based on conscientious or ideological grounds.

NOTE: If additional child protection concerns remain, please consult the relevant decision tree.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.

Is parent making reasonable effort to address child’s needs?

ANSWER ‘YES’ IF:
Neglect: Medical Care—Medical Professionals

• Parent has been provided clear explanation of child’s condition, available treatment and consequences of lack of treatment AND information available indicates that parent is taking little or no action to follow the treatment plan despite efforts of treatment providers, other professionals or other supports to assist the family to overcome any barriers to following the plan.

ANSWER ‘NO’ IF:

• Parent does not have a clear understanding of the child’s condition, available treatment or the consequences of lack of treatment, but the parent is willing to learn more about child’s condition, treatment options and consequences, or to discuss ways to consistently follow treatment plan.

OR

• Parent is making his/her best efforts to follow the treatment plan, but is experiencing barriers beyond his/her control such as lack of access to services, lack of knowledge about available services, transportation issues or other logistical barriers.
NEGLECT: MEDICAL CARE—NON-MEDICAL PROFESSIONALS

Does the child have a physical health condition that appears to require immediate care but care is not being provided?

ANSWER ‘YES’ IF:

- The child’s condition is in need of immediate medical care that is not being provided. The reporter confirms with Queensland Ambulance Service/medical professional, takes action, and advises parent.

- The parent is stating they do not intend to seek medical care or parent unable to organise care for any reason (e.g. substance abuse, mental illness, developmental disability or cannot understand need for care or cannot make necessary arrangements for care).

ANSWER ‘NO’ IF:

Parent was unable to be contacted at time of decision to seek treatment. There is no evidence of inappropriate parenting behaviour previously.

NOTE: Before proceeding to the next question, provide first aid and/or seek emergency medical care and advise parent.

Is parent refusing to provide any ongoing medical care?

ANSWER ‘YES’ IF:

- The parent is stating that he/she does not intend to seek medical care or evaluation, or parent is unable to organise care for any reason (e.g. parent is intoxicated, mentally ill, developmentally disabled or cannot understand the need for care or cannot make necessary arrangements for care).

ANSWER ‘NO’ IF:

- Parent was not available at the time a decision to seek treatment was needed (e.g. could not be reached by phone in an emergency situation).

Does child have a medical condition or disability that requires an ongoing medical treatment plan that is not being followed?

ANSWER ‘YES’ IF:

- You have information from a reliable source that child has a medical condition or disability and a current treatment plan OR child’s symptoms clearly indicate a significant chronic medical condition and you have consulted with a medical professional who advises that the symptoms you describe suggest a need for professional medical evaluation/intervention.
AND

- You have had a conversation with the parent about your concerns and encouraged him/her to obtain medical evaluation and/or follow existing treatment plan.

AND

- Parent informs you that he/she does not plan to seek medical evaluation or follow a plan OR states he/she will do so, but after a reasonable period of time does not follow through OR, after reasonable efforts to contact parent, you have been unable to do so.

ANSWER ‘NO’ IF:

- No ongoing treatment is necessary. Document previous concerns and monitor child’s well-being.

Is parent making reasonable effort to address child’s needs?

ANSWER ‘YES’ IF:

- Parent does not have a clear understanding of the child’s condition, available treatment or the consequences of lack of treatment but is willing to learn more about child’s condition, treatment options and consequences, or to discuss ways to consistently follow treatment plan.

OR

- Parent is making his/her best efforts to follow the treatment plan, but is experiencing barriers beyond his/her control such as lack of access to services, lack of knowledge about available services, transportation issues or other logistical barriers.

ANSWER ‘NO’ IF:

- Parent has been provided clear explanation of child’s condition, available treatment and consequences of lack of treatment AND information available indicates that parent is taking little or no action to follow the treatment plan despite efforts of treatment providers, other professionals or other supports to assist the family to overcome any barriers to following the plan.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence,
mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

- ANSWER ‘NO’ IF:

  - The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
Is child/young person suicidal OR has committed or is threatening serious violence OR is causing significant self-harm?

ANSWER ‘YES’ IF:

- **Child is suicidal.** Child has recently attempted suicide, has a plan for suicide or has written a suicide note.

  Also include a child who is making comments about suicidal ideas, combined with behaviour changes (such as giving away possessions, not participating in favourite activities, running away) or in the context of significant loss or trauma.

  If you are aware that a child has a history of suicide attempts, a friend or family member who has committed or attempted suicide, or that the child has a mental health diagnosis or a current substance abuse problem, answer ‘yes’ even if suicidal concerns are vague. If you are in doubt, discuss with Child Safety – RIS and/or mental health services.

- **Child has committed or is threatening serious violence.** Child has recently caused death or serious violence, or has a plan to do so.

  Also include a child who is expressing extremely violent ideas, either directly or indirectly stating intent to harm others (e.g. writing/drawing extremely violent themes). Also include a child who is becoming increasingly aggressive and violent.

  If concerns are somewhat vague, answer ‘yes’ if any of the following are also known: Child has a history of harming animals or people; child has a drug problem; child has access to weapons like guns and knives; or child expresses feeling victimised and left out. If in doubt, discuss with Child Safety – RIS and/or mental health services.

- **Child is causing significant self-harm** that requires immediate medical or psychological intervention. Self-harm includes self-inflicted injuries or other self-inflicted physical or psychological damage.

  - **Self-inflicted injuries.** Child has recent injuries and admits inflicting injuries, or the pattern of injuries appears self-inflicted.

  - **Other self-inflicted physical or psychological damage.** Child’s behaviour has caused or is likely to cause serious physical or psychological damage to self. Serious damage requires immediate medical or psychological evaluation or intensive treatment (e.g. acute drug overdose).
For example:

- Child is using alcohol, illegal drugs, prescription drugs or other substances in ways that, based on age, quantity, frequency and duration of use, are likely to cause serious physical or psychological damage, including dependency.

- Child has disrupted eating patterns, such as refusing to eat for prolonged periods to the extent that he/she is losing weight, or child is forcing self to vomit.

- Child demonstrates persistent disregard for his/her own safety in ways that have or are likely to result in serious injury or death.

**NOTE:** If appropriate, seek emergency services assistance (police/ambulance/mental health) and do not leave the child unattended and ensure the safety of others.

**Are you aware that parents are refusing to provide or access mental health care that the child requires?**

**ANSWER ‘YES’ IF:**

- The parent is aware of the child's need for mental health care. You have explained the concerns for the child's mental health to the parent, or have reliable information that the parent has been informed of the concerns.

  **AND**

- You have explained to the parent the benefits of mental health services for the child; and/or explained actions the parent needs to take to support child (e.g. counselling, following through with a behaviour modification plan, providing medication); or you have reliable information that the parent has been informed.

  **AND**

- The parent refuses to provide or access mental health care. You have spoken with the parent and he/she states that he/she will not provide or access mental health care or follow through with recommended actions, or you have reliable information that the parent has refused mental health care.

  **OR**

- The parent is not able to understand the concerns or benefits of mental health services and they refuse to provide or access the required mental health care.
Are you aware that lack of required mental health care is due to reluctance, a lack of capacity to participate or unavailability of services?

ANSWER ‘YES’ IF:

- The child requires parent to take actions that parent is physically, cognitively or emotionally unable to take. (For example, parents/carers are cognitively impaired and do not comprehend a medication plan or behaviour modification plan; or adolescent is able to physically resist parent’s efforts to monitor child).

OR

- The parents/carers are reluctant to seek treatment because of cultural/religious considerations, language barriers and/or social stigma.

OR

- The child is resistant to mental health services that the parent is willing to provide or access.

OR

- The mental health services required by the child are not available, or the family does not know how to access them.

OR

- The mental health services required by the child involve financial cost the family cannot afford.

ANSWER ‘NO’ IF:

- Parents are cooperating with mental health services and providing reasonable services and interventions based on child’s need, even if these services and interventions are not resolving child’s issues.

IF ‘NO’:

- Family would benefit from a family support service. If a family support service is available, inform the family and make a referral. If no service is available, or family refuses, report to Child Safety – RIS.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;
• More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

• The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.

Are child’s mental health symptoms interfering with his/her daily activities, performance, relationships or development?

A child’s mental health symptoms may include depression (e.g. sadness and/or withdrawal), anxiety, eating disorders or early psychotic indicators (e.g. hearing voices, paranoia).

ANSWER ‘YES’ IF:

• **Activities**: Child has stopped or significantly reduced participation in things he/she previously enjoyed; OR child is no longer performing activities of daily living that were once achieved, so that hygiene and/or appearance has deteriorated; OR child is participating in increased risk taking and/or anti-social behaviour that is persistent and not able to be modified through appropriate interventions.

• **Performance**: Child’s performance in social, family or educational settings has declined from a level previously achieved. A child who previously participated in class is no longer participating; a child who excelled in some skill is now performing at a markedly lower level.

• **Relationships**: The child displays inappropriate attachment or has withdrawn from relationships that were previously important, or his/her behaviour jeopardises important relationships, including conflictual, manipulative and/or aggressive behaviours. Include family and non-family relationships (e.g. peers).

• **Development**: The child is no longer performing at a developmental level previously achieved. For example, child who was toilet trained is now soiling or wetting; OR child’s withdrawal from relationships or activities has been prolonged to the extent that he/she is falling behind on developmental milestones.

Are you professionally competent to form an opinion that, if untreated, child’s mental health symptoms will worsen in the next several months?

ANSWER ‘YES’ IF **ALL OF THE FOLLOWING ARE TRUE:**
- You have specific training, qualifications and experience in mental health.
- Child’s mental health symptoms will most likely worsen in next several months if untreated.
- You have had the opportunity to assess the child.
NEGLECT: HYGIENE/CLOTHING

MEDICAL ONLY:
Does the child have a medical condition caused or exacerbated by inadequate hygiene or clothing?

ANSWER ‘YES’ IF:

- The child has a condition that is likely to result in death, disfigurement, loss of bodily function or prolonged significant pain and suffering, AND this illness/injury resulted from or is made worse by poor hygiene or inadequate clothing.

FOR EXAMPLE:
Untreated eczema, multiple insect bites, recurrent skin infection, infected scabies, recurrent UTIs, gastrointestinal infection due to poor hygiene, heat exhaustion, hypothermia.

NON-MEDICAL STARTS HERE:
Is there a pattern or a significant incident where the child is:
Filthy/unhygienic; or
Inadequately clothed; AND
Does child require or likely will require medical care; or
Is child significantly affected emotionally and/or behaviourally?

ANSWER ‘YES’ IF:

Over an extended period of time, there are numerous instances in which the child is filthy or unhygienic, or has inadequate clothing; OR, if child has only been sighted on one occasion, observations suggest that the condition has been present over an extended period of time.

- Filthy or unhygienic:

  » Child is dirty to a point where his/her skin has been stained, i.e. there is obvious discolouration due to the skin not being washed;

  » Child has significant nappy rash, which may be causing bleeding and/or blistering, and parent is not changing the child adequately so that the child is left in a soiled nappy for long periods of time;

  » The child has medical conditions that can be attributed to uncleanliness; for example, boils, scabies, poor oral hygiene or excessive ear discharge to the point that the child’s hearing appears affected;

  » The child has hair that is matted to the point that a comb cannot be run through it, has clumps of hair falling out, and/or persistent head lice infestation that is untreated; and/or

  » The child smells strongly of urine, faeces, menses or putrid smell suggestive of infection.

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Inadequately clothed:

» Considering the child’s chronological and developmental age, the child routinely presents with clothes that are not suitable for the current climate, e.g. wearing a singlet and shorts in winter, and parents have no plausible explanation for this AND no steps have been taken to fix the situation.

» The child’s current clothing could lead to medical issues if not addressed immediately, e.g. developing hypothermia or heatstroke. Take into consideration that children under age 5, or who have a disability, have complex communication difficulties and are unable to express discomfort due to inappropriate clothing. In addition they cannot take action to self-regulate either physiologically or by moving to a more moderate temperature.

AND

• Does child require or is child likely to require medical care? There is a significant risk of illness or injury if the current condition of the child’s clothing or hygiene is unresolved.

OR

• Is child significantly affected emotionally and/or behaviourally? The child has one or more indicators from the ‘Examples of Psychological Harm Indicators’ table that appear related to or exacerbated by hygiene or clothing concerns.

The following table is a guide. Consider consultation with Child Safety – RIS or a professional with expertise in child mental health if you are uncertain. Select the age group that best fits the child’s age, or if child is developmentally delayed, consider the approximate developmental level of the child.

| Examples of Psychological Harm Indicators |
|-------------------------------------------|---------------------------------|---------------------------------|---------------------------------|
| **Infant**                                | **Toddler**                     | **School Age**                  | **Teen**                        |
| • Not responding to cuddling.             | • Regression in toilet training, language or other skills. | • Bed wetting.                  | • Involved in violent relationships. |
| • Not smiling or making sounds.           | • Head banging.                 | • Significant behaviour changes. | • Difficulty maintaining long-term significant relationships. |
| • Losing developmental milestones already achieved. | • Regressive behaviour. |                               |                                 |
| • Inconsolable.                           | • Difficulties sleeping.        |                               |                                 |
| • Head banging.                           |                                 |                               |                                 |
| • Slow weight gain.                       |                                 |                               |                                 |
| • Upset by loud noises, quick movements, displays startle response. | • Self-harming/suicidal/social isolation. | • Constant worry about violence/dangers. |                                 |
| • Withdrawn, not playful and/or play imitates violence between parents/carer. | • Desensitisation to violence. | • Decline in school performance. |                                 |
| • Unusually extreme separation anxiety or no | • Feels worthless about life and him/herself. | |                                 |
Examples of Psychological Harm Indicators

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
</table>
| Separation anxiety.            | • Unable to value others or show empathy.  
|                                 | • Lacks trust in people.              |                                      |                                       |
| • Loss of interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity). |                                      |                                      |                                       |
| • Poor school attendance.      |                                      |                                      |                                       |
| • Extreme anxiety, such as inability to sit still that is NOT related to ADHD/insecure/attention seeking. |                                      |                                      |                                       |
| • Lacks interpersonal skills necessary for age-appropriate functioning. |                                      |                                      |                                       |
| • Extreme insecurity.          |                                      |                                      |                                       |
| • Takes extreme risks; is markedly disruptive, bullying or aggressive, particularly with female teachers. |                                      |                                      |                                       |
| • Avoids adults or is obsessively obsequious/submissive to adults. |                                      |                                      |                                       |
| • Highly self-critical.        |                                      |                                      |                                       |
| • Feelings of hopelessness, misery, despair. |                                      |                                      |                                       |
| • Significant change in child’s personality/behaviour (stopped all social activities, a new pattern of getting involved in fights, failing in school despite history of good performance, becoming involved in offences). |                                      |                                      |                                       |
| • Alcohol or other drug abuse. |                                      |                                      |                                       |
| • Unusual attachment to an adult other than parent. |                                      |                                      |                                       |

More than occasional difficulty sleeping or eating, losing weight, eating compulsively and becoming obese (and/or bulimic).
Episodes of physical complaints for which there is no known physical cause (e.g. stomach aches, headaches)
Flat affect (i.e. rarely smiles or cries).

ANSWER ‘NO’ IF:

- Concerning conditions occur occasionally.
- Conditions caused by child’s hygiene or clothing do not require medical treatment, such as a nappy rash that can be treated with over-the-counter remedies, one-off head-lice infestations that are treated routinely, child is chilled due to minimal clothing in cool weather, but not in danger of hypothermia.
- Child is not adversely affected emotionally.

Are you aware that the family is refusing or avoiding services OR are you aware of reasons family would be unable to remedy situation with assistance?

ANSWER ‘YES’ IF:

- You have discussed your concerns about the child with his/her parent and the parent refuses to accept resources or support and, as a result, the hygiene or inadequate clothing concerns are unresolved;
- Despite reasonable efforts, parent has not engaged in conversation with you about your concerns; or
- Parent has agreed to provide proper hygiene or adequate clothing, but has not followed through within a reasonable timeframe, or has not maintained hygiene or adequate clothing.
ANSWER ‘NO’ IF:

- Parent provides plausible explanation for child’s appearance and is providing appropriate intervention. For example, child’s appearance is explained as due to underlying disease, or lack of hygiene or clothing is due to poverty alone.

IF ‘NO’:

Family would benefit from family support services. If a family support service is available, inform the family and make a referral. If no service is available, or if family refuses, report to Child Safety – RIS.

Is the child filthy or unhygienic or especially inadequately clothed?

OR

Have you observed that the child’s clothing and/or hygiene needs are frequently not being attended to?

OR

Does the child exhibit emotions and/or behaviours that indicate he/she is upset, embarrassed or otherwise affected?

ANSWER ‘YES’ IF:

- Filthy or unhygienic: In situations that would reasonably require a child to be clean and wearing clean clothing, the child appears unwashed and clothing is un laundered;

OR

- Inadequately clothed: In situations that would require clothing to keep the child warm, the child is dressed such that the child is uncomfortably cold, or in situations that would require protection from overheating, the child is dressed in ways that are too warm, or child is wearing clothing that is so large it is hard to keep on properly, or so small it is uncomfortable;

OR

- Clothing and/or hygiene needs are frequently not being attended to: Parent is inattentive to child’s needs for hygiene or adequate clothing on a regular basis;

OR

- Child exhibits emotions and/or behaviours that indicate he/she is upset, embarrassed or otherwise affected. The child expresses that he/she is upset or embarrassed by his/her lack of cleanliness or adequate clothing, or child appears upset or embarrassed. For infants and very young children, answer
‘yes’ if child appears uncomfortable, or adults or peers avoid contact with child due to hygiene.

ANSWER ‘NO’ IF:

- Child appears very dirty in situations that would be expected, such as during and shortly after outdoor play or activities.
- Child is inadequately clothed because of choices the child has made rather than choices the parent has made.

Are you aware that family is currently benefiting from services or assistance to address problem?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with parent about your concerns and have provided resources for effective services/interventions, or the family has sought services on their own. This may include help getting necessary clothing, soaps or shampoos, or learning ways to keep child clean;

  AND

- Parent has agreed to services, and within a reasonable period of time has engaged in services and is making progress toward reducing risk of harm to child.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

  AND

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
SEXUAL ABUSE OF CHILD (AGE 0<16 YEARS)

Use this tree when the child has not reached his/her 16th birthday.

Has child made a reasonably clear statement of sexual abuse?

ANSWER ‘YES’ IF:

The child states (with words, pictures or gestures) that one or more of the following has occurred:

- Any sexual contact including sexual relationships where an inappropriate power differentiation or age gap exists. (Exclude genital contact that is clearly accidental. Exclude sexual contact initiated by another child which is age-consistent exploration. Appropriate responses to age-consistent exploration should be initiated);

- Non-contact abusive behaviours such as flashing, exposing to child, having a child pose or perform in a sexual manner, looking at child’s genitals for sexual gratification, exposure to sexually explicit material or acts, communication of graphic sexual matters (including email or SMS);

- Sexual activity in exchange for money or goods; or

- Child pornography.

NOTE: It is not necessary that the child provide details of time and place, specific actions or specific names.

Do you have information that child has a sexually transmitted infection or is pregnant and has experienced significant harm?

ANSWER ‘YES’ IF:

- You are a medical professional who has diagnosed and/or treated the child for genital trauma, or the child is younger than age 14 and you have diagnosed and/or treated the child for a sexually transmitted infection that you are concerned is the result of harm resulting from sexual abuse or for pregnancy;

- You are a non-medical professional who is aware of a pregnancy in a child younger than age 14, and to the best of your knowledge, no report has been made to the Queensland Police Service or Child Safety – RIS; or

- The child is aged 14–16 years and has a sexually transmitted infection or is pregnant as a result of sexual contact with others of significant age and/or developmental difference or other highly suggestive or suggestive indicators are present as described in the table on page 83.
Have you or someone else witnessed sexual abuse of the child, including photos/videos?

ANSWER ‘YES’ IF:

- You personally observed another person perpetrating sexual abuse to the child;
- A third party witnessed another person perpetrating sexual abuse to the child and told you about it, but to the best of your knowledge this was not reported to Queensland Police Service or Child Safety – RIS; and/or
- You or another person came across photos or videos of the child that are sexually graphic, or viewed communication between child and a third party that is sexually graphic.

Is there someone with access to the child who is a known sex offender, or who appears to be ‘grooming’ the child?

ANSWER ‘YES’ IF:

- You have information that an individual with access to a child is a registered sex offender, was previously convicted of a sexual offence, is currently being investigated or has previously been investigated for a sexual offence against children; and/or
- You have information that an individual with access to a child appears to be ‘grooming’ the child in order to engage the child in a sexual relationship. Grooming is a pattern of behaviour aimed at engaging a child as a precursor to sexual abuse, such as giving the child gifts, developing a close relationship characterized by secrecy or exploiting a child’s loneliness.

Access includes:

» Lives in child’s household;
» Is in an intimate relationship with child’s parent/sibling;
» Is in a trusting relationship with child and family; and/or
» Is given responsibility to supervise child.

Does the concerning behaviour involve a household member or is there reason to suspect a household member?

ANSWER ‘YES’ IF:

- The child has provided specific information about who is perpetrating sexual abuse, and it is, or includes, a parent or household member;

OR

- The child has not specifically named the person(s) who is perpetrating sexual abuse, but also has not specifically stated that a person in his/her household is causing the harm directly (i.e. having sexual contact with the child) or
indirectly (i.e. arranging for sexual contact to occur or knowingly permitting sexual contact to occur).

ANSWER ‘NO’ IF:

- Child clearly states that the only persons perpetrating sexual abuse are not members of the child’s household.

Is there a parent who may be able and willing to protect the child from further harm?

ANSWER ‘YES’ IF:

- You or another person has met with a parent who lives in the home and is aware of the sexual abuse, sexually transmitted infection, pregnancy or sex offender who appears to be grooming the child AND the parent provides a description of ways he/she is acting to protect the child from further harm. For example, parents indicate or are demonstrating the need to pay attention, monitor, supervise, provide sexuality and personal safety education and therapy if required, protection from harm or a legal response.

ANSWER ‘NO’ IF:

- The parent denies that sexual abuse has occurred and does not provide support for the child or the parent acknowledges the abuse but refuses to act protectively to prevent further harm, e.g. does not increase supervision or does not stop access by the known sex offender;

  OR

- You have no information regarding the presence of a parent who may be able and willing to meet the child’s care, well-being and safety needs.

Would the child or family benefit from support services?

ANSWER ‘YES’ IF:

- The parent or child have indicated that they would benefit from engaging with a support service to address therapeutic or educational needs.

ANSWER ‘NO’ IF:

- The child and family are already engaged with support or are not willing to engage with a support service at this time.

Is the child displaying behaviours that are:

- Excessive, secretive, compulsive, coercive, degrading or threatening?
• Characterised by significant age, developmental and/or power differences between the children involved?

• Of concern because of the nature of the activities and the manner in which they occur?

OR

• Has the child made an indirect statement of sexual abuse?

ANSWER ‘YES’ IF:

• The child displays sexual behaviours such as those indicated in the table below, based on child’s age/developmental level.

<table>
<thead>
<tr>
<th>Examples of Child Problematic Severe Sexualised Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 5 Years</td>
</tr>
<tr>
<td>• Simulation of explicit foreplay or sexual behaviour in play.</td>
</tr>
<tr>
<td>• Persistent masturbation.</td>
</tr>
<tr>
<td>• Persistent touching of the genitals of other children.</td>
</tr>
<tr>
<td>• Persistent attempts to touch the genitals of adults.</td>
</tr>
<tr>
<td>• Sexual behaviour between young children involving penetration with objects.</td>
</tr>
<tr>
<td>• Forcing other children to engage in sexual play.</td>
</tr>
<tr>
<td>5–9 Years</td>
</tr>
<tr>
<td>• Persistent masturbation, particularly in front of others.</td>
</tr>
<tr>
<td>• Sexual behaviour engaging significantly younger or less able children.</td>
</tr>
<tr>
<td>• Sneaking into the rooms of sleeping younger children to touch or engage in sexual play.</td>
</tr>
<tr>
<td>• Simulation of sexual acts that are sophisticated for their age, e.g. oral sex.</td>
</tr>
<tr>
<td>• Persistent sexual themes in talk, play, art, etc.</td>
</tr>
<tr>
<td>9–13 Years</td>
</tr>
<tr>
<td>• Persistent masturbation, particularly in front of others.</td>
</tr>
<tr>
<td>• Sexual activity, e.g. oral sex or intercourse.</td>
</tr>
<tr>
<td>• Arranging a face-to-face meeting with an online acquaintance.</td>
</tr>
<tr>
<td>• Sending nude or sexually provocative images of self or others electronically.</td>
</tr>
<tr>
<td>• Coercion of others, including same age, younger or less able children, into sexual activity.</td>
</tr>
<tr>
<td>• Presence of Sexually Transmitted Infection (STI).</td>
</tr>
<tr>
<td>13–18 Years</td>
</tr>
<tr>
<td>• Compulsive masturbation (especially chronic or public).</td>
</tr>
<tr>
<td>• Degradation/humiliation of self or others with sexual themes, e.g. threats, phone, email, touch.</td>
</tr>
<tr>
<td>• Attempt/force others to expose genitals.</td>
</tr>
<tr>
<td>• Preoccupation with sexually aggressive pornography.</td>
</tr>
<tr>
<td>• Sexually explicit talk with younger children.</td>
</tr>
<tr>
<td>• Sexual harassment, forced sexual contact.</td>
</tr>
<tr>
<td>• Sexual contact with others of significant age and/or developmental difference.</td>
</tr>
<tr>
<td>• Sending nude or sexually provocative images of self or others electronically.</td>
</tr>
<tr>
<td>• Joining adults-only online dating service.</td>
</tr>
<tr>
<td>• Sexual contact with animals.</td>
</tr>
<tr>
<td>• Genital injury to others/self.</td>
</tr>
</tbody>
</table>

OR

• Child has made statements that represent a possible disclosure of sexual abuse but statement lacks specificity. For example, ‘I don’t like how Daddy touches me’ or ‘Daddy and I have a secret I am not supposed to tell’.

NOTE: For non-verbal children, signs and symptoms alone can be reported if you are concerned about sexual abuse and no other explanation exists. These complicated situations should be discussed with your supervisor.
ANSWER ‘NO’ IF:

- None of the child’s sexual behaviours are indicated in the table or are of similar seriousness to those listed in the table.

OR

- Child has made statements that lack any detail about where or whether there was any discomfort with the touch (e.g. ‘Daddy touches me’) and where it is highly unlikely that the child means that the contact was sexual.

Is child displaying behaviours that suggest harm resulting from sexual abuse?

Is the child displaying behaviours that are:

- Outside ‘normal’ sexual behaviour in terms of persistence, frequency or inequality in age and developmental abilities?

- Unusual or different for a particular child?

ANSWER ‘YES’ IF:

- The child displays sexual behaviours such as those indicated in the table below, based on child’s age/developmental level.

<table>
<thead>
<tr>
<th>Examples of Child Problematic Moderate Sexualised Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth to 5 Years</strong></td>
</tr>
<tr>
<td>- Preoccupation with adult sexual type behaviour.</td>
</tr>
<tr>
<td>- Pulling other children’s pants down/skirts up against their will.</td>
</tr>
<tr>
<td>- Preoccupation with touching another’s genitals (often in preference to other child-focused activities).</td>
</tr>
<tr>
<td>- Chronic peeping.</td>
</tr>
<tr>
<td>- Following others into toilets to look at them or touch them.</td>
</tr>
<tr>
<td><strong>5–9 Years</strong></td>
</tr>
<tr>
<td>- Questions about sexual activity that persist or are repeated frequently despite an answer being given.</td>
</tr>
<tr>
<td>- Writing sexually threatening notes.</td>
</tr>
<tr>
<td>- Engaging in mutual masturbation.</td>
</tr>
<tr>
<td>- Use of adult language to discuss sex, e.g. ‘Do you think I look sexy?’ or ‘Look at my dolls—they’re screwing’.</td>
</tr>
<tr>
<td><strong>9–13 Years</strong></td>
</tr>
<tr>
<td>- Uncharacteristic behaviour, e.g. sudden provocative changes in dress, mixing with new or older friends.</td>
</tr>
<tr>
<td>- Consistent bullying involving sexual aggression.</td>
</tr>
<tr>
<td>- Pseudo maturity, including inappropriate knowledge and discussion of sexuality.</td>
</tr>
<tr>
<td>- Giving out identifying details to online acquaintances.</td>
</tr>
<tr>
<td>- Preoccupation with chatting online.</td>
</tr>
<tr>
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- Violation of others’ personal spaces.
- Single occurrence of peeping, exposing, non-consenting sexual touch with known peers; pulling skirts up/pants down; mooning and obscene gestures.
- Unsafe sexual behaviour, including unprotected sex, sexual activity while intoxicated, multiple partners and frequent changes of partner.
- Oral sex and/or intercourse (age and developmental ability to give consent must be considered).

ANSWER ‘NO’ IF:
- The child’s sexual behaviours are more consistent with ‘normal’ sexual behaviour for his/her age/development, as indicated in the table below.

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<td>- Consenting oral sex and/or intercourse with a partner of similar age and developmental ability (age and developmental ability to give consent must be considered).</td>
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Is the parent currently engaged with support services?

ANSWER ‘YES’ IF:
- You or another person has had a conversation with parent or other adult household member about your concerns and provided resources for effective services/interventions or the family has sought services on their own.
ANSWER ‘NO’ IF:

- You have no information about whether parent/other adult household member has been offered or engaged in services.

**Does the family have complex and/or multiple needs?**

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
SEXUAL ABUSE OF YOUNG PERSON (AGE 16–17 YEARS)

Use this tree when the child has reached his/her 16th birthday but not his/her 18th birthday.

Has young person made a reasonably clear statement of sexual abuse?

ANSWER ‘YES’ IF:

The young person states (with words, pictures or gestures) that one or more of the following has occurred:

- Any unwanted sexual contact. (Exclude genital contact that is clearly accidental. Exclude sexual contact initiated by another child/young person which is age-consistent exploration. Appropriate responses to age-consistent exploration should be initiated).

- Any unwanted non-contact abusive behaviours such as flashing, exposing to young person, having a young person pose or perform in a sexual manner, looking at young person’s genitals for sexual gratification, exposure to sexually explicit material or acts, communication of graphic sexual matters (including email or SMS).

- ‘Unwanted’ can be determined by the young person stating it was unwanted or from indications that the contact occurred in a context of force, coercion or exploitation.

NOTE: It is not necessary that the young person provide details of time and place, specific actions or specific names.

Have you or someone witnessed sexual abuse of the young person, including photos/videos?

ANSWER ‘YES’ IF:

- You personally observed another person perpetrating sexual abuse* to the young person.

- A third party witnessed another person perpetrating sexual abuse* to the young person and told you about it, but to the best of your knowledge, this was not reported to Queensland Police Service or Child Safety – RIS.

*Sexual abuse for the purpose of this definition includes:

» Any unwanted sexual contact. (Exclude genital contact that is clearly accidental. Exclude sexual contact initiated by another child/young person which is age-consistent exploration. Appropriate responses to age-consistent exploration should be initiated).
» Any unwanted non-contact abusive behaviours such as flashing, exposing to young person, having a young person pose or perform in a sexual manner, looking at young person’s genitals for sexual gratification, exposure to sexually explicit material or acts, communication of graphic sexual matters (including email or SMS).

- You or another person came across photos or videos of the young person that are sexually graphic, or viewed communication between child and a third party that is sexually graphic.

**Is there someone with access to the young person who is a known sex offender or appears to be ‘grooming’ the young person?**

**ANSWER ‘YES’ IF:**

- You have information that an individual with access to a young person is a registered sex offender, was previously convicted of a sexual offence, has been charged but not convicted of a sexual offence or is currently being investigated or has previously been investigated for a sexual offence against children.

- You have information that an individual with access to a young person appears to be ‘grooming’ the young person in order to engage the young person in a sexual relationship. ‘Grooming’ is a pattern of behaviour aimed at engaging a young person as a precursor to sexual abuse such as giving the young person gifts, developing a close relationship characterised by secrecy, exploiting a young person’s loneliness.

Access includes:

- Lives in young person’s household;
- Is in an intimate relationship with young person’s parent/sibling;
- Is in a trusting relationship with young person and family; or
- Is given responsibility to supervise young person.

**Is young person engaged in a sexual relationship that is not consensual, is not fully comprehended or suggests an inappropriate power differential or age gap?**

**ANSWER ‘YES’ IF:**

Young person is involved in a sexual relationship that the young person characterises as consensual; however, at least one of the following is present:

- The partner of the young person is an adult. (Use discretion when considering individuals who have recently turned 18 years of age);

- The partner of the young person is in a position of responsibility or authority over the young person or is related to the young person; and/or
• The young person does not seem to fully understand the sexual nature of the relationship or the consequences of sexual contact.

Is young person engaged in prostitution or pornography?

• Does young person exchange sexual activities for something of value? It does not matter whether the young person or another person gains the value.

AND/OR

• Does the young person create, or is the young person depicted in, materials of a sexually graphic nature?

Does the concerning behaviour involve a household member or is there reason to suspect a household member?

ANSWER ‘YES’ IF:

• The young person has provided specific information about who is perpetrating sexual abuse and it is, or includes, a parent or household member.

OR

• The young person has not specifically named the person(s) who is perpetrating sexual abuse, but also has not specifically stated that a person in his/her household is perpetrating sexual abuse directly (i.e. having sexual contact with the young person) or indirectly (i.e. arranging for sexual contact to occur or knowingly permitting sexual contact to occur).

ANSWER ‘NO’ IF:

Young person clearly states that the only persons perpetrating sexual abuse are not members of the young person’s household.

Is there a parent who may be able and willing to protect the young person from further harm?

ANSWER ‘YES’ IF:

• You or another person has met with a parent who lives in the home and is aware of the sexual abuse, sexually transmitted infection, pregnancy or sex offender who appears to be grooming the young person AND the parent provides a description of ways he/she is acting to protect the young person from further harm. For example, parents indicate or are demonstrating the need to pay attention; monitor; supervise; provide sexuality and personal safety education and therapy, if required; protection from harm or a legal response.
ANSWER ‘NO’ IF:

- The parent denies that sexual abuse has occurred and does not provide support for the young person or the parent acknowledges the abuse but refuses to act protectively to prevent further harm, e.g. does not increase supervision or does not stop access by the known sex offender.

OR

- You have no information regarding the presence of a parent who is able and willing to meet the young person’s care, well-being and safety needs.

Would the young person or family benefit from support services?

ANSWER ‘YES’ IF:

- The parent or young person have indicated that they would benefit from engaging with a support service to address therapeutic or personal safety educational needs.

ANSWER ‘NO’ IF:

- The young person and family are already engaged with support or are not willing to engage with a support service at this time.
CHILD PROBLEMATIC SEXUAL BEHAVIOUR – SELF-DIRECTED/TOWARD OTHERS

NOTE: Use this decision tree when you are concerned that a child is displaying sexual behaviour that is interfering with the child’s or other children’s sense of safety, social, emotional and educational development.

Consider whether the child displaying the problematic sexual behaviour has him/herself experienced sexual abuse or been exposed to inappropriate sexual practices, images or other materials within or outside his/her family or care environment or to physical or emotional abuse, domestic violence and/or neglect.

Is the child behaving in sexual ways that are:

- Excessive, secretive, compulsive, coercive, degrading or threatening?
- Characterised by significant age, developmental and/or power differences between the children involved?
- Of concern because of the nature of the activities and the manner in which they occur?

OR

- Has the child made an indirect statement of sexual abuse?

ANSWER ‘YES’ IF:

- The child displays sexual behaviours such as those indicated in the table below, based on child’s age/developmental level.

### Examples of Child Problematic Severe Sexualised Behaviours

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Behaviours</th>
</tr>
</thead>
</table>
| Birth to 5 Years | - Simulation of explicit foreplay or sexual behaviour in play.  
- Persistent masturbation.  
- Persistent touching of the genitals of other children.  
- Persistent attempts to touch the genitals of adults.  
- Sexual behaviour between young children involving penetration with objects.  
- Forcing other children to engage in sexual play. |
| 5–9 Years | - Persistent masturbation, particularly in front of others.  
- Sexual behaviour engaging significantly younger or less able children.  
- Sneaking into the rooms of sleeping younger children to touch or engage in sexual play.  
- Simulation of sexual acts that are sophisticated for their age, e.g. oral sex.  
- Persistent sexual themes in talk, play, art, etc. |
| 9–13 Years | - Persistent masturbation, particularly in front of others.  
- Sexual activity, e.g. oral sex or intercourse.  
- Arranging a face-to-face meeting with an online acquaintance.  
- Sending nude or sexually provocative images of self or others electronically.  
- Coercion of others, including same age, younger or less able children, into sexual activity.  
- Presence of Sexually Transmitted Infection (STI). |
Examples of Child Problematic Severe Sexualised Behaviours

| 13–18 Years | • Compulsive masturbation (especially chronic or public).  
• Degradation/humiliation of self or others with sexual themes, e.g. threats, phone, email, touch.  
• Attempt/force others to expose genitals.  
• Preoccupation with sexually aggressive pornography.  
• Sexually explicit talk with younger children.  
• Sexual harassment, forced sexual contact.  
• Sexual contact with others of significant age and/or developmental difference.  
• Sending nude or sexually provocative images of self or others electronically.  
• Joining adults-only online dating service.  
• Sexual contact with animals.  
• Genital injury to others/self. |

OR

• Child has made statements that represent a possible disclosure of sexual abuse but statement lacks specificity. For example, ‘I don’t like how Daddy touches me’ or ‘Daddy and I have a secret I am not supposed to tell’.

NOTE: For non-verbal children, signs and symptoms alone can be reported if you are concerned about sexual abuse and there is no other explanation. These complicated situations should be discussed with your supervisor.

ANSWER ‘NO’ IF:

• None of the child’s sexual behaviours are indicated in the table, or of similar seriousness to those listed in the table.

OR

• Child has made statements that lack any detail about where or whether there was any discomfort with the touch (e.g. ‘Daddy touches me’) and it is highly unlikely that the child means that the contact was sexual.

Is there a parent able and willing to take appropriate action?

ANSWER ‘YES’ IF:

• You or another person has met with a parent who lives in the home to discuss the problematic sexual behaviours AND the parent indicates an ability and willingness to engage with appropriate services to protect the child from experiencing these behaviours.

ANSWER ‘NO’ IF:

• You have discussed your concerns about the child with his/her parent and the parent refuses to accept resources or support or parent has agreed to engage with services, but has not followed through within a reasonable timeframe, and, as a result, the problematic sexual behaviours continue;
• Despite reasonable efforts, parent has not engaged in conversation with you about your concerns.

OR

• You have no information regarding the presence of a parent who is able and willing to meet the child’s care, well-being and safety needs.

**Does the family have complex and/or multiple needs?**

**ANSWER ‘YES’ IF:**

• There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

• More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

**ANSWER ‘NO’ IF:**

• The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.

**Is the child behaving in sexual ways that are:**

• Outside ‘normal’ sexual behaviour in terms of persistence, frequency or inequality in age and developmental abilities?

• Unusual or different for a particular child?

**ANSWER ‘YES’ IF:**

• The child displays sexual behaviours such as those indicated in the table below, based on child’s age/developmental level.
### Examples of Child Problematic Moderate Sexualised Behaviours

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<th>Age</th>
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<td>• Pulling other children’s pants down/skirts up against their will.</td>
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<td>• Explicit sexual conversation using sophisticated or adult language.</td>
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<td>• Preoccupation with touching another’s genitals (often in preference to other child-focused activities).</td>
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<td>• Chronic peeping.</td>
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<td>• Following others into toilets to look at them or touch them.</td>
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<td>5–9 Years</td>
<td>• Questions about sexual activity that persist or are repeated frequently, despite an answer being given.</td>
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<td>• Writing sexually threatening notes.</td>
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<td>• Engaging in mutual masturbation.</td>
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<td>• Use of adult language to discuss sex, e.g. ‘Do you think I look sexy?’ or ‘Look at my dolls—they’re screwing’.</td>
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<td>9–13 Years</td>
<td>• Uncharacteristic behaviour, e.g. sudden provocative changes in dress, mixing with new or older friends.</td>
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<td>• Consistent bullying involving sexual aggression.</td>
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<td>• Pseudo maturity, including inappropriate knowledge and discussion of sexuality.</td>
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- The child’s sexual behaviours are more consistent with ‘normal’ sexual behaviour for his/her age/development, as indicated in the table below.

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            • Exhibitionism, e.g. flashing or mooning amongst same age peers.  
            • Increased need for privacy.  
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            • Use of Internet to chat online. |
| 13–18 Years | • Sexually explicit conversations with peers.  
                • Obscenities and jokes within the cultural norm.  
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                • Interest in erotica.  
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                • Solitary masturbation.  
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                • Sexual activity including hugging, kissing, holding hands, foreplay, mutual masturbation.  
                • Consenting oral sex and/or intercourse with a partner of similar age and developmental ability (age and developmental ability to give consent must be considered). |

**Is there information that the parent has taken appropriate action?**

**ANSWER ‘YES’ IF:**

• Parent provides a description of ways he/she is acting to protect the child from experiencing and/or displaying problematic sexual behaviour. For example, parent indicates or demonstrates the need to pay attention; monitor; supervise; provide sexuality and personal safety education and therapy, if required; protection from harm or a legal response.

**ANSWER ‘NO’ IF:**

• You have no information regarding the presence of a parent who is currently responding protectively to address problematic sexual behaviour.
EMOTIONAL/PSYCHOLOGICAL HARM

Do you have reason to believe that the child experiences or is exposed to any of the following?

- Chronic/severe domestic and family violence.
- Significant parental mental health and/or substance abuse concerns.
- Parental behaviours that are persistent and/or repetitive and have a significant negative impact on a child’s development, social needs, self-worth or self-esteem.
- Parental criminal and/or corrupting behaviour.
- Parental behaviours that deliberately expose a child to traumatic events.

ANSWER ‘YES’ IF:

Child or another person has told you, or you have observed the presence of any of the following conditions in child’s home.

- Child’s parent(s) are in a violent/abusive relationship that is chronic and/or severe.
  - Violent: Physical altercation(s) that have already occurred, are occurring or are threatened;
  - Abusive: May include verbal, demeaning, stalking, controlling behaviour or threats of harm;
  - Chronic: Pattern of ongoing incidents; and/or
  - Severe: Resulted in an injury to any participant or bystander that required medical care, or that involved use of a dangerous weapon (e.g. gun, knife, throwing an object heavy enough to cause an injury requiring medical care).

- Parent has a mental health and/or substance abuse concern that is apparent in behaviours such as the following:
  - Parent has a distorted perception of reality;
  - Parent does not provide emotional support for the child;
  - Parent threatens or attempts suicide, homicide, harms pets; and/or
  - Parent’s behaviour is extremely erratic.

- Parent’s behaviour is characterised by persistently and severely criticising, punishing or demeaning/scapegoating child. This requires a pattern of behaviour. A single observation (e.g. observing severe demeaning of child by parent) may be included if you have no prior contact with family and are unlikely to have continuing contact IF the single incident is severe.
Criticising: There is a pattern in which virtually everything the child does is criticised and there is little or no praise to balance the criticism, and the criticism is not constructive or helpful, but rather is personally attacking;

Punishing: There is a pattern in which child is nearly always under punishment; punishment is meted out for minor infractions or for behaviours that are within expected child behaviour for age/development; or punishment is emotionally brutal (physical brutality should be considered under physical harm). This includes threats of harm, threats of abandonment, isolation, etc.;

Demeaning: Parent publicly humiliates child; and/or

Scapegoating: Blaming child for circumstances in the family that are not the fault of the child, or consistently accusing one child of fault for incidents that were caused by other household members.

- Parent engages in illegal behaviour and exposes or involves child in this behaviour.
- Parent knowingly allows or forces a child to observe traumatic events either live or depicted. For example, kills a pet in front of the child; harms self or others in front of child.

Does the child exhibit emotions and/or behaviours that indicate the child is significantly affected?

ANSWER ‘YES’ IF:

- You suspect the parent’s behaviour has contributed to or exacerbated the child’s emotional/behavioural harm.

OR

- The child has one or more indicators from the ‘Examples of Emotional/Psychological Harm Indicators’ table.

The following table is a guide only. These behaviours may be age/developmentally appropriate or there may be an alternative explanation for these behaviours other than emotional/psychological harm.
### Examples of Psychological Harm Indicators

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not responding to cuddling.</td>
<td>• Regression in toilet training, language or other skills.</td>
<td>• Bed wetting.</td>
<td>• Involved in violent relationships.</td>
</tr>
<tr>
<td>• Not smiling or making sounds.</td>
<td>• Head banging.</td>
<td>• Significant behaviour changes.</td>
<td>• Difficulty maintaining long-term significant relationships.</td>
</tr>
<tr>
<td>• Losing developmental milestones already achieved.</td>
<td>• Regressive behaviour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inconsolable.</td>
<td>• Difficulties sleeping.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Head banging.</td>
<td>• Inconsolable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Slow weight gain.</td>
<td>• Head banging.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Upset by loud noises, quick movements, displays startle response.</td>
<td>• Self-harming/suicidal/social isolation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Withdrawn, not playful and/or play imitates violence between parents/carers.</td>
<td>• Constant worry about violence/dangers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unusually extreme separation anxiety or no separation anxiety.</td>
<td>• Desensitisation to violence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Flat affect (i.e. rarely smiles or cries).</td>
<td>• Significant decline in school performance.</td>
<td>• Feels worthless about life and him/herself.</td>
<td></td>
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<td>• Difficulties sleeping.</td>
<td>• Unusually extreme separation anxiety or no separation anxiety.</td>
<td>• Unable to value others or show empathy.</td>
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<td>• Loss of interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity).</td>
<td>• Lacks trust in people.</td>
<td>• High self-critical.</td>
<td></td>
</tr>
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<td>• Poor school attendance.</td>
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<td>• Extreme anxiety, such as inability to sit still that is not related to ADHD/insecure/attention seeking.</td>
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<td>• Lacks interpersonal skills necessary for age-appropriate functioning.</td>
<td>• Highly self-critical.</td>
<td>• Significant change in child’s personality/behaviour (stopped all social activities, a new pattern of getting involved in fights, failing in school despite history of good performance, becoming involved in offences).</td>
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</tr>
<tr>
<td>• Extreme insecurity.</td>
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<td>• Alcohol or other drug abuse.</td>
<td></td>
</tr>
<tr>
<td>• Takes extreme risks; is markedly disruptive, bullying or aggressive, particularly with female teachers.</td>
<td>• Lacks interpersonal skills necessary for age-appropriate functioning.</td>
<td>• Unusual attachment to an adult other than parent.</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td>• Takes extreme risks; is markedly disruptive, bullying or aggressive, particularly with female teachers.</td>
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<td>• Alcohol or other drug abuse.</td>
<td></td>
</tr>
</tbody>
</table>

**Practice Tip**

While the child’s behaviour may point to emotional harm, it should be noted that emotional harm is not always observable. A child subject to emotional harm may show no affect when an emotional response would be expected. This lack of affect may be a coping mechanism resulting from the harm the child has suffered or continues to suffer.
Does the child exhibit emotions and/or behaviours that indicate the child is moderately affected?

**ANSWER ‘YES’ IF:**

<table>
<thead>
<tr>
<th>Examples of Moderately Affected</th>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Difficulty self-soothing.</td>
<td>• Less interested in play.</td>
<td>• Some difficulty concentrating.</td>
<td>• Unusually withdrawn.</td>
<td></td>
</tr>
<tr>
<td>• Play consistently imitates demeaning behaviour between parents/carers.</td>
<td></td>
<td>• Above average worry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occasional or mild separation anxiety or no separation anxiety.</td>
<td></td>
<td>• Some decline in school performance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduced interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity).</td>
<td></td>
<td>• Low self-esteem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Declining school attendance.</td>
<td></td>
<td>• Guarded with other people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mild anxiety.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Below average interpersonal skills necessary for age-appropriate functioning.</td>
<td></td>
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<tr>
<td>• Less secure than peers.</td>
<td></td>
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<tr>
<td>• Trouble relating to adults or unusually compliant with adults.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Somewhat self-critical.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Feelings of sadness.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• Noticeable change in child’s personality/behaviour.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Seeks closeness to an adult other than parent.</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Occasional difficulty sleeping or eating.

**Practice Tip**

While the child’s behaviour may point to emotional harm, it should be noted that emotional harm is not always observable. A child subject to emotional harm may show no affect when an emotional response would be expected. This lack of affect may be a coping mechanism resulting from the harm the child has suffered or continues to suffer.

**ANSWER ‘NO’ IF:**

- Despite exposure to potentially harmful parental conditions or behaviours, child is managing with minimal negative consequences.

OR

- There are explanations for child behaviour other than parental actions or inactions.

**Is the child afraid to go/remain home or are you concerned for child’s safety at home?**

**ANSWER ‘YES’ IF:**

- Child expresses concern that if he/she goes or remains home:
> Child is unable to cope with the parent’s behaviour and this may result in child harming self or others (e.g. suicide attempt, cutting, using alcohol/drugs, running away); OR
> Parent is behaving in ways that place the child in imminent danger of significant harm (e.g. exposed to a violent incident).

- Observation indicates that it is highly likely that if child goes home, he/she will be significantly harmed or will harm self or others.

**Are the parents willing and/or have the capacity to engage with services/other supports to assist the child and family?**

**ANSWER ‘NO’ IF:**

- The parents are unresponsive to child’s emotional/psychological concerns and expect others to respond to the child, or are unwilling to engage in any discussion about changing their own behaviour that is affecting child and/or addressing child’s symptoms of emotional/psychological harm;

- The parents disagree about services needed for child, with one blocking engagement. For example, domestic and family violence is identified and the aggressor is blocking access to services, or one parent is mentally ill and is denying the child’s need for services;

- The parents are unable to engage with services/other supports due to cognitive, physical or emotional limitations;

- The parents are reluctant to seek intervention because of cultural/religious considerations or social stigma; or

- The services required are not available or parent does not know how to access them.
PREGNANT WOMAN—UNBORN CHILD

NOTE: An unborn child includes unborn children from the time of conception until the birth of the baby. While reports relating to an unborn child are not mandatory, those with mandatory reporting responsibility should consider the benefits for the pregnant woman and unborn child after birth of making a report to:

1. Enable Child Safety and other agencies to mobilise services for the potential benefit of the pregnant woman and unborn child after birth; or

2. Enable Child Safety to prepare appropriate statutory/protective intervention following the birth of the child.

Are you aware of a history of significant abuse or neglect of siblings of the unborn child, or have siblings been removed or died in circumstances of abuse or neglect or does any household member have a history of significant abuse against children?

ANSWER ‘YES’ IF:

You have information (which may be gathered in consultation with Child Safety – RIS and/or Child Safety as well as from the parent or third party) that:

- The pregnant woman or another adult who will be living with the baby after birth has previous abuse or neglect reports in which he/she is the perpetrator. The victim may be any child, regardless of whether that child is part of the current household.
- The pregnant woman or another adult who will be living with the baby after birth has previously had a child removed from his/her care by Child Safety.
- The pregnant woman or another adult who will be living with the baby after birth has been involved in a child death in circumstances of abuse and/or neglect.

Are you aware of any of the following circumstances that suggest that either parent may be unable to care for the baby upon birth?

- Suicidal
- Self-harming
- Substance abuse/misuse
- Mental illness
- Domestic/family violence
- Cognitive or intellectual impairment
- Significant medical condition
- Homeless

ANSWER ‘YES’ IF:

Consider any parent who will be living with baby upon birth.
- **Suicide risk.** Pregnant woman has recently attempted or threatened suicide, or is making plans that suggest an imminent suicide attempt.

- **Self-harming.** Pregnant woman is engaging in significant self-harming behaviour.

- **Serious and persistent substance abuse** by pregnant woman or other parent includes dependent use of any illegal or prescription drugs or alcohol to the level of intoxication where either parent could not be responsive to the needs of the infant upon birth.

- **Mental health illness.** Either parent is exhibiting significant symptoms of mental health illness to the extent that either parent is unable to provide care and protection for the infant upon birth. This includes situations in which either parent has been diagnosed with mental health illness that requires medication or treatment that is not taken as prescribed (whether due to prescribed cessation during pregnancy or other reason) or she/he has never been diagnosed and is showing significant symptoms. Significant symptoms include the following:

  » Being unable to carry out daily activities such as eating and self-care;

  » Being unable to manage emotions such as anger, sadness or anxiety to the extent that he/she cannot focus attention on attending to an infant’s needs; and/or

  » Hearing voices, seeing things that are not there, or having thoughts of unrealistic/unsupportable beliefs of persecution, etc. Especially concerning are hostile/negative expressions about the unborn child, or denial of the pregnancy.

- **Domestic/family violence.** There is current domestic violence towards the pregnant woman that includes physical assaults that have involved a serious injury* or use of a weapon or extremely isolating and controlling behaviour.

  *Serious injury during the incident includes but is not limited to strangulation, sexual assault, fractures, internal injuries, disfigurement, burns, death and/or any injury that may require hospitalisation.

- **Cognitive or intellectual impairment.** The pregnant woman or other parent has limited ability to understand information that will be necessary for the care of the infant. For example, either the pregnant woman or other parent has a cognitive impairment and is unable to understand feeding, sleeping or bathing instructions, or has extremely unrealistic expectations of what parenting will be like.

- **Significant medical condition.** Either parent has a significant medical condition or physical disability to the extent that either parent is unable to provide care and protection for an infant after the birth.

- **Homeless.** The pregnant woman has no safe place to stay with baby after birth.
Are you aware that the pregnant woman has accepted referrals to services to address concerns OR that there are other family members who will provide for child’s safety and care upon birth?

ANSWER ‘YES’ IF:

- You have already had a conversation with the pregnant woman about your concerns and have provided a referral, or the pregnant woman or family has accessed services on their own.

OR

- There is at least one other adult who will be living in the home with the baby who will be able to provide for the child’s basic needs and protect child from any concerns the other parent may present.

ANSWER ‘NO’ IF:

- Pregnant woman has refused services or lacks capacity to access services.

AND

- Pregnant woman would be the only parent available to provide for the baby.

AND

- All other adults have risk factors or would otherwise be unable/unwilling to provide safety or basic care for the baby.

Are you aware of reasons parent would be unable to remedy situation with assistance?

ANSWER ‘YES’ IF:

- You have discussed your concerns about the unborn child following birth with his/her parent and the parent refuses to accept resources or support, and as a result the safety and basic care of the unborn child after birth are unresolved.

AND/OR

- Despite reasonable efforts, parent has not engaged in conversation with you about your concerns.

ANSWER ‘NO’ IF:

- Parent is able and willing to follow through and access services and assistance within a reasonable timeframe.
PARENT CONCERN: SUBSTANCE ABUSE

If you have a parent concern and you are a QH employee consider consulting with a child protection liaison officer (CPLO) or child protection advisor (CPA). If you are a DETE employee consider consulting with a guidance officer or senior guidance officer.

Does the parent’s substance abuse impact or is it likely to impact his/her ability to meet the child’s needs and/or does the child’s behaviour indicate the significant impact of substance abuse?

ANSWER ‘YES’ IF:

- You reasonably suspect that a parent is abusing alcohol or other drugs to the extent that it is having a negative impact on his/her capacity to parent the child, his/her own health, finances, relationships, employment, legal issues, etc. Your awareness may be based on personal observations or credible statements by the child or another person.

Indicators of substance abuse (examples):

<table>
<thead>
<tr>
<th>Type of Indicator</th>
<th>What You May Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Assessment/Treatment</td>
<td>• Diagnosed by a professional as having an addiction to alcohol or drugs.</td>
</tr>
<tr>
<td></td>
<td>• Received/receiving treatment for addiction to alcohol or drugs.</td>
</tr>
<tr>
<td>Direct Observation of Use</td>
<td>• Observed parent use or possession of illegal drugs.</td>
</tr>
<tr>
<td></td>
<td>• Observed parent consumption of alcohol to the point of intoxication.</td>
</tr>
<tr>
<td>Legal</td>
<td>• Arrests for drunk driving or other alcohol- or drug-related offences.</td>
</tr>
<tr>
<td>Work</td>
<td>• Excessive absences that may reflect hangover, withdrawal or active use.</td>
</tr>
<tr>
<td></td>
<td>• Poor performance on the job because of impaired judgment.</td>
</tr>
<tr>
<td>Relationships</td>
<td>• Increasingly, relationships are limited to people who also abuse alcohol or drugs.</td>
</tr>
<tr>
<td></td>
<td>• Losing relationships with non-using friends and relatives.</td>
</tr>
<tr>
<td>Mood</td>
<td>• Increasing sadness.</td>
</tr>
<tr>
<td></td>
<td>• Rapidly changing moods.</td>
</tr>
<tr>
<td>Physical</td>
<td>• While intoxicated/high:</td>
</tr>
<tr>
<td></td>
<td>» Slurred speech</td>
</tr>
<tr>
<td></td>
<td>» Poor coordination</td>
</tr>
<tr>
<td></td>
<td>» Agitation</td>
</tr>
<tr>
<td></td>
<td>» Pupils pin-point or dilated</td>
</tr>
<tr>
<td></td>
<td>• Long term:</td>
</tr>
<tr>
<td></td>
<td>» Emaciated</td>
</tr>
<tr>
<td></td>
<td>» Skin lesions</td>
</tr>
<tr>
<td></td>
<td>» Tooth loss</td>
</tr>
</tbody>
</table>

AND

- One of the following is true:
Parent is not meeting child’s needs or is likely to be unable to meet child’s needs. On more than one occasion, parent did not provide child with food, supervision, adequate housing, safe living conditions (e.g. drug paraphernalia was accessible to child) or other basic care because parent was under the influence of alcohol or other drugs; or could not provide because financial resources were spent on alcohol/drugs; or parent’s life is so organised around drug-seeking that he/she is inattentive to child’s needs. Consider child's age/developmental status. Older children/young people are less dependent on their parent to meet basic needs, whilst infants/newborns have no ability to protect themselves or meet any of their own needs.

**NOTE:** If failure to meet basic needs meets criteria for neglect, use neglect decision tree first and use this decision tree if you have already ruled out neglect.

Child’s behaviour indicates significant impact of parent’s substance abuse. Child exhibits indicators of emotional disturbance. The following table provides examples, but it is a guide only. If you are not familiar with indicators of emotional disturbance, you are encouraged to consult with a professional in your agency with expertise in this area or Child Safety – RIS.

The following list is not exclusive, but may include:

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not responding to cuddling.</td>
<td>• Regression in toilet training, language or other skills.</td>
<td>• Bed wetting.</td>
<td>• Involved in violent relationships.</td>
</tr>
<tr>
<td>• Not smiling or making sounds.</td>
<td>• Head banging.</td>
<td>• Significant behaviour changes.</td>
<td>• Difficulty maintaining long-term significant relationships.</td>
</tr>
<tr>
<td>• Losing developmental milestones already achieved.</td>
<td>• Regressive behaviour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inconsolable.</td>
<td>• Difficulties sleeping.</td>
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<td></td>
</tr>
<tr>
<td>• Head banging.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Slow weight gain.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Upset by loud noises, quick movements, displays startle response.</td>
<td></td>
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</tr>
<tr>
<td>• Withdrawn, not playful and/or play imitates violence between parents/carer.</td>
<td></td>
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</tr>
<tr>
<td>• Unusually extreme separation anxiety or no separation anxiety.</td>
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<td>• Loss of interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity).</td>
<td>• Self-harming/suicidal/social isolation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Poor school attendance.</td>
<td>• Constant worry about violence/dangers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extreme anxiety, such as inability to sit still that is NOT related to ADHD/insecure/attention seeking.</td>
<td>• Desensitisation to violence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lacks interpersonal skills necessary for age-appropriate functioning.</td>
<td>• Decline in school performance.</td>
<td></td>
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</tr>
<tr>
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</table>
Examples of Psychological Harm Indicators

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feelings of hopelessness, misery, despair.</td>
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<tr>
<td>• Significant change in child’s personality/behaviour (stopped all social activities, a new pattern of getting involved in fights, failing in school despite history of good performance, becoming involved in offences).</td>
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</tr>
<tr>
<td>• Alcohol or other drug abuse.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unusual attachment to an adult other than parent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than occasional difficulty sleeping or eating, e.g. losing weight, eating compulsively and becoming obese (and/or bulimic).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes of physical complaints for which there is no known physical cause (e.g. stomach aches, headaches)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flat affect (i.e. rarely smiles or cries).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** If parent caused significant psychological harm or is likely to cause significant psychological harm, use the psychological harm decision tree first and use this decision tree if you have already ruled out psychological harm.

**Is there another parent who cares for and protects the child?**

**ANSWER ‘YES’ IF:**

You or another person has met with a second parent who lives in the home who does not abuse alcohol or drugs and who provides care and protection appropriate to the child’s needs including:

- Second parent is fully aware of the other parent’s substance abuse issues and impact or potential impact on the children;

AND

- Second parent provides a description of ways he/she is acting to protect the child.

**ANSWER ‘NO’ IF:**

- This is a single-parent family.

OR

- All adults abuse alcohol/drugs.

OR

- At least one adult does not abuse alcohol/drugs but does not meet child’s needs (e.g. emotionally unable, physically unable, financially unable); or you have no information regarding the presence of another adult in the household who can meet the child’s care, well-being and safety needs.
Are you aware that the family is currently benefiting from services or assistance to address the substance abuse?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with either the using or non-using parent about your concerns and have provided resources for services/interventions, or the family has sought services on their own. This may include treatment for the substance-abusing parent, plans for someone else to care for the child, etc.

AND

- Parent has agreed to services or assistance, and based on time elapsed since services were recommended, has engaged in services and is making progress toward reducing risk of harm to child. For example, the parent is not using when responsible for the child, or the non-abusing parent is assuming more responsibility.

ANSWER ‘NO’ IF:

Parent has refused services, indicated acceptance but after a reasonable period of time has not engaged in services or, having engaged in services, is not effectively using services to reduce risk of harm to child. This may be evidenced by the following:

- Indicators that child’s needs are not being met;
- Isolation of child; and/or
- Capacity of the parent to provide adequate care for the child.

Has parent refused or avoided services to reduce risk?

ANSWER ‘YES’ IF:

- You or another person has had a conversation with at least one parent about your concerns and the parent states that there is no substance abuse issue in the home, or acknowledges the issue but states that no services will be pursued.

- The family states that they will pursue services, but after a reasonable period of time has not followed through and the problem continues to have an adverse impact on the child.

ANSWER ‘NO’ IF:

- The parent is willing to engage in new or additional services to address the substance abuse concern.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:
There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

The family does not require an intensive case management response however has an unmet need which would benefit from a direct referral to a support service targeted at providing support for this need.
PARENT CONCERN: MENTAL HEALTH

If you have a parent concern and are a QH employee consider consulting with a child protection liaison officer (CPLO) or child protection advisor (CPA). If you are a DETE employee consider consulting with a guidance officer or senior guidance officer.

Does the parent’s mental health concern impact or is it likely to impact his/her ability to meet the child’s needs and/or does the child’s behaviour indicate the significant impact of parent’s mental health concern?

ANSWER ‘YES’ IF:

- You are aware that a parent has a mental health concern. Your awareness may be based on personal observations or credible statements by the child or another person. Include parents/carers who you reasonably suspect have mental health signs and symptoms to the extent that these signs and symptoms are having a negative impact on them (e.g. capacity to fulfil parenting role, health, finances, relationships, employment, legal issues). Indicators of mental health concern (examples):

<table>
<thead>
<tr>
<th>Examples of Indicators of Mental Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Mental Health Concern</strong></td>
</tr>
</tbody>
</table>
| ALL | - Parent has been diagnosed with mental illness.  
- Parent is receiving therapy for mental illness.  
- Parent is on medication for mental illness. |
| Mood Disorders | - Suicide attempts, threats or preparations.  
- Extremely sad for long periods of time and there is no obvious reason.  
- Loss of energy, unable to manage routine tasks and self-care.  
- Loss of appetite, weight loss or uncontrolled eating.  
- Unable to sleep.  
- Loss of interest in activities, withdrawal. |
| Anxiety | - Worries and fears that are extremely out of proportion and that interfere with daily life. |
| Psychotic Disorders | - Hears voices or sees things that others do not.  
- Unfounded beliefs that others are conspiring against him/her.  
- Beliefs that thoughts are being ‘planted’.  
- Unfounded beliefs of self-importance, powers. |
| Compulsions/Obsessions | - Hoarding.  
- Excessive hand washing, fear of germs. |
| Personality Disorders | - Completely focused on him/herself and oblivious to the needs of those around him/her. |

AND

- One of the following is true:

  » Parent is not meeting child’s needs OR will likely be unable to meet child’s needs. On more than one occasion, parent did not provide child with food, supervision, stable housing, safe living conditions or other
basic care because parent was experiencing mental health symptoms. Consider child’s age/developmental status. Older children/young people are less dependent on their parent to meet basic needs, whilst infants/newborns have no ability to protect themselves or meet any of their own needs.

NOTE: If failure to meet needs meets criteria for neglect, use neglect decision tree first and use this decision tree if you have already ruled out neglect. NOTE: Do not include education non-attendance unless relevant.

» Parent’s emotional status inhibits or prevents him/her from forming a relationship with his/her infant/newborn. For example, mother is depressed (including post natal depression) and not responsive to infant. This may be observed by identifying depression in the mother, or by observing behaviours such as refusing to hold newborn, failure to respond to infant’s cues, etc.

» Child’s behaviour indicates significant impact of parent’s mental health concern. Child exhibits indicators of emotional disturbance. The following table provides examples, but it is a guide only. If you are not familiar with indicators of emotional disturbance, you are encouraged to consult with a professional in your agency with expertise in this area of child protection.

<table>
<thead>
<tr>
<th>Examples of Indicators of Emotional Disturbance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant</strong></td>
</tr>
<tr>
<td>● Not responding to cuddling.</td>
</tr>
<tr>
<td>● Not smiling or making sounds.</td>
</tr>
<tr>
<td>● Losing developmental milestones already achieved.</td>
</tr>
<tr>
<td>● Inconsolable.</td>
</tr>
<tr>
<td>● Head banging.</td>
</tr>
<tr>
<td>● Upset by loud noises, quick movements.</td>
</tr>
<tr>
<td>● Withdrawn, not playful and/or play imitates violence between parents/carers.</td>
</tr>
<tr>
<td>● Unusually extreme separation anxiety or no separation anxiety.</td>
</tr>
</tbody>
</table>

- Self-harming/suicidal.
- Constant worry about violence/dangers.
- Desensitisation to violence.
- Decline in school performance.
- Feels worthless about life and him/herself.
- Unable to value others or show empathy.
- Lacks trust in people.
### Examples of Indicators of Emotional Disturbance

<table>
<thead>
<tr>
<th>Infant</th>
<th>Toddler</th>
<th>School Age</th>
<th>Teen</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Increased aggressive behaviour.</td>
<td>- Loss of interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity).</td>
<td>- Extreme insecurity.</td>
<td>- Extreme anxiety, such as inability to sit still that is not related to ADHD.</td>
</tr>
<tr>
<td></td>
<td>- Extreme anxiety, such as inability to sit still that is not related to ADHD.</td>
<td>- Lacks interpersonal skills necessary for age-appropriate functioning.</td>
<td>- Extreme attention seeking.</td>
</tr>
<tr>
<td></td>
<td>- Takes extreme risk; is markedly disruptive, bullying or aggressive.</td>
<td>- Avoids adults or is obsessively obsequious/submissive to adults.</td>
<td>- Highly self-critical.</td>
</tr>
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<td></td>
<td>- High self-critical.</td>
<td>- Feelings of hopelessness, misery, despair.</td>
<td>- Significant change in child’s personality/behaviour (stopped all social activities, a new pattern of getting involved in fights, failing in school despite history of good performance, becoming involved in offences).</td>
</tr>
<tr>
<td></td>
<td>- More than occasional difficulty sleeping or eating, displays startle response, losing weight, eating compulsively and becoming obese (and/or bulimic), episodes of physical complaints for which there is no known physical cause (e.g. stomach aches, headaches).</td>
<td></td>
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</tbody>
</table>

**NOTE:** If parent caused significant psychological harm to the child, or is likely to cause significant psychological harm, use the psychological harm decision tree first and use this decision tree if you have already ruled out psychological harm.

### Is there another parent or caregiver who cares for and protects the child?

**ANSWER ‘YES’ IF:**

You or another person has met with a second parent who lives in the home who does not have a mental health concern and who provides care and protection appropriate to the child’s needs including:

- Second parent is fully aware of the other parent’s mental health issues and impact or potential impact on the children;

**OR**

- Second parent provides a description of ways he/she is acting to protect the child such as assuring that the parent with mental health concerns is never alone with the children.

**ANSWER ‘NO’ IF:**

- This is a single-parent family.

**OR**

- All adults have mental health concerns.

**OR**
- At least one adult does not have mental health concerns, but does not meet child’s needs (e.g. emotionally unable, physically unable, financially unable or legally unable such as Family Court Orders).

OR

- You have no information regarding the presence of another adult in the household who can meet the child’s care, well-being and safety needs.

Are you aware that family is currently benefiting from services or assistance to address the mental illness?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with either parent about your concerns and have provided resources for effective services/interventions, or the family has sought services on their own.

AND

- Parent has agreed to services, and based on time elapsed since services were recommended, has engaged in services.

ANSWER ‘NO’ IF:

You are not aware whether the parent is currently receiving services; OR parent indicated acceptance but after a reasonable period of time has not engaged in services; or, having engaged in services, is not effectively using services to reduce risk of harm to child. This may be evidenced by the following:

- Indicators that child’s developmental needs are not being met;
- Absence of services isolates child; and/or
- Capacity of the parent to provide adequate care for the child.

Has parent refused or avoided services to reduce risk?

ANSWER ‘YES’ IF:

- You or another person has had a conversation with at least one parent about your concerns, and the parent states that there is no mental health issue in the home, or acknowledges the issue but states that no services will be pursued.

- The family states that they will pursue services, but after a reasonable period of time has not followed through and the problem continues to have an adverse impact on the child.

ANSWER ‘NO’ IF:

- The parent is willing to engage in new or additional services to address the mental health concern.
Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
PARENT CONCERN: INTELLECTUAL OR COGNITIVE DISABILITY

If you have a parent concern and are a QH employee consider consulting with a child protection liaison officer (CPLO) or child protection advisor (CPA). If you are a DETE employee consider consulting with a guidance officer or senior guidance officer.

Does the parent’s intellectual or cognitive disability impact or is it likely to impact on his/her ability to meet the child’s needs, or does the child’s behaviour indicate the significant impact of parent’s intellectual or cognitive disability?

ANSWER ‘YES’ IF:

- You are aware that a parent has an intellectual or cognitive disability. Your awareness may be based on assessment by relevant professionals, or personal or credible statements by the child or another person. Include parents/carers whom you reasonably suspect of having an intellectual or cognitive disability to the extent that symptoms are having a negative impact on them (e.g. health, finances, relationships, employment, legal issues).

<table>
<thead>
<tr>
<th>Indicators of Intellectual or Cognitive Disability or Learning Impairment</th>
<th>What You May Notice</th>
</tr>
</thead>
</table>
| **Diagnosis and Early Intervention** | • Parent has been diagnosed with intellectual or cognitive disability or has a learning impairment.  
• Parent has been offered appropriate and accessible support services for intellectual or cognitive disability or learning impairment. |
| **Ability to Care for Their Child** | • Parent lacks skills to meet basic living and developmental needs and ensure the safety of his/her child, despite access to the information and opportunities to learn. |
| **Ability to Process Information** | • In conversations, the parent cannot think and respond within a typical span of time.  
• Parent is unable to read, or has extremely limited reading skills despite opportunities to learn. |
| **Communication** | • The parent needs assistance to communicate clearly about how he/she is able to meet the child’s developmental needs and ensure the safety of the child. |

AND

- One of the following is true:
  » Parent is not meeting child’s needs or will likely be unable to meet child’s needs. On more than one occasion, parent did not provide child with food, supervision, stable housing, safe living conditions or other basic care because parent did not have the intellectual capacity to understand the child’s needs, follow plans for meeting the child’s needs or make decisions about child needs. Consider child’s age/developmental status; older children/young people are less dependent on their parent to meet basic needs, whilst infants/newborns have no ability to protect themselves or meet any of their own needs.
NOTE: If failure to meet needs meets criteria for neglect, use neglect decision tree first and use this decision tree if you have already ruled out neglect. NOTE: do not include education non-attendance unless relevant.

» Parent’s intellectual or cognitive disability or learning impairment inhibits or prevents him/her from forming a relationship with his/her infant/newborn. For example, mother cannot process information and as a result is not responsive to infant. This may be observed behaviours such as refusing to hold newborn, failure to respond to infant’s cues, etc.

» Child’s behaviour and/or living conditions indicate significant impact of parent’s intellectual or cognitive disability or learning impairment. Child exhibits adverse impact. The following table provides examples, but it is a guide only. If you are not familiar with ways children can be adversely affected by a parent’s cognitive disability, you are encouraged to consult with Child Safety - RIS or a professional with expertise in this area. If you are a QH employee consider consulting with a child protection liaison officer (CPLO) or child protection advisor (CPA). If you are a DETE employee consider consulting with a guidance officer or senior guidance officer.

<table>
<thead>
<tr>
<th>Possible Impacts of Parent Intellectual Ability on Child</th>
<th>What You May Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>• Parent engages in incorrect feeding practices, and is unable to understand instructions regarding appropriate feeding.</td>
</tr>
<tr>
<td></td>
<td>• Parent has ignored indicators of illness that should prompt medical attention.</td>
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<tr>
<td></td>
<td>• Child is behind on developmental milestones.</td>
</tr>
<tr>
<td>Toddlers</td>
<td>• Falling behind on developmental milestones.</td>
</tr>
<tr>
<td></td>
<td>• Allowed to play in dangerous situations.</td>
</tr>
<tr>
<td>School Age</td>
<td>• Parent is unable to assist child with schoolwork where he/she may be reasonably expected to do so.</td>
</tr>
<tr>
<td></td>
<td>• Child assumes responsibility for self and siblings.</td>
</tr>
</tbody>
</table>

Are there indicators that there is another parent who can support the parent with an intellectual or cognitive disability to care for and protect the child?

ANSWER ‘YES’ IF:

You or another person has met with a second parent in the home who does not have an intellectual or cognitive disability or learning impairment and who provides care and protection appropriate to the child’s needs including:

• Second parent is fully aware of the other parent’s intellectual or cognitive disability or learning impairment and impact or potential impact on the children.

• Second parent provides a description of ways he/she is acting to protect the child such as assuring that the parent with intellectual disability is never alone with the children where there is a risk of harm.
ANSWER ‘NO’ IF:

- This is a single-parent family.

OR

- All adults living with the child have an intellectual or cognitive disability.

OR

- At least one adult does not have an intellectual or cognitive disability, but does not meet child’s needs (e.g. emotionally unable, physically unable, financially unable or legally unable such as Family Court Orders).

Are you aware that the parent with an intellectual or cognitive disability is currently benefiting from appropriate supports and services?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with either parent about your concerns and have provided resources for effective services/interventions, or the family has sought services on their own;

AND

- Parent has agreed to services, and based on time elapsed since services were recommended, has engaged in services.

ANSWER ‘NO’ IF:

You are not aware whether the parent is currently receiving or able to access services; or parent indicated acceptance but after a reasonable period of time has not engaged in services; or, having engaged in services, is not effectively using services to reduce risk of harm to child. This may be evidenced by the following:

- Indicators that child’s basic living and developmental needs are not being met; and/or

- Absence of services for the parent isolates the parent and/or the child; and/or

- Capacity of the parent to provide adequate care for the child.

Has parent been unable to access appropriate supports and services?

ANSWER ‘YES’ IF:

- You or another person had a conversation with at least one parent about your concerns, and the parent stated that there is no person with an intellectual or cognitive disability or learning impairment, or acknowledged the issue but stated that no services will be pursued.

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• The family states that they will pursue services, but after a reasonable period of time has not followed through and the problem continues to have an adverse impact on the child.

ANSWER ‘NO’ IF:

• The parent is willing to engage in new or additional services to manage the intellectual disability.

Does the family have complex and/or multiple needs?

ANSWER ‘YES’ IF:

• There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

• More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

ANSWER ‘NO’ IF:

• The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
PARENT CONCERN: DOMESTIC VIOLENCE

If you have a parent concern and are a QH employee consider consulting with a child protection liaison officer (CPLO) or child protection advisor (CPA). If you are a DETE employee consider consulting with a guidance officer or senior guidance officer.

Has there been an incident of domestic violence where one or more of the following occurred and a child normally resides in the home?

- Use of weapon (gun, knife, etc.)
- Attempt to strangle/suffocate/kill
- Serious injury to adult
- Physical injury to a child
- Serious threat to harm child/adult/self
- Significant escalation in pattern of violence

ANSWER ‘YES’ IF:
One or more of the following is occurring or has recently occurred:

- One or more parents or adults in the home used a weapon capable of causing significant injury. For example, a gun, knife, blunt object such as a hammer or a flammable liquid. Use means that the weapon was deployed (i.e. fired gun, slashed with knife, swung object, poured flammable liquid) or displayed in a threatening manner (i.e. pointed gun or showed it implying threat, held knife or blunt object in threatening manner);

- An adult attempted to kill a household member by any other means (i.e. strangle or suffocate);

- A parent/adult suffered a serious injury during the incident including but not limited to strangulation, sexual assault, fractures, internal injuries, disfigurement, burns, death and/or any injury that may require hospitalisation;

- A child suffered physical injury during the incident, including bruising, cuts or burns, or other more severe injuries. The child need not have been the intended target of the violence, but may have been injured as a result of proximity to the intended target of the violence (e.g. infant being carried by the mother) or whilst in the process of running away from/evading the violence;

- Threat of significant harm to child or another parent/adult or self (e.g. threat to kill self, sexual assault, kidnap, hold hostage, murder, serious injury or harm); and/or

- The child/parent/other adult discloses a significant increase in the number and severity of incidents. For example, there are now injuries that may not be significant, but there are repeated episodes of minor injuries and the injuries are getting worse or are happening more often.
Was a child:

- Attempting to intervene?
- In parent’s arms or close enough proximity to be hurt?
- Significantly emotionally/psychologically distressed by incident(s)?
- The subject of a previous unborn child report related to domestic violence?

ANSWER ‘YES’ IF:

- Child attempted to intervene. During a physical altercation between adults, a child attempted to hold back the aggressor and/or protect the victim or participated in assaulting the victim; and/or

- Child was in parent’s arms or in close enough proximity to be hurt. During a physical altercation between adults, either adult was holding a child in his/her arms OR a child was near enough to the altercation that even though child was not attempting to intervene, the course of the altercation did or was likely to include the child’s location; and/or

NOTE: Consider the range of potential harm based on use of weapons/duration of incident compared to child’s location. For example, if a gun was involved, the child’s presence anywhere in the home should be answered ‘yes’. If an object was thrown, a child’s presence anywhere in range of the throw should be answered ‘yes’. If adults carried the altercation from room to room over many minutes to hours, a child anywhere in the home should be answered ‘yes’.

- Child significantly emotionally/psychologically distressed by incident(s). During and/or following the incident(s) the child demonstrated significant emotional distress. Examples include shaking with fear, inconsolable sobbing, cowering or hiding OR showing little or no emotion especially when the violence has been longstanding.

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<td>Not smiling or making sounds.</td>
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<td>Inconsolable.</td>
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<td>Head banging.</td>
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<tr>
<td>Slow weight gain.</td>
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<td>Upset by loud noises, quick movements/displays startle response.</td>
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<td>Withdrawn, not playful and/or play imitates violence between parents/carers.</td>
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<td>• Loss of interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity).</td>
<td>• Poor school attendance.</td>
<td>• Extreme anxiety, such as inability to sit still that is NOT related to ADHD/insecure/attention seeking.</td>
<td>• Lacks interpersonal skills necessary for age-appropriate functioning.</td>
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<td>• Poor school attendance.</td>
<td>• Extreme anxiety, such as inability to sit still that is NOT related to ADHD/insecure/attention seeking.</td>
<td>• Takes extreme risks; is markedly disruptive, bullying or aggressive, particularly with female teachers.</td>
<td>• Extreme insecurity.</td>
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<td>• Extreme anxiety, such as inability to sit still that is NOT related to ADHD/insecure/attention seeking.</td>
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<td>• Avoids adults or is obsessively obsequious/submissive to adults.</td>
<td>• Alcohol or other drug abuse.</td>
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<td>• Lacks interpersonal skills necessary for age-appropriate functioning.</td>
<td>• Takes extreme risks; is markedly disruptive, bullying or aggressive, particularly with female teachers.</td>
<td>• HIGHLY self-critical.</td>
<td>• Feelings of hopelessness, misery, despair.</td>
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<td>• Extreme insecurity.</td>
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More than occasional difficulty sleeping or eating e.g. losing weight, eating compulsively and becoming obese (and/or bulimic). Episodes of physical complaints for which there is no known physical cause (e.g. stomach aches, headaches).

- You have information that whilst mother was pregnant with this child, a report was made to Child Safety (whether accepted or not) because of concerns related to domestic violence AND since that report the violence has continued.

**ANSWER ‘NO’ IF:**

- Child was not directly in harm’s way.

**AND**

- No child in the home was the subject of a prenatal report related to domestic violence, OR if such a report was made, effective steps toward eliminating the violence have occurred.

**Are you aware of the presence of risk factors including:**

- Current DVO or family law contact orders;
- Recent/imminent divorce or separation;
- Stalking, extremely controlling behaviour or sexual assault of a parent;
- Aggressor has significant mental health issues or severe alcohol or drug abuse; and/or
- One or a combination of additional risk factors?

**ANSWER ‘YES’ IF:**

- There is a current DVO (provisional, interim or final) due to violence against a household member or there is a current family law contact order prohibiting
contact of one or more household members by another person because of violence;

- The most recent violent incident was, or appears to have been, triggered by a divorce or separation within an intimate relationship of one or more household members within the past six months; OR one family member is planning to separate in the near future; OR a court date to finalise a divorce is imminent;

- The aggressor has been stalking (following; aggressive phone, email, text, mail contact; watching) the parent; OR the aggressor has exhibited other highly controlling behaviour (persistent isolation from family and friends; complete control of all money; repeatedly denying access to ceremonies, land, family, religious observance; forcing people to do things against their beliefs; repeatedly locking the victim in or outside the house); OR the aggressor has forced sexual contact on parent;

- The aggressor has mental health issues that have resulted in violent or aggressive behaviour. For example, aggressor is extremely paranoid, not in touch with reality, hearing or seeing things others do not see; OR aggressor frequently uses alcohol or other drugs to an extent that he/she becomes violent and out of control; or

- None of the above are present, but one or a combination of several risk factors suggest that further violence is likely in the near future.

Examples of risk factors include the following:

» Parent experiencing domestic violence is in a constant state of fear;
» Parent experiencing domestic violence fears for the child’s safety;
» Recent or prolonged unemployment is causing stress;
» Severe financial stress;
» Severe social isolation;
» Mental health concerns;
» Abuse of alcohol or other drugs;
» A history of prior DVO or family law contact orders;
» Weapons in the home;
» Parent experiencing domestic violence is pregnant;
» Cruel treatment of animals/family pets by the person using violence;
» Conflict over family law issues;
» A child in the home is not a biological child of person using violence;
» A history of domestic violence.

Are you aware the family is currently benefiting from services or assistance to address domestic violence?

ANSWER ‘YES’ IF:

- You or another person have already had a conversation with parent about your concerns and have provided resources for effective supports/services/solutions, or the family has sought supports/services/solutions on their own. This may include
accessing a domestic violence service or other resources or solutions to support the ongoing safety of the child.

**Does the family have complex and/or multiple needs?**

**ANSWER ‘YES’ IF:**

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

**ANSWER ‘NO’ IF:**

- The family does not require an intensive case management response but has an unmet need and would benefit from a direct referral to a support service targeted at providing support for this need.
FAMILY AND CHILD CONNECT OR INTENSIVE FAMILY SUPPORT SERVICES

Have you obtained consent from the family to refer directly to services?

ANSWER ‘YES’ IF:

- The family has given their consent to refer them directly to services.

ANSWER ‘NO’ IF:

- The family has not given their consent to be referred directly to services.

Are you from a particular prescribed entity?

ANSWER ‘YES’ IF:

You are from a particular prescribed entity defined at section 159M of the Child Protection Act 1999. This includes certain professionals who are employees of:

- Child Safety and Disability Services;
- Adult corrective services;
- Education;
- Housing;
- Police;
- Disability services;
- Community services;
- Public health;
- Mater health services;
- A health service within the meaning of Hospital and Health Boards Act 2011; or
- The principal of a school that is accredited, or provisionally accredited, under the Education (Accreditation of Non-State Schools) Act 2001.

If you are unsure whether you are from a particular prescribed entity or are a delegated professional to share information under section 159M, consult with your supervisor before referring a family without consent.

ANSWER ‘NO’ IF:

You are not from a particular prescribed entity such as those listed above.

If you are unsure whether you are from a particular prescribed entity or are a delegated professional to share information under section 159M, consult with your supervisor.

Consent is required to refer the family for support. Document your concerns. Also consider:

- Seeking consent from the family;
- Providing information to the family about available resources; and/or
- Monitoring the family.
Is it necessary to conduct further identification of family needs prior to determining the most appropriate support service for the family?

ANSWER ‘YES’ IF:

• Further identification of family needs is required prior to determining the most appropriate support service for the family.

ANSWER ‘NO’ IF:

• You have enough information about the needs of the family to indicate that an intensive family support service is the most appropriate service to address the family’s needs.
CULTURAL NOTES

Working With Aboriginal and Torres Strait Islander People and Communities
Aboriginal and Torres Strait Islander people are overrepresented in the child protection system for a variety of reasons. As a result of the policies, practices and actions of government agencies in the past, there continues to be a disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system. Consultation, respectful relationships and cultural sensitivity are needed in order to work effectively with Aboriginal people to ensure the safety of children/young people.

Aboriginal and Torres Strait Islander people’s right to participate in the care and protection of their children is contained in the Child Protection Act 1999. The Child Protection Act 1999 recognises that the safety, welfare and well-being of a child is the paramount consideration for a reporter or a worker. Consequently, while being aware of cultural sensitivities, the reporter’s focus must remain on ensuring the safety, welfare and wellbeing of the child as prescribed by the Act.

If behaviours are occurring that you suspect place a child at risk of significant harm, they should not be minimised or dismissed on cultural grounds. Likewise, behaviours or practices that are culturally unfamiliar to a reporter should not be reported if they do not place the child at risk of harm.

Any cultural information that may assist in the assessment of a case should always be included in a report.

Working With Culturally and Linguistically Diverse Communities
Culture and experience do influence parenting and caregiving practices; however, it is critical that reporters maintain a focus on the impact or effects of these on the child. Where there are grounds to suspect harm from parent behaviours, reporters must take the necessary reporting actions. Behaviours that are suspected of causing harm should not be minimised or dismissed on cultural grounds.

Workers must focus on the impact of the behaviour or practice on the child and ask, ‘Does this cause or threaten harm?’

However, behaviours/practices that are influenced by culture should not be reported simply because they are different or unfamiliar to the reporter, nor should practices be reported where they do not cause significant harm nor place the child at risk of significant harm.

Reporters with information about the possible bearing of cultural, linguistic, refugee, migration and/or settlement factors on the case are encouraged to provide this information as part of their report. This information can assist in the subsequent assessment of the case.
GLOSSARY

Attachment
Attachment is an emotional bond to another person. Psychologist John Bowlby was the first attachment theorist, describing attachment as a ‘lasting psychological connectedness between human beings’ (Bowlby, 1969). Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life.

Child Exploitation Material
Child exploitation material means material that, in a way likely to cause offence to a reasonable adult, describes or depicts someone who is, or apparently is, a child under 16 years:

a. In a sexual context, i.e. engaging in a sexual activity;
b. In an offensive or demeaning context; or
c. Being subjected to abuse, cruelty or torture.

Complex Needs
Possible indicators of complex and/or multiple needs include:

- There is at least one complex issue impacting on the child or family’s wellbeing. Examples of complex issues include, but are not limited to: family violence, mental illness, substance misuse, learning difficulties, homelessness and poverty AND/OR;

- More than one issue is impacting on the child or family’s wellbeing.

“YES” may also be considered for a single, non-complex need if the family needs extensive help to address that need.

Developmental Delay
Developmental delay usually refers to a developmental lag, meaning that a child’s cognitive abilities do not match the expectations for his/her chronological age. It is important to note that children continue to grow and develop over a period of time and at individual rates. Sometimes development lags because of a physical, visual or hearing impairment; illness or malnutrition; or other environmental factors. In some cases, when the situation is rectified or therapy and supports put in place, the developmental delay may be redressed.

Developmental Milestones
Developmental milestones are a set of functional skills or age-specific tasks that most children can do at a certain age range, and which are used to check on children’s development. Although each milestone has an age level, the actual age when a normally developing child reaches that milestone can vary.

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2 s207A Criminal Code 1899

Domestic and Family Violence
Domestic and family violence is violent or abusive behaviour by a person toward someone who is their partner, ex-partner or co-parent, family member, carer or person they are providing care for. Domestic and family violence includes not only physical and sexual abuse, but also emotional and psychological abuse, economic abuse, threats, coercive behaviour, or any other behaviour that controls, dominates or causes fear for the safety and well-being of the direct victim or any other person, such as children.

The Parent Concern: Domestic Violence decision tree is intended for situations involving violence toward a child’s parent or another adult in the child’s household. Violence or abuse directed toward a child should be assessed using the Physical Abuse, Emotional Abuse or Sexual Abuse trees.

Domestic Violence Order (DVO)
Domestic Violence Order (DVO) is an order made by a court that restricts the behaviour of the person against whom the order has been made, who is called the respondent. The purpose of a DVO is to protect a person, who is called the aggrieved, from further domestic violence in the future. For the court to make a DVO, the respondent and the aggrieved must be in a spousal, intimate personal, family or informal care relationship.

A DVO can also name a relative (including a child) or other associate of the aggrieved for that person’s protection. A DVO will always state that the respondent must be of good behaviour toward the aggrieved and any named person and not commit further acts of domestic violence. Other conditions can be included if necessary, such as prohibiting the respondent from contacting the aggrieved or a named person, or going within a certain distance of his/her home or workplace.

In Queensland there are two types of DVOs:

- Protection Orders are the final order made by the court.
- Temporary Protection Orders (TPO) are made while the court is still to hear and decide an application for a protection order.

Harm
Members of the community and mandatory reporters who form a reasonable suspicion that a child may be in need of protection should report their concerns to the Department of Communities, Child Safety and Disability Services (Child Safety). The Child Protection Act 1999\(^3\) (the Act) clarifies that in forming this suspicion the reporter should consider whether the child:

- Has suffered significant harm, is suffering significant harm or is at unacceptable risk of suffering significant harm; and

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\(^3\) S10 Child Protection Act 1999
May not have a parent able and willing to protect the child from harm.

Section 9 of the Act defines harm as the following:

1. Harm, to a child, is any detrimental effect of a significant nature on the child’s physical, psychological or emotional well-being.

2. It is immaterial how the harm is caused.

3. Harm can be caused by:
   a. Physical, psychological or emotional abuse or neglect; or
   b. Sexual abuse or exploitation.

4. Harm can be caused by:
   a. A single act, omission or circumstance; or
   b. A series or combination of acts, omissions or circumstances.

Section 13C of the Act provides guidance on what to consider in identifying significant harm and developing a reasonable suspicion that a child may not have a parent able and willing to protect him/her. For example, it considers the detrimental effects on the child’s body or psychological state and their nature and severity, the child’s age and the reporter’s professional knowledge.

Household Member
A household member is any person who has significant in-home contact with the child, including those who have a familial or intimate relationship with any person in the home. This includes stepparents or partners of a parent living with the child who may not be the child’s primary parent.

Mandatory Reporter
Sections 13E and 13F of the Act specify certain professionals who must report a reasonable suspicion that a child may be in need of protection as a result of significant physical or sexual abuse. Mandatory reporters include doctors, registered nurses, approved teachers, certain police officers, officers of the Public Guardian, employees of the Department of Communities, Child Safety and Disability Services and employees of licensed care services.

It should be noted that Mandatory Reporters should also report a reasonable suspicion that a child is in need of protection caused by any other type of abuse.

Non-Organic Failure to Thrive (NOFTT)
Failure to thrive (also called psychosocial failure to thrive) is defined as decelerated or arrested physical growth (height and weight measurements fall below the fifth percentile, or there is a downward change in growth across two major growth percentiles) associated with poor developmental and emotional functioning. Organic failure to thrive occurs when there is an underlying medical cause. NOFTT occurs in a child who is usually younger than 2 years old and has no known medical condition that causes poor growth.
Psychological, social or economic problems within the family almost always play a role in the cause of NOFTT. Emotional or maternal deprivation is often related to nutritional deprivation. The mother or primary carer may neglect proper feeding of the infant because of preoccupation with the demands or care of others, her own emotional problems, substance abuse, lack of knowledge about proper feeding or lack of understanding of the infant’s needs. Organic failure to thrive is caused by medical complications of premature birth or other illnesses that interfere with feeding and normal bonding activities between parents and infants.

**Parent**
A parent of a child is defined⁴ as the child’s mother, father or someone else (other than the chief executive) having or exercising parental responsibility for the child. However, a person standing in the place of a parent of a child on a temporary basis is not a parent of the child. A parent of an Aboriginal child includes a person who, under Aboriginal tradition, is regarded as a parent of the child. A parent of a Torres Strait Islander child includes a person who, under island custom, is regarded as a parent of the child.

**Procuring Prostitution⁵**
A person who procures another person to engage in prostitution, either in Queensland or elsewhere, is procuring prostitution. ‘Procuring’ includes knowingly enticing or recruiting for the purposes of sexual exploitation.

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⁴ s11 Child Protection Act 1999  
⁵ s229G Criminal Code 1899