SUBMISSION

TO

PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY

BY

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About the author:-

Dr John AM Gall – I am a medical practitioner practicing in the field of Forensic and General (principally occupational) Medicine and am a specialist Forensic Physician with an appointment as a consultant to the Victorian Forensic Paediatric Medical Service (VFPMS), Royal Children's Hospital and Monash Medical Centre. I work mainly in private practice and am a Director of Southern Medical Services Pty Ltd and Principal of Era Health. Era Health is a group of three medical centres located in the Melbourne CBD (a private "super clinic"), North Melbourne and Melbourne Airport.

Of relevance to this Inquiry, I have practiced in the field of Clinical Forensic Medicine for seventeen years, three of these as a Forensic Medical Officer attached to the Department of Forensic Medicine, Victoria Police, three years as a full-time and two years as a half-time consultant in Clinical Forensic Medicine, Victorian Institute of Forensic Medicine (VIFM). Currently, I am a sessional specialist with the Victorian Paediatric Forensic Medical Service and have been in this position for the last five years. In this role, in addition to clinical practice, I am actively involved in training paediatric registrars. I am also work privately in clinical forensic practice.

I was an Honorary Senior Lecturer in the Department of Forensic Medicine (VIFM), Monash University, for five years. My academic role included extensive teaching of all aspects of forensic medicine to undergraduates and graduates of medicine and law and some paramedical groups. With co-authors, I wrote and taught the subject '*Custodial Medicine*' in Monash University's Graduate Diploma of Forensic Medicine. I devised, developed and administered an international continuing education programme in forensic medicine for five years until my resignation from the VIFM. This programme was published quarterly in the Journal of Forensic and Legal Medicine. With co-authors, I have also edited and published two books, *Forensic Medicine – Colour Guide* in 2003 and *Current Practice in Forensic Medicine* in 2011. During my time at the VIFM I was engaged in forensic medical research and have published some of my findings in this field. I am a member of the International Editorial Board of the Journal of Forensic and Legal Medicine and Internet Journal of Forensic Medicine and Toxicology and Vice President of the Australasian Association of Forensic Physicians.

My experience in clinical forensic medicine has involved all aspects of the discipline including sexual and physical assaults of both adults and children, custodial medicine, toxicology, traffic medicine, mental health issues and fitness for interview. I have given evidence at all levels of the court system on a very large number of occasions.

General

Thank you for the opportunity to present some comments to the Inquiry regarding the issue of Victoria's vulnerable children. Colleagues with whom I work at the Royal Children's Hospital have prepared and presented a more detailed response attending to all aspects of the inquiry. I have restricted myself to attending to Items 3 (3.1, 3.2 and 3.4) and 6.1.1 as these areas that impact upon the provision of medical services daily within the child protection system. Further, many of the issues raised have been raised in meetings and/or correspondence between either VFPMS and Child Protection, DHS, or me and Child Protection, DHS (CP). Unfortunately, little, if any,

improvement has been achieved, a situation that is neither in the best interests of the potentially vulnerable children seen by both services nor in the best interests of improving an integrated service delivery approach.

Before discussing the various issues below, a brief introduction to the Victorian Forensic Paediatric Medical Service:

Victorian Forensic Paediatric Medical Service (VFPMS)

The Victorian Forensic Paediatric Medical Service (VFPMS) is a forensic medical service available statewide that provides a series of services including: -

- forensic assessments of children who have been physically abused
- forensic assessments of children who have been allegedly sexually abused
- medical assessments of children who have allegedly been physically abused, sexually abused, are suffering from neglect or psychological abuse
- the provision of full paediatric assessments of children including determination of developmental stages
- general medical services to children
- provision of advice on the management of at risk and vulnerable children

The services are provided by one or a combination of senior paediatric trainees (usually in the last 12 months prior to becoming consultants), general paediatricians and general practitioners in regional area, and senior consultant paediatricians and forensic physicians in metropolitan Melbourne.

IT SHOULD BE NOTED THAT THE VIEWS EXPRESSED IN THIS SUBMISSION ARE THE VIEWS OF THE AUTHOR AND DO NOT NECESSARILY REPRESENT THE VFPMS. THIS IS A SEPARATE AND INDEPENDENT SUBMISSION AND IS NEITHER PART OF NOR REPRESENTS THE VIEWS OF THE VFPMS.

Abbreviations used:

VFPMS – Victorian Forensic Paediatric Medical Service

CP – Child Protection, DHS

3. The quality, structure, role and functioning of: family services; statutory child protection services, including reporting, assessment, investigation procedures and responses; and out-of-home care, including permanency planning and transitions; and what improvements may be made to better protect the best interests of children and support better outcomes for children and families.

3.1 Over recent years Victoria has been developing an increasingly integrated service delivery approach to the support of vulnerable children and families. From a systems perspective what are the strengths and weaknesses of this approach? How should any identified weaknesses be addressed?

The concept of an integrated service delivery approach is commendable. Unfortunately, this approach does not appear to be working with respect to the integration of the forensic medical service into the child protection system. Child Protection (CP) act as a central point of management of child abuse cases in those for which the VFPMS has any input. Police, other doctors and CP refer potential cases of abuse to VFPMS for an assessment.

The VFPMS doctors provide, in turn, a report to police and/or CP on the referred child and this includes an opinion regarding the likelihood of abuse and recommendations for management based on extensive past experience and medical knowledge. Unfortunately and invariably, the recommendations made by VFPMS appear to be ignored. This defies the benefits of an integrated service delivery approach as the written advice and recommendation from highly experienced professionals (VFPMS) who have a broad and in depth detail of children and their parents is ignored.

A second issue of concern is the absence of information sharing. In order to assess vulnerable children it is imperative that the assessing doctor is provided with all the necessary information on which to base an opinion. This information needs to be as accurate and as full as possible. Too frequently, CP provide VFPMS with very selective and limited information, if any information at all, with which to make a decision. This makes it very difficult to provide a relevant and balanced medical opinion and to provide the necessary assistance that CP may be seeking.

Greater integration of the medical service with that of the welfare sector would be of significant benefit to vulnerable children and their families. The welfare sector seem to view themselves as a very separate service to that of the medical service and it tends to leave one believing that CP and VFPMS work for opposing groups rather than being different elements of the one overall group. This same feeling of exclusion is not expressed towards the medical service by the police (who acknowledge and generally follow our recommendations and provide us with information to assist our assessment of the case), only the welfare groups and principally CP.

One simple means by which this weakness could be addressed is that there is a requirement for the welfare sector to consider and utilize the recommendations made by the medical professionals and that, unless there is good reason, that the recommendations are followed as provided. Further, improved integration could be achieved by the inclusion of VFPMS in case discussions on a regular rather than infrequent occasion.

3.2 Providing a quality service to vulnerable children and their families is dependent on having a skilled workforce. What are the strengths and weaknesses of current workforce arrangements eg working conditions, training and career paths? How might any weaknesses be addressed?

There are two areas that I wish to comment in regards to this, one relates to CP and the other to VFPMS.

a) CP

Over the many years of providing services in relation to child protection, one regular point of note is that the child protection workers are generally young, inexperienced and, for whatever reason, rarely seen on a second occasion. It is, therefore, assumed that the turnover is relatively high. Working with vulnerable children and their families is a challenging and at times stressful area. The current apparent structure within CP suggests that those in most areas working at the coal face are very junior and inexperienced and that decisions are made by more senior personnel remote from that coal face. This seems to be the situation more so in the metropolitan region than in regional Victoria where older CP workers are in direct contact with the children and their families and seem to be able to make decisions without the necessity of referral back to 'team leaders'. This has several problems in the metropolitan area that a) the workers directly involved with the families do not have the necessary life experiences to adequately address the situation immediately at hand and b) decisions cannot be made directly with the family but await committee or more senior decisions being handed down by persons remote from the particular family concerned.

The recommendation for change would be: -

a) that more senior, mature (ie, older and life-experienced rather than young, course-educated) staff be appointed to provide coal face contact with the children and their families
b) the hierarchical system within DHS be reduced so that decisions can be made more by staff at the coal face rather than having to rely on committee meetings far removed from the coal face

b) VFPMS

As discussed, working with vulnerable children and their families can be particularly stressful and there is nothing more stressful than some of the issues that confront the service as a result of bureaucratic bullying, inactivity and ignorance. It is difficult to recruit and retain Doctors in this work due to the nature whereby after hours and court requirements are extensive and burdensome. For a medical workforce that principally works in private practice, attending to these can be onerous. In many respects, a medical service staffed by full-time or part-time, rather than sessional staff would be ideal but this may only be able to be achieved within the Melbourne metropolitan region. Regional areas would not necessarily have the workload to justify full time staff.

Other issues that need to be addressed within this service to ensure ongoing recruitment and retention of experienced staff include:-

- Adequate remuneration and training for all staff but particularly regional and remote staff
- Recognition of their contribution – too often the service is ignored or taken for granted until problems arise whereupon somehow the doctors are required to solve issues for CP or others at 'the last minute'
- Limited on-call requirements to reduce 'burn-out' (NB each after-hours case takes 2-3 hours for an initial consultation)

- Funding and encouragement to undertake research into child abuse issues
- Acceptance by the two hospitals (Royal Children's Hospital and Monash Medical Centre) that VFPMS is a legitimate unit that requires an inpatient facility in addition to suitable outpatient facilities. The outpatient facilities need to be appropriate and not, as frequently is the case, some out-of-the-way room that is poorly lit and ventilated, and ill-equipted for the nature of the service provided

b. Statutory child protection services, including reporting, assessment, investigation procedures and responses;

3.4 What are the strengths and weaknesses of our current statutory child protection services in relation to responding to and assessing suspected child maltreatment?

This has been discussed in part above. Within CP, there are significant weaknesses relating to: -

a) inexperience of workers
b) remote decision making
c) preoccupation with processes and not outcomes
d) failure to information share
e) failure to understand the role of and to acknowledge and act upon the opinions, advice and recommendations made by the medical staff of VFPMS
f) contempt for VFPMS
g) no feedback system to VFPMS
h) inability to comprehend and act upon neglect, psychological abuse and cumulative harm

a) <u>Inexperienced workers</u>

When dealing with vulnerable children and their families, contrary to obsessions with 'qualifications', life experience surpasses any theoretical knowledge. Those attending on these cases are too young and need a greater deal of life experience (ie maturity) to enable them to better assess and manage the cases before them.

b) <u>Remote decision making</u>

This has been discussed above. Decisions regarding the appropriate management of potentially vulnerable children need to be made at the time of assessment and should not be referred to some 'team leader' remote from the professional advice provided and the family it concerns.

c) <u>Preoccupation with processes and not outcomes</u>

As with many public organizations and bureaucracies, there is a preoccupation with processes. Much that some degree of 'process' is necessary, when managing vulnerable children, each case needs to be assessed and managed individually. It is a requirement of this type of investigation that workers with sufficient skill and knowledge undertake the work to ensure that the investigation and management of each case is tailored to the circumstances that present. It is not possible to do this if there is a flowchart that requires strict adherence. Success in case management should not be based on completion and ticking of all boxes within a chart as seems to be the situation with welfare groups and, in particular, CP. Success in dealing with

vulnerable children is to ensure that they are safe, secure and well managed not only for the present but with every prospect of this being the case in the future. Failure to do so merely adds to tomorrow's problems – so true is the adage "a stitch in time saves nine".

I have attended a number of meetings involving Child Protection and the various professional and community agencies involved with vulnerable families. Of note during these meetings is the preponderance of discussion by welfare groups but little committed action. I have made attempts to change this with the various agencies being asked to commit to achieving a particular outcome by a certain date. This is met with varying enthusiasm, usually distain. Meetings without an agreed commitment to actions and timelines are a pointless exercise and merely an example of management failure. The meetings, thus, become yet one of the processes discussed above. Meetings should not be used as an alternative to work. Their purpose is to information share, set agendas and ensure that those adgendas and timelines are met.

Again, effective management, is not a matter of protocols and ticking boxes but one of actual beneficial outcomes for the families and children involved. There is no point in having protocols may with all the boxes ticked but the family is really not better off.

d) Failure to information share

In order to assess vulnerable children it is imperative that the assessing doctor is provided with all the necessary information on which to base an opinion. This information needs to be as accurate and as full as possible. Too frequently, CP provide VFPMS with very selective and limited information, if any information at all, with which to make a decision. This makes it very difficult to provide a relevant and balanced medical opinion and to provide the necessary assistance that CP may be seeking.

e) Role of VFPMS

Despite many lectures and information being provided regarding the role of VFPMS to CP, general knowledge regarding the role of VFPMS remains very poor and may be a consequence of the high turnover within the Department. Thus, the functions of VFPMS are not well utilized by CP and when utilized, the advice and recommendations tend to be ignored. This, in turn, aggravates an already unsatisfactory situation for a potentially vulnerable child.

The interaction between CP and VFPMS is one where CP does not seem to appreciate that we are both working on the same side. Every effort is made to provide highly professional advice to CP which, unfortunately, goes unheeded in almost every instance. This renders the medical examination a complete waste of time and of little benefit to the service which it is serving. Recommendations are provided to enable a better outcome for the children and a failure to follow these is not to anyone's benefit and certainly not to the benefit of the child.

f) Contempt for VFPMS

Weekly, CP arrange for children to be assessed by VFPMS. In some cases, information is now being provided. Too frequently, information is not only not provided but the child to be assessed is accompanied to one of our units by a CP

worker who has merely been assigned the task of transporting and accompanying the child. The worker has no information about the case.

If the VFPMS assessment is important, surely the person working with the case would attend and ensure the doctor was given appropriate and helpful information. Why does this so frequently not occur? Is it because a forensic examination is just yet another 'process' that needs to be undertaken to 'tick' that box as part of case process completion? Or is it contempt for the medical service?

g) Feedback

Currently, CP provide no feedback regarding any case of alleged child abuse that has been seen at the request of Cp or reported to CP. Feedback is very important as it is one method whereby the VFPMS service can self monitored and improved as appropriate and whereby processes can be adjusted.

h) Inability to comprehend and act upon neglect, psychological abuse and cumulative harm

Despite the previous and now revised Act, there seems to be ongoing problems in some workers' understanding of psychological abuse and neglect, and of cumulative harm. No-one (welfare, CP and lawyers) seems to be able to manage and prosecute psychological abuse despite that fact that the ramifications of such abuse can be far reaching and affect the child throughout their life. Similarly, neglect also fails to attract the attention it requires. Needless to say, the concept of cumulative harm is beyond most, if not all, CP workers, welfare workers and the legal profession.

Child and Adolescent Mental Health Service (CAMHS)

I will briefly comment regarding CAMHS. From a medical perspective, psychiatric assessments of vulnerable children are sometimes essential in determining appropriate management. Efforts to utilize CAMHS has proved inevitably fruitless. There are always difficulties securing a referral to the service, the appointments are never prompt but normally months away, and the reports provided, if provided, fail to address the issues raised in the referral. In general, I have found the service to be unsatisfactory.

3.4.1 How might the identified weaknesses be best addressed? If there are places where some statutory child protection services work more effectively that elsewhere, what appear to be the conditions associated with this and how might these conditions be replicated elsewhere in the State?

In brief:

a) For CP:-
   a. engage more senior (ie, older and life-experienced rather than young, course-educated) staff to provide coal face contact with the children and their families – perhaps a junior and senior person could work together in an apprenticeship arrangement
   b. the hierarchical system within DHS needs to be reduced so that decisions can be made more by staff at the coal face rather than having to rely on committee meetings far removed from the coal face

c. change the measurement of successful case management from one of processes completed to one of satisfactory case outcome (safe, secure and well managed not only for the present but with every prospect of this being the case in the future)
d. require CP to information share with VFPMS
e. further educate CP in the role of and to acknowledge and act upon the opinions, advice and recommendations made by the medical staff of VFPMS
f. educate both CP workers and relevant lawyers on the concepts of and ways to comprehend and act upon neglect, psychological abuse and cumulative harm
g. provide feedback to VFPMS about cases

b) For CAMHS
   a. establish working protocols and agreements between CAMHS and VFPMS to enable the timely assessment of vulnerable children and of the provision of meaningful reports

c) For VFPMS
   a. ensure adequate remuneration and training for all staff but particularly regional and remote staff
   b. recognize the contribution of this service to child protection overall
   c. limit on-call requirements to reduce 'burn-out'
   d. encourage the provision of funding and encourage VFPMS staff to undertake research into relevant child abuse issues
   e. encourage acceptance by the two hospitals (Royal Children's Hospital and Monash Medical Centre) and regional hospitals that VFPMS is a legitimate unit that requires a metropolitan inpatient facility in addition to suitable outpatient facilities. The outpatient facilities need to be appropriate and not, as frequently is the case, some out-of-the-way room that is poorly lit and ventilated, and ill-equipted for the nature of the service provided

3.4.3 What has been the impact of the Victorian system of mandatory reporting on the statutory child protection services? Have there been any unintended consequences from the introduction of the Victorian approach to mandatory reporting and, if so, how might these unintended consequences be effectively addressed?

Mandatory reporting may be of benefit to politicians at various stages in responding to adverse reports that may appear in the press. Unfortunately, as with any legislation or plan, it is important to ensure that the services necessary to implement any change are available and that the service is adequately staffed. There is little point in passing legislation if it is not possible to either police or effectively implement. One example of this was given above, the failure of CP and their lawyers to effectively manage and prosecute neglect, psychological abuse and cumulative harm.

Although many legislators may have the best of intentions to protect vulnerable children, there are certain unintended consequences from the introduction of the Victorian approach to mandatory reporting. Effectively, there are inadequate Child Protection services to investigate all reported cases which, depending upon the quality of the triage, can result in serious cases being overlooked. This would then lead to an unintended consequence of increasing the vulnerability of already vulnerable children. This issue can be addressed by ensuring, whenever any

decision is made to alter the legislation that there is an adequate workforce available to implement the legislative changes.

Other very important issues that relate to overworked CP workers is that mandated reporters view their efforts to report as being futile (due to perceived in action by CP) and begin to not report, again opening a means for a serious and potentially fatal case of abuse to escape attention.

6. Possible changes to the processes of the courts referencing the recent work of and options put forward by the Victorian Law Reform Commission.
6.1 In light of recent child protection legislative changes, trends in other jurisdictions, and in particular the options put forward by the Victorian Law Reform Commission1:
6.1.1 What changes should be considered to enhance the likelihood that legal processes work in the best interests of vulnerable children and in a timely way?

Although the legislation within Victoria describes both child physical abuse, sexual abuse, neglect and psychological abuse, psychological abuse appears to be rarely, if ever, acted upon and neglect infrequently acted upon. Similarly the concept of cumulative harm to children due to ongoing neglect, ongoing physical abuse, ongoing sexual abuse and ongoing psychological abuse is not understood by either CP or the legal profession. Neglect and psychological abuse can be far more devastating and affect a child's wellbeing than perhaps a single episode of physical or sexual abuse. Ongoing sexual and physical abuse, neglect and ongoing psychological abuse can be cumulative thus leading to a far more serious outcome for the child. These concepts appear be addressed or deleted from the legislation.

Finally, the issue of the Children's Court clinic. There is a conflict of interest in the existence of this clinic. In an adversarial system, which seems to be the most appropriate system, imperfect though it may be, all evidence provided should be open to scrutiny. The Court Clinic escapes this scrutiny. It should be abolished.

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