



The Structured Decision Making[®] System
for Child Protection Services

Queensland Child Protection Guide 2.1

March 2019



Department of Child Safety, Youth and Women

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.

The Department of Child Safety, Youth and Women, an agency of the Queensland Government, is licenced to reproduce, install and display SDM materials for internal purposes. Any modification or addition must be approved by the National Council on Crime and Delinquency (NCCD). NCCD will then grant a licence to use such agreed-upon modifications or additions for internal purposes only.

VERSION HISTORY

2.1	2019, February	<ul style="list-style-type: none">• Wording change to question on neglect: nutrition tree for clarity.• Modified path on universal tree 2
-----	----------------	--

TABLE OF CONTENTS

PURPOSE	1
PROCEDURES.....	3
COMPLETION INSTRUCTIONS	4
SELECTING A DECISION TREE.....	12
Physical Harm	21
Neglect: Supervision	35
Neglect: Physical Shelter/Environment	41
Neglect: Nutrition	46
Neglect: Medical Care—Registered Health Professionals	49
Neglect: Medical Care—Non-Registered Health Professionals.....	55
Neglect: Mental Health	58
Neglect: Hygiene/Clothing	62
Sexual Abuse.....	67
Emotional/Psychological Harm.....	73
Child is a Danger to Self Or Others	78
Pregnant Woman—Unborn Child.....	83
Parent Concern: Problematic Alcohol or Other Drug Use	89
Parent Concern: Mental Health.....	93
Parent Concern: Intellectual or Cognitive Disability	97
Parent Concern: Domestic and Family Violence.....	101
Universal Tree 1	108
Universal Tree 2	111
Universal Tree 3	113
GLOSSARY.....	117
REFERENCES.....	123
APPENDICES	
A. Supervision Levels	
B. Psychological Impact on Child	

The NCCD Children’s Research Center is a nonprofit social research organisation and a centre of the National Council on Crime and Delinquency.

Structured Decision Making® and SDM® are registered in the US Patent and Trademark Office.

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—Regional Intake Service (CS-RIS) promptly, whilst also enabling families facing less serious concerns 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 CS-RIS;
- 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.

This CPG is intended to complement—not replace—professional judgment, expertise and critical thinking. The guide should be applied within the professional's 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 the reporter believes is appropriate. Finally, this guide is a dynamic document. Continual evaluation and feedback will be used to refine this manual over time.

Working Across Difference

Workers engage with families, children and communities whose ethnicity, economic status, age, gender, culture, religion, spirituality, sexual orientation and upbringing may differ greatly from their own. Intrinsicly, people are influenced by personal experiences and therefore can be biased when assessing others who differ from themselves.

Considerations Regarding Aboriginal or Torres Strait Islander Children and Families

Throughout the document, there are references to Aboriginal or Torres Strait Islander child-rearing practices. These practices are derived from a body of cultural knowledge specific to Aboriginal or Torres Strait Islander persons and are defined as incorporating the following.

- Independence
- Responsibility of children at an earlier age
- Cultural authority (within kinship/clan groups)
- Cultural responsibility (passing on of knowledge or skills)

Aboriginal and Torres Strait Islander societal structures have been changed and influenced from the colonisation of Australia through to the present day. The majority of Aboriginal and Torres Strait Islander peoples have been directly or indirectly affected by past Federal and State government policies and interventions. These interventions have contributed to a breakdown in knowledge of child-rearing practices, supportive family kinship and community structures and guidance offered by traditional laws. The influence of past government interventions and policies must be considered holistically when considering child protection concerns.

When working with Aboriginal and Torres Strait Islander individuals, it is important to seek to understand strengths of their unique parenting practices and kinship structures, the strengths of community caring, collective decision making and network capabilities surrounding the child and family. Cultural connection is a strong protective factor for keeping children safe within their families, significantly influencing their identity and providing a sense of belonging that will contribute to the child's safety and well-being.

The cultural commentary used throughout this guide is learned communal knowledge obtained from the historical and contemporary experience and personal history of Aboriginal or Torres Strait Islander peoples.

PROCEDURES

WHICH CHILDREN

All persons under age 18 whom you encounter in the course of your professional duties.

WHO

Professionals who encounter concerns related to possible abuse or neglect of children. This includes mandatory and non-mandatory reporters.

WHEN TO USE THIS GUIDE

When you become concerned that a child you encounter in the course of your professional duties may be abused or neglected by a parent or adult household member.

If a child may be harmed by someone who is not a parent or household member or who is a child in the household, do the following.

- Notify police if appropriate.
- If concerned about whether a parent is protecting child from the person causing harm, turn to the Neglect: Supervision decision tree.
- If concerned about whether a parent is providing medical or mental health care needed by child as a result of being harmed, turn to the Neglect: Medical or Neglect: Mental Health decision tree.

DECISIONS

Each path through a decision tree leads to a decision point as described below.

- Report to CS-RIS.
- Refer to voluntary prevention resource.
 - » Family and Child Connect (FaCC)
 - » Intensive Family Support (IFS) services
 - » Aboriginal and Torres Strait Islander Family Wellbeing Service (ATSIFWS)
- Report or referral not required.

NOTE: When a report or referral to voluntary prevention services is not required, referrals may be made, with family consent, for other resources. See completion instructions for further detail.

COMPLETION INSTRUCTIONS

URGENT CONCERNS

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 '000' and ask for the appropriate service to respond to the emergency.

NOTE: At any time whilst completing a decision tree, you are encouraged to consult with the child protection advice area within your agency if you have access to one. For example, if you work for Queensland Health (QH), this would be your Child Protection Liaison Officer. If you work for Queensland Police Service (QPS), this would be your Child Protection and Investigation Unit. If you work with the Department of Education (DoE), this would be your guidance officer/senior guidance officer or Principal Advisor—Student Protection.

1. From the home page, click 'Start'. Select your agency or organisation and click 'Next'. Then, select the decision tree that best represents your concern for the child and click 'Next'. If you have more than one concern, start with the most serious concern. If you are uncertain, select 'Unsure' and click 'Next'. This will guide you through a few questions to select the best decision tree or trees for your concerns.

NOTE: If the decision is 'report', it is *not necessary* to complete any additional decision trees. Contact CS-RIS and explain *all* of your concerns, even if you did not complete a decision tree for each one.

2. Start with the first question on the selected decision tree. Apply the definition to the information known to you, and determine whether a 'yes' or 'no' answer fits best. In the offline CPG, follow the arrow for either 'yes' or 'no' to the next question or to a decision point. In the online CPG, select 'Yes' or 'No' in the left frame, checking it against the definition that appears on the right part of the screen.

PRACTICE GUIDANCE

Answering 'yes' or 'no' to any statement is based on information available to the reporter. Reporters are not required to establish proof. In selecting 'yes' or 'no', the reporter is not asserting that the statement is definitively yes or no, but rather that information available to the reporter is reasonably supportive of a 'yes' or 'no' answer.

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. It is possible that a supervisor/colleague could help clarify your response.

- i. Queensland Health: Child Protection Liaison Officer or Child Protection Advisor
 - ii. QPS: Child Protection Investigation Unit
 - iii. Department of Education: Guidance Officer or Senior Guidance Officer
 - b. Are any other decision trees relevant? Did the online tree selection help suggest additional decision trees that would be applicable? 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 be construed not as conducting an investigation but as simply 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 a professional in your agency or DCSYW 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. If the recommendation is to report to CS-RIS, continue to Step 7. If the recommendation is anything other than to report to CS-RIS, make sure to complete decision trees related to any other concerns that you may have. Once you have either addressed all your concerns or reached a recommendation to report to CS-RIS on at least one concern, continue to Step 7.
7. Please treat the CPG 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 do one of the following.
- a. Follow the recommendation.
 - b. Consult with a professional in your agency. If needed, consult with CS-RIS.

- c. State and non-state school staff should also consider mandatory reporting obligations to QPS in relation to sexual abuse or likely sexual abuse in accordance with ss. 364–366B of the *Education (General Provisions) Act 2006*.
8. After completing 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.
9. Take the action recommended as follows.

1. Report to Child Safety—Regional Intake Service

CS-RIS receives information and child protection concerns from community members, government and non-government agencies during business hours (Monday to Friday, 9:00 a.m. – 5:00 p.m.).

During business hours, use the General Line to report to your regional intake service (RIS). Direct lines to RIS are available for use by mandatory reporters including QH; DoE; Queensland Catholic Education Commission; Independent Schools Queensland and QPS.

Reports *may* be made via email when allowed by your department. However, direct telephone contact is recommended to ensure that the information transfer is optimal.

Outside of these hours, the Child Safety After Hours Service Centre can be contacted on:

1800 177 135 or
 07 3235 9999 (general numbers) or
 3235 9901 (agency number), or
CSAHSCIntake@csyw.qld.gov.au.

The QPS after-hours line is only to be used after hours.

Regional Contact Details for Reporting Child Protection Concerns—Partner Agencies			
RIS	General Line	Direct Line	Email
Brisbane RIS	1300 682 254	1300 705 339	BrisbaneRISIntake@csyw.qld.gov.au
Central Queensland RIS	1300 703 762	1300 683 042	CQRISIntake@csyw.qld.gov.au
Far North Queensland RIS	1300 684 062	1300 683 596	FNQRISIntake@csyw.qld.gov.au
North Coast RIS	1300 703 921	1300 705 201	NCRISIntake@csyw.qld.gov.au
North Queensland RIS	1300 706 147	1300 704 514	NQRISIntake@csyw.qld.gov.au
South East RIS	1300 679 849	1300 678 801	SERISIntake@csyw.qld.gov.au
South West RIS	1300 683 390	1300 683 259	SWRISIntake@csyw.qld.gov.au
Ipswich RIS	1800 316 855	1800 316 776	IpswichIntake@csyw.qld.gov.au

Regional Contact Details for Reporting Child Protection Concerns—Partner Agencies			
RIS	General Line	Direct Line	Email
Child Safety After Hours Service Centre	1800 177 135 07 3235 9999	1300 681 513 3235 9901 QPS after-hours line 1300 682 724 07 3235 9902	CSAHSCIntake@csyw.qld.gov.au

You should make a report about your concerns to CS-RIS as soon as possible, in accordance with your agency's procedures. In some instances, you may also need to arrange medical care or inform QPS.

Include the following information, to the extent known, in your report or information as required by your agency's policies and procedures.

- Which decision trees you used.
- A description of the specific circumstances that supported your 'yes' or 'no' responses on the decision trees.
- Child details (name, date of birth [DOB], sex, Indigenous status/ethnicity, language).
- Parent 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's protective actions or abilities, if known.
- History of previous relevant contact with service.
- Reporting officer's details (name, position, contact details).

Also 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).

The child safety officer (CSO) will assess the information that you provide, along with information that may be known to the Department of Child Safety, Youth and Women (DCSYW), to determine whether the report:

- Does not meet the threshold for a notification; or
- Is a notification, and an investigation and assessment is required.

Irrespective of what DCSYW does, it is important to maintain your professional relationship with the family for as long and as much as appropriate and possible.

CROSS-REPORTING TO POLICE

DCSYW 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.

The QPS's fundamental role in child protection is the investigation of criminal offences committed upon or by children.

RELEASE OF INFORMATION WHEN REPORTING TO CS-RIS

You can and should provide the following.

- Specifics of the situation, particularly facts that you relied on to answer 'yes' or 'no' on decision trees.
- Information affecting the safety of the child, other family members or responding worker.
- Information to identify child and family.

There are protections from liability for giving information about alleged harm or risk of harm under the *Child Protection Act 1999* (section 197A).

For more information on reporting concerns to DCSYW, visit their website at: <https://www.csyw.qld.gov.au/>.

2. Referral Options (Non-Reports)

The decision to refer a family to FaCC, ATSIFWS or IFS can occur when:

- The concerns have not reached the reporting threshold under the *Child Protection Act 1999* (the Act); AND
- Children and families are experiencing struggles and could be assisted by a support service.

NOTE: Consider whether there are other concerns that require review of other decision trees. Be sure all concerns have been assessed. If any concern leads to a recommendation to report, all concerns are to be reported.

RELEASE OF INFORMATION WHEN MAKING A REFERRAL

- It is preferable to obtain consent. If the child has the capacity and is competent to consent to a referral for themselves or the disclosure of their own information, the child may do so.
- If consent is not possible and you are one of the professionals in a prescribed entity (section 159M of the Act), you may make the referral without consent. Situations that are recommended for referral to FaCC, IFS or ATSIFWS are intended to reflect situations in which a child is likely to become a child in need of protection if no preventive support is provided.
- If you are not one of the professionals in a prescribed entity, you may *not* make the referral without consent.

The following table describes the three types of referral options.

FaCC	IFS	ATSIFWS
Use when it is necessary to conduct further identification of family needs prior to determining the most appropriate support service(s) for the family, OR when family may need help deciding what to do about area of concern.	Use when it appears that the family has multiple complex needs or chronic problems that will benefit from intensive intervention, AND family is committed to intervention.	Use when the family identifies as Aboriginal or Torres Strait Islander and it appears the family has multiple or complex needs or chronic problems that will benefit from intensive intervention, AND the family is committed to intervention.
Provides further identification of family needs, engages the family and provides referrals to the appropriate community-based services. May conduct assessment of safety and risk. May refer to IFS or ATSIFWS.	Provides case management and holistic supports and services.	Provides further identification of family needs, engages the family and provides case management and holistic supports and services.

Referral Steps

- Talk to the family about your concerns and seek their consent to provide a referral to FaCC, IFS or ATSIFWS. Only reporters from prescribed entities may refer a family to these services without the family's consent. See Glossary for list of entities.
- If the family does not consent to a referral and you are not from a prescribed entity, you cannot directly refer the family to these services. 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 family consents, or if not but you are from a prescribed entity, complete a referral to FaCC, IFS or ATSIFWS as indicated by the decision tree.
- If you have further concerns about the child, you could also contact FaCC, IFS or ATSIFWS for information and advice on how to move forward with the family.

3. Report or Referral Not Required

This decision point occurs when the concerns are substantially below the CS-RIS screening threshold for reasonable suspicion that a child is in need of protection. The circumstances do not suggest that family is likely to require child protection intervention in the absence of support services. Still, the family may benefit from formal or informal supports available to them in the community.

NOTE: Consider whether other concerns require review of other decision trees. Be sure all concerns have been assessed. If any concern leads to a recommendation to report, all concerns are to be reported.

If your 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 have an ongoing relationship with the family or are in a position to check back, you are encouraged to check in on the family to see whether they have accessed services or resolved the need on their own. If not, consider providing them with information about oneplace (<http://www.oneplace.org.au>). In the event that the situation has worsened, redo the decision tree with the new information to determine whether a referral to FaCC, Family Wellbeing Service or IFS or a report to CS-RIS is indicated based on the changed situation.

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

NOTE: Some circumstances are not reportable because they do not meet the threshold, 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.

Legislative provisions regarding information exchange are in Chapter 5A of the Act.

NOTE: Nothing in this guide restricts a professional from contacting CS-RIS. If you do report and used the guide, tell the CSO 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.

AFTER THE DECISION

Regardless of the decision and action taken regarding the concern, two things should be done.

1. **Document decision.** Following your agency protocol, prepare a record of your concerns, including the information that led to your 'yes' or '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.
2. **Monitor and support child well-being as appropriate.** If your professional role includes an ongoing relationship with the child 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 OR parent, *you are not required to maintain contact.*

SELECTING A DECISION TREE

If you know which decision tree to use, you may select it directly. (See screen 1 of the following table.) If you are uncertain, you may select the 'unsure' option in screens 1, 2 or 3, which will guide you through questions to suggest a decision tree that best fits your concern. If at any time (on any of the screens) more than one tree is recommended, continue through each tree until you have reviewed all your concerns, OR you have reached a recommendation to report to CS-RIS.

NOTE: This will be automated; but for the time being, start on Screen 1 below and answer the first question. Based on your selection, go to the suggested decision tree. In some instances, additional information is needed. Follow the numbered link to the corresponding screen and answer the next question. Continue until you have a decision tree recommendation or reach 'Report or referral not required.'

When you complete a decision tree, if you reach a recommendation of 'Report to CS-RIS', you are not required to complete additional trees even if you have additional concerns. When making your report, provide information about all your concerns.

If you have not reached a recommendation of 'Report to CS-RIS', you may do the following if applicable.

- Apply your concern to another decision tree that was suggested, if applicable.
- Review relevant decision trees for additional concerns you may have.

If you have not reached a recommendation of 'Report to CS-RIS' after considering all relevant decision trees for all of your concerns, this suggests that the concerns do not meet the threshold for reporting. However, nothing prevents you from making a report.

SELECTING A DECISION TREE TABLE

In the following table, each selectable option is followed (in parentheses) by the name of the tree or the number of the screen that opens when you click it.

Screen	Display
1	<p>If you know which decision tree you need, you may select it here.</p> <p>If you have more than one concern, select the concern with the greatest impact on the child first. If completing that tree does not result in a recommendation to report to CS-RIS, select the next concern. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>If you do not know which decision tree you need, select 'Unsure'.</p> <ul style="list-style-type: none"> • Physical Harm (Physical Harm) • Neglect (2) • Sexual Abuse (Sexual Abuse) • Emotional/Psychological Harm (Emotional/Psychological Harm) • Child is a danger to self or others (Child is a Danger to Self or Others tree) • Pregnant Woman—Unborn Child (Pregnant Woman—Unborn Child tree) • Parent Concern (3) • Unsure (4)
2	<p>If you are concerned about more than one form of neglect, select the form of neglect with the greatest impact on the child first. If completing that tree does not result in a recommendation to report to CS-RIS, select the next concern. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>If you do not know which form of neglect to select, select 'Unsure'.</p> <p>Neglect of:</p> <ul style="list-style-type: none"> • Supervision (Neglect: Supervision tree) • Physical Shelter/Environment (Neglect: Physical Shelter/Environment tree) • Nutrition (Neglect: Nutrition tree) • Medical Care (if yes, 'Are you a Medical Professional?' response takes you to correct Neglect: Medical Care tree) • Mental Health (Neglect: Mental Health tree) • Hygiene/Clothing (Neglect: Hygiene/Clothing tree) • Unsure (9)

Screen	Display
3	<p>If you have more than one concern about a parent, select the concern with the greatest impact on the child first. If completing that tree does not result in a recommendation to report to CS-RIS, select the next concern. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>If you do not know which form of neglect to select, select 'unsure'.</p> <p>Parent concern:</p> <ul style="list-style-type: none"> • Problematic alcohol and other drug use (Parent Concern: Problematic Alcohol and Other Drug Use) • Mental Health (Parent Concern: Mental Health) • Intellectual or Cognitive Disability (Parent Concern: Intellectual or Cognitive Disability) • Domestic and Family Violence (Parent Concern: Domestic and Family Violence) • Unsure (13)
4	<p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next person or item on the list. Continue until you have reviewed all of your concerns considering the potential causes of harm or you have reached a recommendation to report to CS-RIS.</p> <p>Who may be causing harm or creating unacceptable risk of harm to the child?</p> <ul style="list-style-type: none"> • Parent or adult household member (5) • Someone other than parent or adult household member (6) • Child is self-harming (7) • Unknown—<i>could</i> be parent or adult household member (5) • Unknown—<i>cannot</i> be parent or adult household member (6) • None of the above: Child has not been harmed, nearly harmed, or it is unclear whether child has been harmed (8)
5	<p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>What has happened or is at unacceptable risk of happening?</p> <p>Parent or adult household member has:</p> <ul style="list-style-type: none"> • Physically injured child, or nearly injured child (Physical Harm) • Not provided what child needs (9) • Engaged sexually with child (Sexual Abuse) • Treated child badly so that child is emotionally distressed (Emotional/Psychological Harm) • Not kept residence clean, organised and free of hazards (Neglect: Physical Shelter/Environment) • Left child alone, or was inattentive and child was injured or nearly injured (Neglect: Supervision) • None of above (other concerns)

Screen	Display
6	<p>If the actions towards child may be criminal, report to police.</p> <p>Do any of the following apply to parents?</p> <ul style="list-style-type: none"> • Parent was not protective of child (Neglect: Supervision) • Parent did not provide medical care child needed (Neglect: Medical Care) • Parent did not provide mental health care for child (Neglect: Mental Health) • Parent blamed child, berated child, disbelieved child regarding what happened (Emotional/Psychological Harm) • None (other concerns)
7	<p>Secure medical and mental health care as needed.</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns applicable to the parents or until you have reached a recommendation to report to CS-RIS.</p> <p>Do any of the following apply to parents?</p> <ul style="list-style-type: none"> • Parent did not access mental health care for child (Neglect: Mental Health) • Parent is not providing sufficient monitoring and supervision (Neglect: Supervision) • Parent's treatment of child is causing emotional distress or making it worse (Emotional/Psychological Harm) • Parent is doing everything reasonable but child self-harm continues (Child Is a Danger to Self or Others) • None (other concerns)
8	<p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns applicable to the parents or until you have reached a recommendation to report to CS-RIS.</p> <p>What best describes your concerns?</p> <ul style="list-style-type: none"> • Child's behaviour (10) • Child's emotion (11) • Child's development (12) • Child's living environment/homelessness (Neglect: Physical Shelter/Environment) • Parent or other adult household member <ul style="list-style-type: none"> » Physical discipline of child (Physical Abuse) » Treats child badly (Emotional/Psychological Harm) » Does not meet child needs (9) » Condition or characteristic of parent (13) • None of above (other concerns)

Screen	Display
9	<p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>What does child need that is not being provided?</p> <ul style="list-style-type: none"> • A safe place to live (Neglect: Physical Shelter/Environment) • Enough food/nutrition (Neglect: Food) • Medical care, including dental, vision and all aspects of medical care (Neglect: Medical Care. Ask if registered health care provider and take to correct tree.) • Mental health care, counselling, therapy, psychological assessment, etc. (Neglect: Mental Health) • Adult or responsible child supervision (Neglect: Supervision) • Bathing, clean laundry, and necessary clothing (Neglect: Hygiene/Clothing) • None of above (other concerns)
10	<p>If child's troubling behaviours are related to mistreatment by parent or adult household member or conditions in the home, also consider looking at decision trees related to the mistreatment, or to parent concerns.</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>What is child doing that is concerning?</p> <ul style="list-style-type: none"> • Hurting self, including not eating, or making self vomit, etc. (7) • Sexual behaviour: individual or towards another child (14) • Running away, risk taking, offending (Child Is a Danger to Self or Others) • Violent, fighting, assaulting, bullying (Child Is a Danger to Self or Others) • Unsafe sexual contact or child or someone else is getting something of value in exchange for sex, or filming or otherwise recording sex. (15) • Developmentally lagging behind (12) • None of above (other concerns)

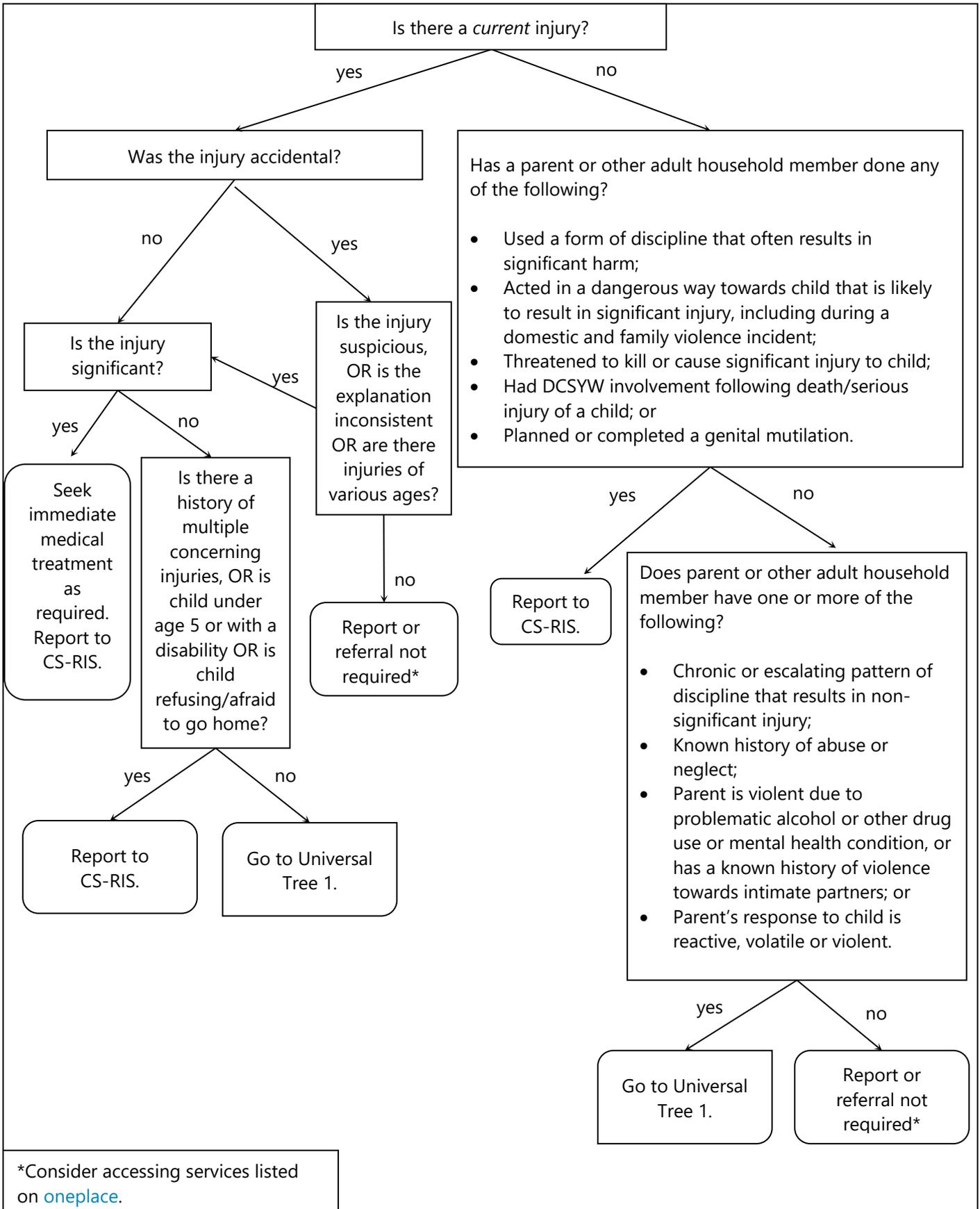
Screen	Display
11	<p>If child's troubling emotions are related to mistreatment by parent or adult household member or conditions in the home, also consider looking at decision trees related to the mistreatment or to parent concerns.</p> <p>Whenever possible, discuss with parent and encourage a mental health evaluation.</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <ul style="list-style-type: none"> • Do you suspect the child's troubling emotions are caused by or made worse by a parent? (Emotional/Psychological Harm) • Does the child need mental health care that the parent is not accessing? (Neglect: Mental Health) • Do the child's emotions lead to behaviour that could harm them or others? (Child Is a Danger to Self or Others) • None of above (other concerns)
12	<p>Whenever possible, discuss with parent and encourage a developmental assessment or support from developmental services.</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <ul style="list-style-type: none"> • Parent does not attend to child in ways that will impact development (Neglect: Supervision) • Parent does not complete recommended developmental assessment (Neglect: Medical Care) • Parent does not provide recommended therapies to support development (Neglect: Medical Care) • None of above (other concerns)

Screen	Display
13	<p>Consider emotional/psychological harm first. If not reportable:</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>Which of the following are present?</p> <ul style="list-style-type: none"> • Parent has problematic alcohol or other drug use (Parent Concern: Problematic Alcohol and Other Drug Use) • Parent has mental health concerns (Parent Concern: Mental Health) • Parent has cognitive or intellectual concerns (Parent Concern: Intellectual or Cognitive Disability) • One parent or adult household member physically assaults or controls another, or one parent is being physically assaulted or controlled by a current or former intimate partner (Parent Concern: Domestic and Family Violence) • Parent is violent (consider Physical Abuse, Emotional/Psychological Harm and Parent Concern: Domestic and Family Violence) • Parent is unable to provide for family (consider any neglect decision tree that reflects unmet needs) • Parent lacks parenting skills (16) • None of above (other concerns)
14	<p>If a crime may have been committed, notify police.</p> <p>If more than one of the following apply, select the first that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <ul style="list-style-type: none"> • It is known that child was previously sexually abused and: <ul style="list-style-type: none"> » Parents are not providing professional help for child to manage sexual behaviours (Neglect: Mental Health); or » Parents are not supervising child given known sexual behaviour (Neglect: Supervision). • There is no known prior sexual abuse of child and: <ul style="list-style-type: none"> » Child's sexual behaviour is with another of similar age, size, power and intellect AND is not forced or coerced (Sexual Abuse—to consider whether child's behaviour reflects having been sexually abused); » Child's sexual behaviour does not involve another child (Sexual Abuse); » Child's sexual behaviour is with someone younger, smaller, less powerful or less developed cognitively and emotionally (Sexual Abuse AND Child Is a Danger to Self or Others); » Child's sexual behaviour is violent, coercive or forceful (Sexual Abuse AND Child Is a Danger to Self or Others); or » Child is texting or posting sexual images to social media (Sexual Abuse AND Child Is a Danger to Self or Others). • There is no known prior sexual abuse of child and child's sexual behaviour (other concerns)

Screen	Display
15	<p>If a crime may have been committed, notify police.</p> <p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <ul style="list-style-type: none"> • Parents are not protecting child from unsafe sex (Neglect: Supervision) • Child continues despite parent's best efforts (Child Is a Danger to Self or Others) • Child is under 16 (Sexual Abuse) • Child is 16 or 17 but is not capable of consenting due to child's emotional or cognitive level, OR child is younger, smaller, or has less power than partner, OR child is being forced or coerced, OR child is being enticed by offers of something of value (Sexual Abuse) • None of above (other concerns)
16	<p>If more than one of the following apply, select the first item that applies. If completing the tree recommended by the guide does not result in a recommendation to report to CS-RIS, select the next item on the list. Continue until you have reviewed all of your concerns or you have reached a recommendation to report to CS-RIS.</p> <p>What is concerning about parenting?</p> <ul style="list-style-type: none"> • Uses physical force or violence (Physical Abuse) • Does not provide what child needs (9) • Does not provide supervision (Neglect: Supervision) • Verbally abusive, bullying, overly strict or unrealistic expectations (Emotional/Psychological Harm) • None of the above (other concerns)
Other concerns	<p>Are there other trees that may apply, or do you have other concerns? Yes, Add Concern (1); No, Continue (Other supports)</p>

Screen	Display
Other supports	<p>If your 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.</p> <p>If you have an ongoing relationship with the family or are in a position to check back, you are encouraged to check in on the family to see whether they have accessed services or resolved the need on their own. If not, consider providing them with information about oneplace (http://www.oneplace.org.au). In the event that the situation has gotten worse, redo the decision tree with the new information to determine whether a referral to FaCC, Family Wellbeing Service or IFS or a report to CS-RIS is indicated based on the changed situation.</p> <p>If you intend to refer the family to a secondary service and need assistance locating an appropriate service, you may also consult with FaCC. You do not need to complete a referral to FaCC or provide any identifying information to FaCC. Simply call to explain the type of secondary service you are seeking and any special considerations (e.g. cultural, transportation, language).</p> <p>NOTE: Some circumstances are not reportable because they do not meet the threshold, 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.</p> <p>Legislative provisions regarding information exchange are in Chapter 5A of the Act.</p> <p>NOTE: Nothing in this guide restricts a professional from contacting CS-RIS. If you do report and used the guide, tell the CSO 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.</p>

PHYSICAL HARM



*Consider accessing services listed on [oneplace](#).

PHYSICAL HARM DEFINITIONS

Is there a *current* injury?

Answer 'yes' if the following apply.

A child has an injury at this time. (Exclude prior injuries that have already healed that you are just learning of.)

AND at least one of the following:

- The injury ranges from a concerning cut or burn or bruise (for example, a bruise located on child's torso or head) to a severe injury (for example, on torso or head). Do not include very minor injuries, defined as those that involve only mild redness, minor welts/scratches/abrasions/bruises to arms or legs or brief and minor pain.

OR

- A child under age 2 or a child of any age who cannot talk or walk has any injury (including very minor). For example, a 12-year-old child with severe developmental disability cannot talk and has bruising on his face and no explanation for the injury; or an 8-year-old child with muscular dystrophy cannot walk or sit without assistance and has unexplained long scratches on her back.

OR

- You suspect that a child has an injury even if you cannot see it. For example:
 - » The child is acting as if they may have head injuries, such as losing consciousness, having blurred vision or having stopped breathing.
 - » The child is acting as if they 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 they have an injury that you are unable to see because it is covered by clothing.
 - » The child is acting as if they may have internal injuries, such as being in pain, vomiting, becoming pale or losing consciousness.

Answer 'no' if any of the following apply.

- The child does not appear to have a current injury;
- The child over age 2 with no developmental disability has very minor injuries;
OR
- You are just learning of a prior injury that has already healed.

Was the injury accidental?

Answer 'yes' if either of the following apply.

- Child reports that injury was caused by someone other than parent or 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.

Answer 'no' if either of the following apply.

- 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 the adult 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

- If the child has not provided an account of the injury: The child is nonverbal (too young; developmentally delayed; or, for any reason, not explaining how the injury was caused). However, the reporter or another person 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.

The following tables show examples.

Non-Accidental	Accidental
<ul style="list-style-type: none"> • Parent or other adult household member said they were going to hurt child. • Parent or other adult household member said they were going to teach child a lesson. • Parent or other adult household member hit or shook child hard enough to cause injury even though they later said they did not mean it or were sorry about it. • Female genital mutilation (FGM). • Injuries are inconsistent with explanation provided. • Any injury to infant or other non-mobile child that does not appear self-inflicted. • Any injury to toddler that is not explained by accidental falls. 	<ul style="list-style-type: none"> • Parent or other adult household member injured child whilst 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). • Parent or other adult household member inadvertently injured child in the course of routine care.

Child Household Member or Other Adult	Adult Household Member
<ul style="list-style-type: none"> • A sibling or other child in the home caused injury. • A child outside of the home caused injury. • A stranger, teacher, coach, neighbour, relative who does not live with the child or any other adult caused injury. <p>NOTE: If injury is caused by a non-adult household member, consider whether adequate supervision is being provided, and if so, complete the neglect supervision tree. (See Appendix A.) Also consider whether a referral to QPS is needed.</p>	<ul style="list-style-type: none"> • A legal parent or guardian caused the injury. • An adult who lives in the child's home caused the injury. • An adult who lives in the home with a child's parent with whom child visits caused the injury.

Is the injury significant?

Answer 'yes' if any of the following apply.

- 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 is under 2 years old or is non-mobile.

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; 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.

Examples of *significant injuries* follow.

Injury Area	Physician Determined	Non-Physician/Others In most instances, a significant injury will require medical assessment or treatment, and a physician will determine whether the injury is significant. However, a layperson can reasonably conclude that an injury is significant if the following circumstances exist.
Head	<ul style="list-style-type: none"> • Skull or facial fractures • Intracranial and retinal haemorrhage • Brain oedema • Injuries to eyes/teeth • Anoxic brain injury • Bruises to the pinna 	<ul style="list-style-type: none"> • Child lost consciousness. • Obviously disfigured nose/jaw • Injury to eyes or teeth; e.g. 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	<ul style="list-style-type: none"> • Cervical fracture • Injury to pharynx/larynx • Ligature marks 	<ul style="list-style-type: none"> • Bruise or redness that goes around neck • Child is unable to talk normally.
Torso	<ul style="list-style-type: none"> • Rib or spinal fractures • Internal organ injuries • Investigation suggests abdominal trauma. • Deep bruises that are consistent with internal injuries even if no internal injuries are currently present 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Broken bones, sprains, dislocations • Ligature marks 	<ul style="list-style-type: none"> • Child is holding an arm or leg in an odd position. • Child cannot bear weight.
Skin	<ul style="list-style-type: none"> • All second- and third-degree burns • All lacerations requiring sutures • Deep bruises that are consistent with underlying haematoma 	<ul style="list-style-type: none"> • 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 in the shape of a hand, fist or another object

Injury Area	Physician Determined	Non-Physician/Others In most instances, a significant injury will require medical assessment or treatment, and a physician will determine whether the injury is significant. However, a layperson can reasonably conclude that an injury is significant if the following circumstances exist.
Other	<ul style="list-style-type: none"> • Genital damage consistent with FGM • Serious damage resulting from circumcision of a boy by an unqualified practitioner 	FGM is suspected for a girl who: <ul style="list-style-type: none"> • Is reluctant to be involved in sports or other physical activities when previously interested; • Has difficulties with toileting or menstruation; 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 any of the following apply.

- Injury is suspicious. An injury is considered suspicious if it is of a type highly correlated with abuse. In most instances, a physician will determine whether 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.

Injury Area	Physician	Non-Physician/Others
Head	<ul style="list-style-type: none"> • Torn fraenum in infant • Bruising to earlobe on both surfaces and underlying scalp • Constellation of injuries consistent with sudden impact • Scalp haematoma 	<ul style="list-style-type: none"> • Facial bruising to soft tissue of cheek • Two blackened eyes • Cuts to face • Bruising to scalp • Bruise to earlobe
Neck	Bruising to neck	
Torso	<ul style="list-style-type: none"> • Multiple rib fractures (especially posterior) • Fractures to spine 	Multiple bruising/lacerations
Arms/Legs	<ul style="list-style-type: none"> • Spiral/oblique fracture • Corner fractures • Bucket handle tears • Multiple fractures of different ages 	

Injury Area	Physician	Non-Physician/Others
Skin	<ul style="list-style-type: none"> • 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 • Sock scald burns† or immersion burns • Marks that cover or nearly cover circumference 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. 	

*Loop marks are wounds (typically welts) shaped like a loop, which is indicative of striking with an electrical cord, rope, or similar object that has been folded over.

†Sock scald 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-sock scald 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 unable to turn over being reported to have been injured whilst moving about.

Refer to the following table for examples of inconsistent explanations.

Area of Injury	Physician	Non-Physician/Others
Head	<ul style="list-style-type: none"> • 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 couch). • Report is of single impact, but actual damage suggests multiple impacts. 	<ul style="list-style-type: none"> • 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.
Neck	Ligature marks or indications of strangulation attempts.	
Torso	Internal injuries to non-ambulatory child with no history of trauma	
Arms or Legs	<ul style="list-style-type: none"> • Broken bones in non-ambulatory child with no history of trauma • Spiral fracture with no history of torquing motion 	
Skin	<ul style="list-style-type: none"> • Report of accidental burn from spilling liquid with no splash marks • Report of accidental burn from tap water, and burn is deeper than expected given water temperature and time of exposure 	

- Injuries of various ages. Multiple injuries appear to have been caused at different times. Timing of injuries is complicated and is primarily a determination made by a physician. Many children experience accidental injuries at different times in their lives, so the mere presence of injuries or healed injuries of different ages is not itself sufficient to indicate answering 'yes'.

Answer 'yes' if the following apply.

- 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.

OR

- Child has scars in the shape of loop marks, multiple linear marks or cigarette burns; scars bearing the shape of objects; or burn scars in stocking pattern or bearing the shape of objects.

AND

- There is no confirmation that prior injuries have been reported to CS-RIS. (NOTE: DCSYW 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 either of the following apply.

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

Is there a history of multiple concerning injuries, OR is child under age 5 or with a disability, OR is child refusing/afraid to go home?

Answer 'yes' if any of the following apply.

- History of multiple concerning injuries. Whilst 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 CS-RIS.
- » Medical history showing a pattern of injuries that were not suspicious considered individually, but in combination led the treating physician to suspect abuse.
- » On at least one prior occasion, the reporter questioned child about an injury; and whilst 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 and family violence among adults in the home including physical and non-physical violence, regardless of whether the violence was criminal.
- Child is under age 5 or has a disability. Child has not reached fifth birthday, OR child is over age 5 but has a developmental disability to the extent that child functions below the average for that age range, OR child has a disability to the extent that child is unable to initiate self-protective behaviours.
- Child is refusing/afraid to go home. Child is stating that they are 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 they are afraid or refusing to go home if they appear extremely anxious (e.g. tearful, shaking, upset stomach). NOTE: If appropriate, child should be kept with reporter until DCSYW is able to respond.

Answer 'no' if all of the following apply.

- You have no information about previous injuries.
- The child is over age 5 and has no known disability. AND
- The child is not expressing concerns that if they go home, they will be injured.

Has a parent or other adult household member done any of the following?

- **Used a form of discipline that can often result in significant harm.**
- **Acted in a dangerous way towards child that is likely to result in significant injury, including during a domestic and family violence incident.**
- **Threatened to kill or cause significant injury to a child.**
- **Planned or completed genital mutilation.**
- **Had DCSYW involvement following the death or serious injury of a child.**

Answer 'yes' if the following apply.

- Used a form of discipline that can often result in significant harm. 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.
 - » Infant is crying, and parent shakes or throws child.

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);
 - » Hit child in *sensitive areas* such as eyes, head, chest/abdomen;
 - » Was out of control whilst disciplining child; or
 - » Exposed child to extreme heat/cold for sufficient duration to result in serious harm.

The follow table describes examples.

Include	Exclude
Hit child repeatedly with buckle end of belt that landed on buttock, upper thighs, lower back.	Hit child on hand causing temporary stinging, but no injury. NOTE: Whilst corporal punishment is not endorsed, it is not prohibited as long as physical force is not applied to any part of a child's head or neck or any other part of a child's body in a way that is likely to cause harm lasting for more than a short period.
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.	Parent or other adult household member who put the child in water instantly realised water was too hot and removed child immediately.

- Acted in a dangerous way towards child that is likely to result in significant injury, including domestic and family violence. Whilst parent or other adult household member did not intend to harm child, parent's 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.

Examples include the following.

- » Domestic and 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 were in the car.
- 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.

- » Parent or other adult household member has a history of violent behaviour, problematic alcohol or drug use, or mental health condition.
- » Parent is separated or divorcing, particularly if proceedings are contentious.
- » Child expresses significant fear of parent/other adult household member or reports prior instances of being injured by parent or other adult household member.

AND

- » Threat is to cause a significant injury or use a form of discipline that often results in significant harm.
- Had DCSYW involvement following the death or serious injury of a child. A parent or other adult household member was previously investigated by DCSYW concerning death or serious injury to a child.
- Planned or completed a genital mutilation.

Answer 'yes' if either of the following apply.

- » A girl is about to have a procedure involving 'partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons' (World Health Organization, 2018).
- » A girl has experienced genital mutilation.

Answer 'no' if there is no indication of a past or planned ceremony in which a girl or her siblings will suffer genital mutilation.

PRACTICE GUIDANCE

The following circumstances warrant further conversation, particularly when child's family is from a country that continues to sanction genital mutilation.

- Child is having a special operation associated with celebrations that may include genital mutilation.
- Child is anxious about forthcoming school holidays or a trip to a country that practises FGM.
- Older siblings are worried about their sister visiting their country of origin.

In Queensland, FGM is a criminal offence and should be reported to police if a person performs a FGM OR takes, or arranges to take, a child out of the state with intention to perform a FGM (Criminal Code Act 1889, section 323A and 323B).

Some countries where FGM has been traditionally performed are now discontinuing the practice. Parents' personal culture may view it as more harmful to *not* perform FGM, and this dynamic is important to understand when working with a family around FGM.

If genital mutilation has already occurred, consider the following.

- If child is in physical pain or is developing infections and the parent is not seeking medical attention, consider the relevant Neglect: Medical Care decision tree for your role.
- If child is experiencing emotional distress and the parent is not providing support, consider the Neglect: Mental Health decision tree.

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

- **Chronic or escalating pattern of discipline that results in non-significant injury**
- **Known history of abuse or neglect**
- **Parent is violent due to problematic alcohol or other drug use or mental health condition or has a known history of violence towards intimate partners.**
- **Parent's response to child is reactive, volatile or violent.**

Answer 'yes' if any of the following apply.

- Chronic or escalating pattern of discipline that results in non-significant 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 age 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. 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).
- Parent is violent due to problematic alcohol or other drug use or mental health condition or has a known history of violence towards intimate partners. Parent or other adult household member has a significant degree of any of the following.
 - » *Problematic alcohol or other drug use.* Reporter has information that parent or other adult household member uses alcohol or other drugs to an extent of becoming agitated, volatile, violent.
 - » *Mental health condition.* Reporter has information that parent or other adult household member is diagnosed with or has symptoms of mental health condition that have already increased aggressive/violent behaviour or are likely to.
 - » *Domestic and family violence.* Reporter has information that parent or other adult household member is a perpetrator in a violent relationship with another adult.
- Parent's response to child is reactive, volatile or violent. Parent reacts to child's actions (whether developmentally typical or problematic) by becoming enraged, assaultive or violent, AND this is part of a pattern of parent behaviour.

Answer 'no' if both of the following apply.

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

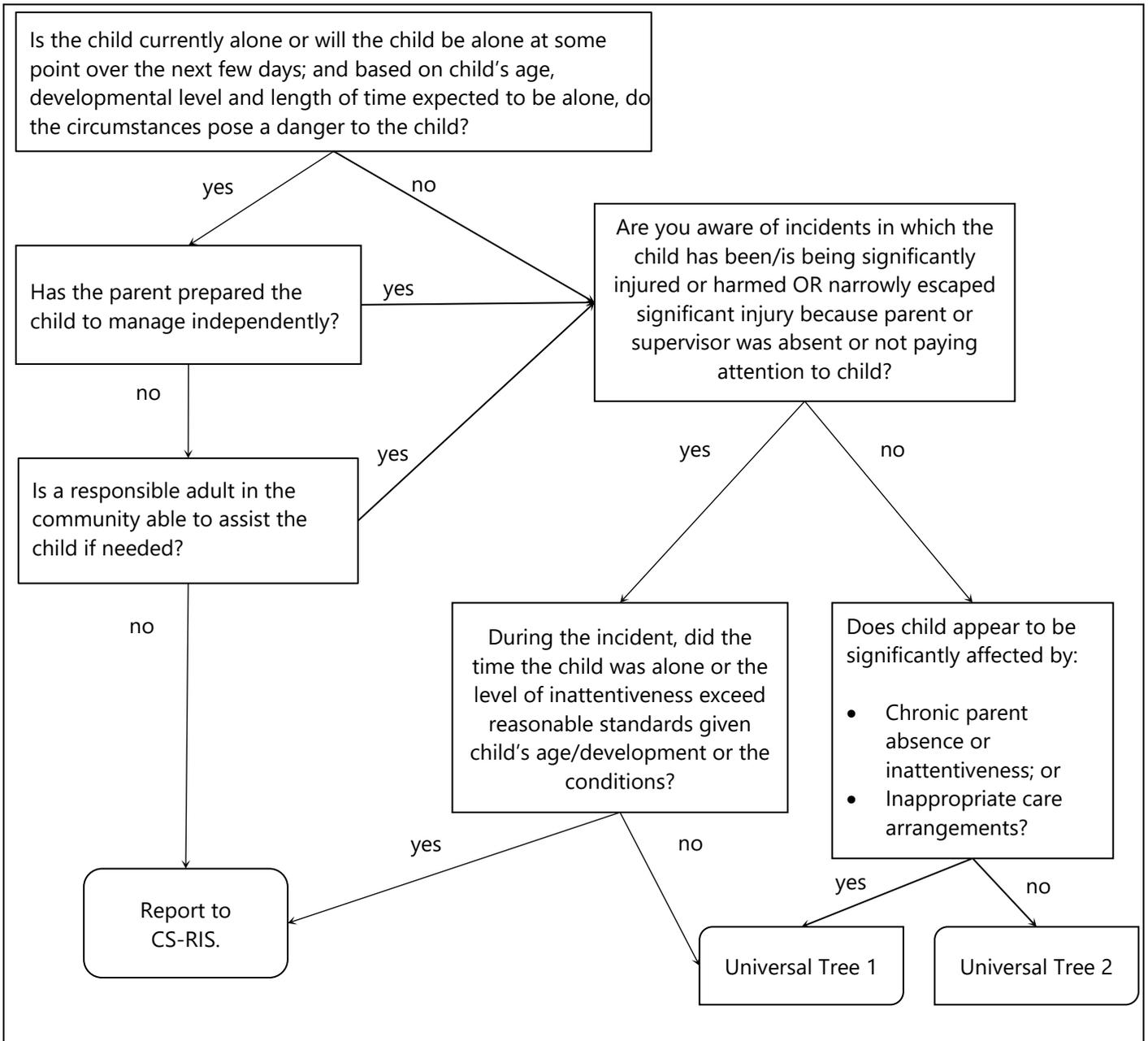
AND

- Parent or other household member is not known to be volatile or violent.

PRACTICE GUIDANCE

If completing the Physical Abuse decision tree does not recommend making a report but parent does have problematic alcohol or other drug use, mental health concerns, or family violence, consider applying the relevant parent concern decision trees as well.

NEGLECT: SUPERVISION



NEGLECT: SUPERVISION DEFINITIONS

Is the child currently alone or will the child be alone at some point over the next few days; and based on child's age, developmental level and length of time expected to be alone, do the circumstances pose a danger to the child?

Answer 'yes' if the child is currently alone or will be 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.

Examples include the following.

- A young or vulnerable child is found alone on street and cannot provide directions to own residence.
- The young 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 temperatures even if windows are left partially open.)
- Parent arranged for another person who poses a danger to the child to supervise or care for the child. For example, someone who is currently under the influence of alcohol or other drugs, has a mental health condition, is intellectually impaired or physically impaired to the extent that they cannot meet child's basic needs or keep child safe, is a known or highly suspected perpetrator of sexual abuse or has previously caused serious physical harm to children in their care.
- A sibling who is present lacks capacity to provide safe supervision or 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 parent or nominated/alternative contacts have been unsuccessful; OR parent is unwilling to collect child, and no alternative arrangement has been or can be made.

Child *may* be considered in danger if left alone in dangerous circumstances dependent on the environmental context, the child's age and the child's individual characteristics. 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 in Appendix A 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 qualify as 'unreasonable amount of time' and 'reasonable supervision' need to be considered in each case individually and depend upon circumstances including the child's age, the child's 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. Appendix A provides some guidance about what may generally be considered age-appropriate and developmentally appropriate circumstances and supervision levels.

Answer 'no' if either of the following apply.

- 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.

Has the parent prepared the child to manage independently?

Answer 'yes' if the parent has taught the child ways to manage potential danger to the extent that the child demonstrates competence to safely be without immediate adult supervision in the context for which they were prepared. This *must* include rehearsal, successful experience and gradual building of competency to manage the degree of independence and the level of potential danger.

Examples include the following. Child:

- Has been taught what to do in emergency if no one is around;
- Has been taught how to safely get from one place to another alone;
- Has been taught to prepare simple foods;
- Has been taught specific items or areas to avoid (e.g. power tools, medications, chemicals, poisonous plants); and
- Can communicate with a responsible adult if needed.

Answer 'no' if child is unprepared for the potential danger. Child may not recognise danger; or upon recognising danger, child lacks knowledge or skill or physical or emotional capacity to respond safely.

Is a responsible adult in the community able to assist the child if needed?

Answer 'yes' if at least one adult is immediately available to the child and understands their responsibility to protect the child and respond to any danger the child is facing (including danger due to child's own actions). The child must know which adults will help them if needed and be able to access their help when needed.

Answer 'no' if the following apply.

- No adult is available to the child, OR if an adult is available, no adult is aware of their responsible role to protect the child.

OR

- Child is unaware of which adults will help them if needed, OR child has been reluctant to seek help when needed.

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

Include injury or harm that is accidental, self-inflicted or caused by an adult who is not a household member or a child who is a household member.

Answer 'yes' if any of the following apply.

- Absent. Parent was not present at time of injury or incident.
- Not paying attention. Parent was present but not paying attention or responding to impending danger such as a child walking towards a street, ledge or body of water or 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; distraction by television, Internet, reading, conversation, texting, household chores or any other distraction.
- Not responding to impending danger. Whether present or not, parent was aware of potential harm to child by another person and did not act to protect child, or did act but was not capable of protecting child, AND the danger is ongoing.

AND

Either of the following is true.

- Child was significantly injured or 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 or harm inflicted by sibling or other child in household.

OR

- An incident occurred that would often result in significant injury or harm, but child escaped harm through third-party intervention 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 or unattended longer or more often.

Answer 'no' if either of the following apply.

- Child was injured or harmed or nearly avoided injury or harm; *however*, a parent or other responsible person was present and attentive; OR
- Parent or adult household member was absent or inattentive; *however*, child was not injured or harmed or nearly injured or harmed.

During the incident, 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 whilst a parent was not looking does not necessarily constitute neglect.

Answer 'yes' if either of the following apply.

- 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 Appendix A. 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 child's age and the child's individual characteristics. 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 qualify as 'unreasonable amount of time' and 'reasonable supervision' need to be considered in each case individually and depend upon circumstances including the child's age, the child's 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. Appendix A provides some guidance about what may generally be considered age-appropriate and developmentally appropriate circumstances and supervision levels.

Answer 'no' if based on child's capability, preparation and circumstances, the time the child was alone or unattended was within reason. See Appendix A for guidance.

Does child appear to be significantly affected by:

- **Chronic parent absence or inattentiveness; or**
- **Inappropriate care arrangements?**

Answer 'yes' if the following apply.

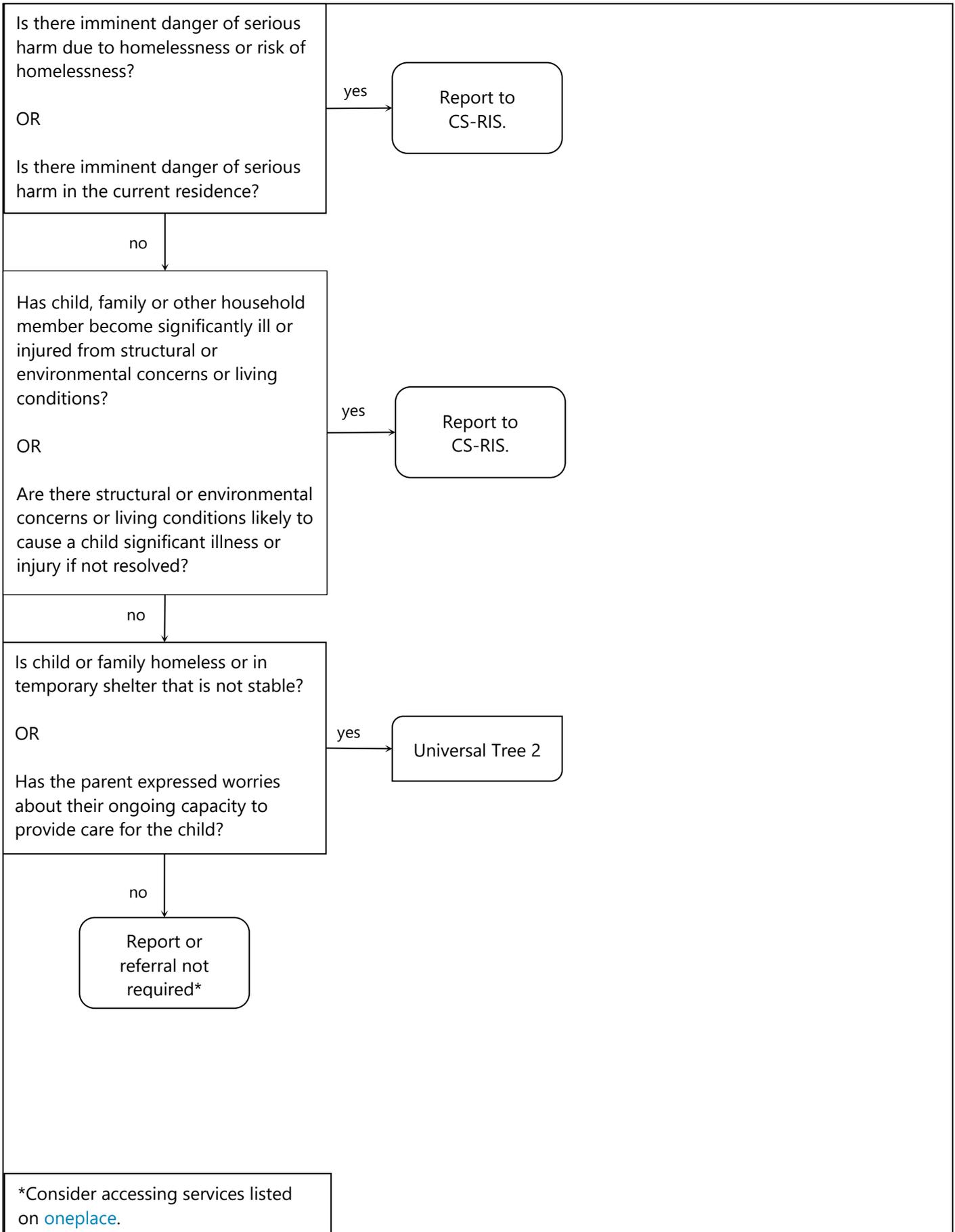
- Child shows significant adverse effects such as those in Appendix B, Table B2.

AND

- There is a pattern of parent being persistently inattentive or leaving child alone or in dangerous company. This can include if the length of time a child is alone or unattended may be less than timeframes in Appendix A but child has been alone or 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 (e.g. involving child in significant alcohol or drug use, offending behaviour).

Answer 'no' if child is not showing significant adverse effects (see Appendix B, Table B2) despite periods of parent absence or inattentiveness. Child may express hopes or wishes for increased parent availability; however, child is coping with minimal impact.

NEGLECT: PHYSICAL SHELTER/ENVIRONMENT



NEGLECT: PHYSICAL SHELTER/ENVIRONMENT DEFINITIONS

PRACTICE GUIDANCE

If appropriate accommodations have not been secured, consider immediate actions to meet this need.

Is there imminent danger of serious harm due to homelessness or risk of homelessness?

OR

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

Answer 'yes' if the following apply.

- Is there imminent danger of serious harm due to homelessness or risk of homelessness? The child/family has no residence or is about to lose their residence, AND at least one of the following applies.
 - » The parent 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 family is staying in temporary shelter or housing (e.g. car, boarding house) that exposes them to danger from violent or sexual crime.
 - » The parent is refusing access or threatening to refuse access to the family home or is refusing to provide alternative care arrangements.

- Is there imminent danger of serious harm in the current residence? The physical structure is likely to result in a serious injury or illness to the child in the near future. Examples include the following.
 - » Electrical wiring is exposed.
 - » Extremely dangerous objects or materials are accessible to the child (e.g. chemicals, power equipment, guns, knives, medication, illegal substances).
 - » House is structurally unsafe.
 - » Significant amounts of animal or human faeces litter the premises.

- » Child needs medical devices or refrigerated medicine and has no access to electricity.
- » The physical environment exacerbates the child's existing serious medical conditions.

AND the child is vulnerable.

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 both of the following apply.

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

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

OR

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

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

Answer 'yes' if either of the following apply.

- 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.

- 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.

Answer 'no' if either of the following apply.

- No structural or environmental concerns exist; OR
- Structural or environmental concerns exist, but no person in the household has become ill or injured as a result.

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

Answer 'yes' if 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 not routinely eliminated; insect/rodent infestation; no access to facilities to bathe; no access to laundry facilities.
- *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 or alcohol, or matches or 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.

Answer 'no' if either of the following apply.

- No structural or environmental concerns exist.
- OR
- Structural or environmental concerns exist. However, these concerns are unlikely to result in illness or injury. For example:
 - » A degree of clutter or dirt that poses little or no likelihood of illness or injury;
 - » Single, corrected instance of a dangerous object within child's reach; or
 - » Unconventional sleeping arrangements that are not dangerous.

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

OR

Has the parent expressed worries about their ongoing capacity to provide care for the child?

Answer 'yes' if either of the following apply.

- Is child or family homeless or in temporary shelter that is not stable? The child/family does not have a permanent residence, and one of the following applies.
 - » The child or family has a place to stay at the moment, but there is no realistic long-term plan to either remain or establish alternative shelter before the current shelter is no longer an option.
 - » A child or family has access to a safe place to stay but refuses to stay there.

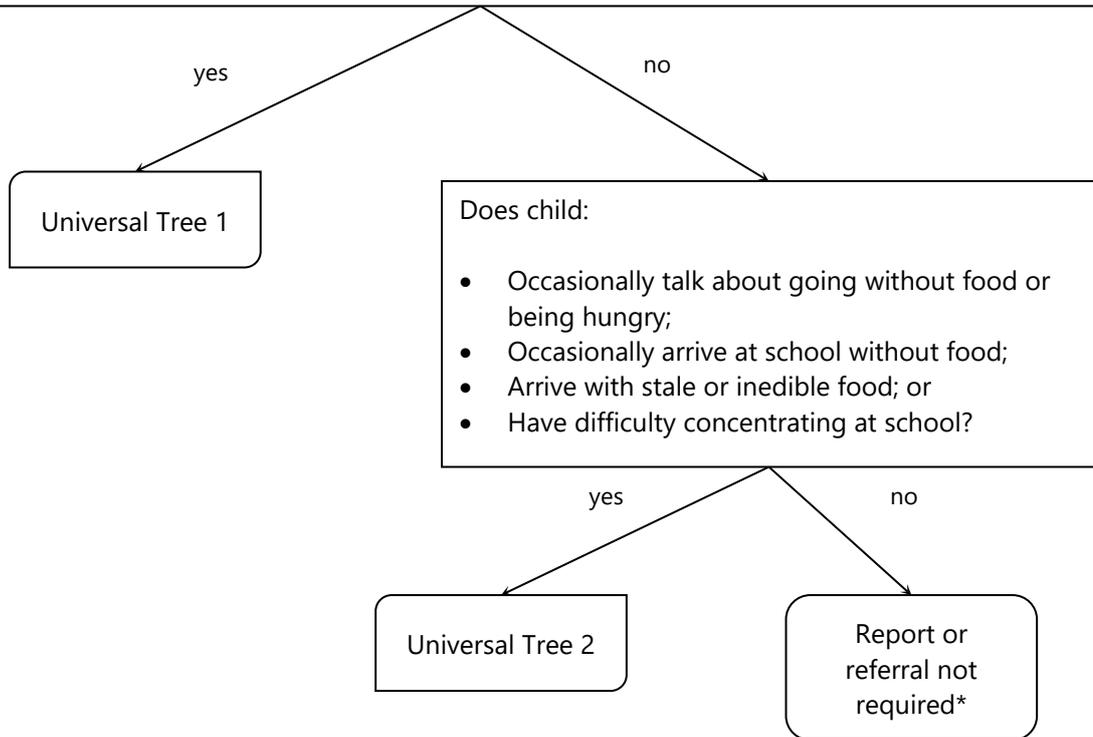
OR

- Has the parent expressed worries about their ongoing capacity to provide care for the child? The parent has disclosed their worries about their future ability or willingness to care for the child, and it is possible the child will have no safe care arrangement.

NEGLECT: NUTRITION

Does child:

- Have persistent hunger;
- Experience persistent withholding of food or fluids as a deliberate act;
- Appear thin, frail or listless or have significant weight loss; or
- Frequently beg/steal/hoard food?



*Consider accessing services listed on [oneplace](#).

NEGLECT: NUTRITION DEFINITIONS

Does child:

- **Have persistent hunger;**
- **Experience persistent withholding of food or fluids as a deliberate act;**
- **Appear thin, frail or listless or have significant weight loss; or**
- **Frequently beg/steal/hoard food?**

Answer 'yes' if any of the following apply.

- Have persistent hunger. Child frequently mentions hunger, frequently 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.

- Experience persistent withholding of food or fluids as a deliberate act. Parent routinely withholds meals or limits meals to nutritionally inadequate amounts or 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 age 5 who is otherwise healthy.

- Appear thin, frail or listless or have significant weight loss. A child appears to be unusually thin, appears 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.

NOTE: Also consider Neglect: Medical Care decision tree.

- Frequently begs/steal/hoard 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 or creating caches of food in hiding places that child may eat later or may forget. Select yes even if child successfully sources food or food is routinely provided by others.

Do not report: Asking for or stealing food where the purpose appears to be unrelated to alleviating unremitting hunger, such as child keeping some secret snacks or treats.

Does child:

- **Occasionally talk about going without food or being hungry;**
- **Occasionally arrive at school without food;**
- **Arrive with stale or inedible food; or**
- **Has difficulty concentrating at school?**

Answer 'yes' if without a plausible explanation¹, any of the following apply to the child.

- Occasionally talk about going without food or being hungry. Child describes missing meals at home or having food withheld as a punishment or talks about being unable to sleep due to hunger.
- Occasionally arrive at school without food. More than just a few times, child arrives at school with no breakfast or without lunch and has no means to secure lunch, but child shows no other signs of malnutrition.
- Arrive with stale or inedible food. Child is provided food, but it is stale or inedible.
- Have difficulty concentrating at school. 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 any of the following apply.

- There has been a single incident of child going without eating.
- There have been no more than a few incidents of child arriving at school without lunch.
- Child's lack of concentration is likely related to reasons other than lack of nutrition.

Also answer 'no' if child describes being hungry at times a child would likely be hungry; or if from the context, the child is describing normal cycles of hunger and satiety.

¹ For example, child is prone to losing 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.

NEGLECT: MEDICAL CARE—REGISTERED HEALTH PROFESSIONALS

A registered health professional is a person qualified to make a diagnosis or treat the condition being reported.

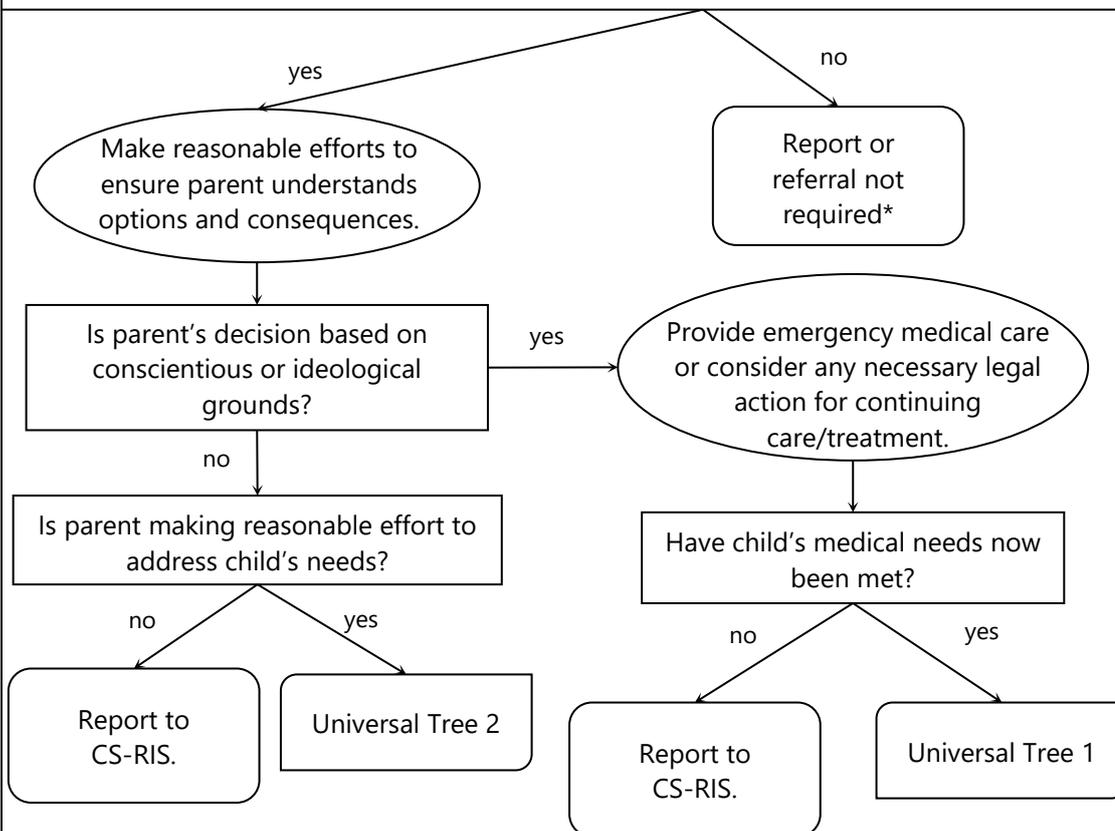
Does child require medical care for an *acute* condition for which parent did not access necessary medical treatment?

OR

Does child have a *chronic* condition requiring an 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 with medical support needs that are not being met?



*Consider accessing services listed on [oneplace](#).

NEGLECT: MEDICAL CARE—REGISTERED HEALTH PROFESSIONALS DEFINITIONS

A registered health professional is someone qualified to diagnose or treat the condition being reported.

Does child require medical care for an *acute* condition for which parent did not access necessary medical treatment?

OR

Does child have a *chronic* condition requiring an 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 with medical support needs that are not being met?

Does child require medical care for an *acute* condition for which parent did not provide necessary medical treatment?

Answer 'yes' if the following apply.

- 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 parent is 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 and discussed the options—including any religious or ideological grounds for refusal—and the consequences of inaction.
 - » No care. Parent may or may not be providing home care, but the child's condition requires immediate professional medical care. Consider whether most parents would seek professional medical care for the same condition 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-degree burns, colds and brief episodes of fever, and minor respiratory conditions in an otherwise healthy child).

- » Insufficient care. Parent has sought medical evaluation and care and a qualified health professional has prescribed a treatment plan, but the parent is not following the plan to the extent that the child's recovery is compromised.

Do not report: Deviations from plan that, whilst not desirable, cannot be demonstrated to have significantly compromised child's recovery or be likely to do so. For example, missing a dose of medication with no negative results or missing a follow-up or final checkup when all indications are child was progressing satisfactorily.

- » Lack of timely care. Parent may have sought medical evaluation and care, but this care was delayed to the extent that child's condition is now critical or child is more likely to have increased suffering or lasting harm.
- » Inappropriate care. Parent may have sought medical evaluation and care but is adding or substituting alternative treatments that are having or are likely to have a significant adverse effect on child's health. Inappropriate health-seeking behaviours may involve unnecessary, invasive medical procedures.

Answer 'no' if any of the following apply.

- Child's condition is such that with or without treatment, the outcomes will be similar.
- The proposed treatment is experimental or not considered to be the standard of care.

OR

- Whilst child may fare marginally better with treatment, the burden of treatment is substantial; and many parents would opt out of treatment in similar circumstances.

Does child have a *chronic* condition that requires an ongoing treatment plan, AND the plan is not being followed, AND this is likely to result in significant harm?

Answer 'yes' if the following apply.

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

AND

- Parent is providing no care, inadequate care or inappropriate care.
 - » No care. Parent is completely disregarding recommended medical treatment plan. They may be providing home or alternative care.
 - » Inadequate care. Parent is following parts of the medical treatment plan but is not following substantial portions of the plan.
 - » Inappropriate care. Parent may be following the medical treatment plan but is 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.

AND

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

Answer 'no' if any of the following apply.

- Child's condition is such that outcomes with or without treatment will be similar.
- The proposed treatment is experimental or is not considered to be the standard of care.

OR

- Whilst child may fare marginally better with treatment, the burden of treatment is substantial; and many parents would opt out of treatment in similar circumstances.

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

Answer 'yes' if child has complex health needs or a disability that requires ongoing medical care (for example, 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 child's capacity is significantly limited.

Answer 'no' if any of the following apply.

- Child's condition is such that with or without treatment, the outcomes will be similar.
- The proposed treatment is experimental or is not considered to be standard of care.

OR

- Whilst child may fare marginally better with treatment, the burden of treatment is substantial and many parents 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 versus not treating, AND the parent states that the reason parent 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 either of the following apply.

- Parents are unable 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, registered health professional has additional child protection concerns.

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

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

Answer 'yes' if either of the following apply.

- 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 their best efforts to follow the treatment plan but is experiencing barriers beyond parent's 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. 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.

Have child's medical needs now been met?

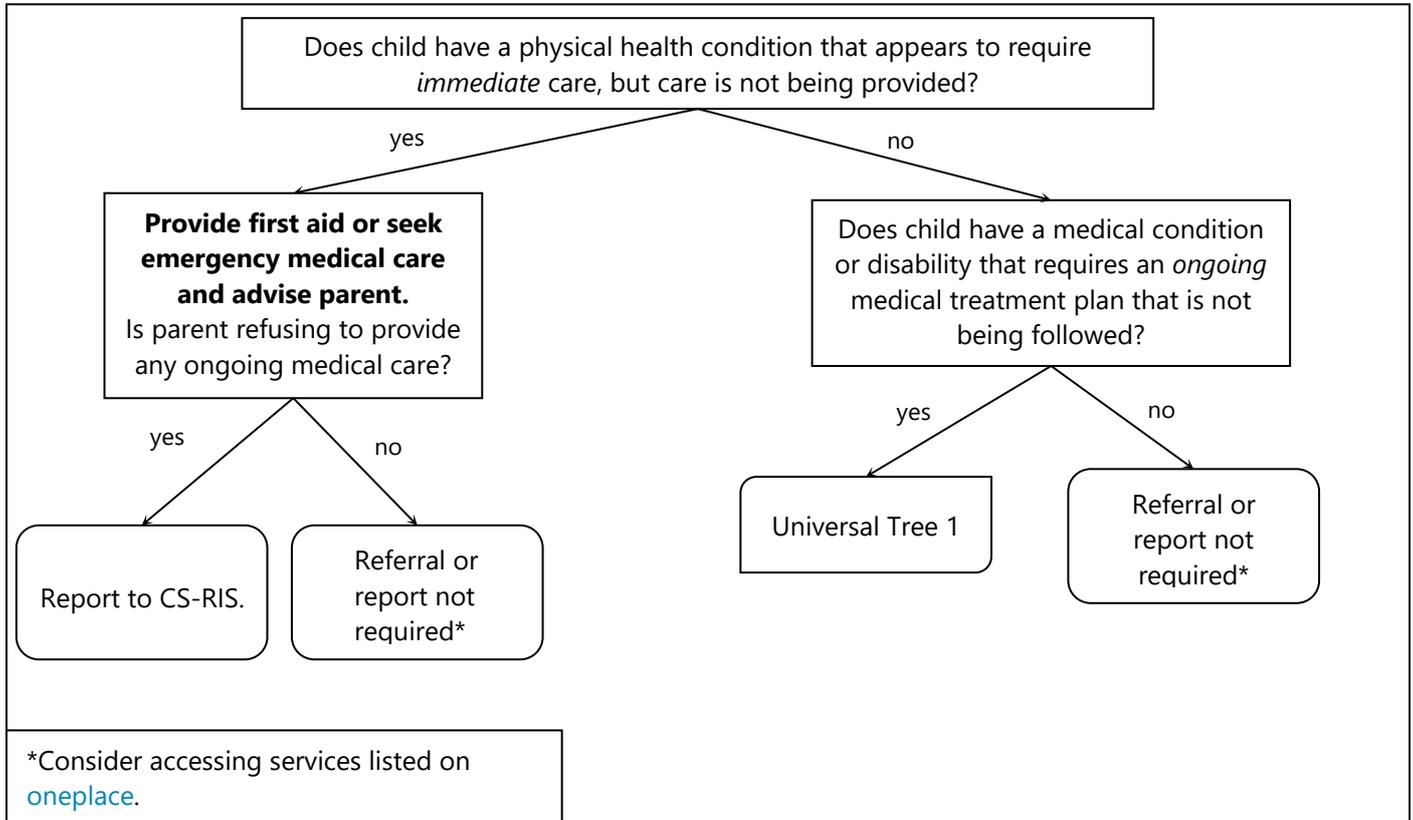
Answer 'yes' if after providing emergency medical care or legal action, all medical needs of the child are met and there are no additional child protection concerns.

Answer 'no' if emergency care or legal remedies have not resolved the child's ongoing need for medical care, which parents continue to refuse on conscientious or ideological grounds.

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

NEGLECT: MEDICAL CARE—NON-REGISTERED HEALTH PROFESSIONALS

A non-registered health professional is any health professional who is not registered through the Australian Health Practitioner Regulation Agency and any person who is not a health professional.



NEGLECT: MEDICAL CARE—NON-REGISTERED HEALTH PROFESSIONALS DEFINITIONS

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

Answer 'yes' if the following apply.

- The child's condition requires 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 is unable to organise care for any reason (e.g. problematic alcohol or other drug use, mental health condition, developmental disability, 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 and there is no evidence of inappropriate parenting behaviour previously.

NOTE: Before proceeding to the next question, provide first aid or seek emergency medical care, call 000 and advise parent.

Is parent refusing to provide any ongoing medical care?

Answer 'yes' if the parent is stating that they do not intend to seek medical care or evaluation, or parent is unable to organise care for any reason (e.g. parent is intoxicated, has mental health condition, is developmentally disabled, 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).

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

Answer 'yes' if the following apply.

- Child has a medical condition or disability, and a current treatment plan, OR child's symptoms indicate a chronic medical condition. You have consulted with a registered health professional who advises a need for professional medical evaluation or intervention, noting that not receiving follow-up treatment would result in significant harm.

AND

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

AND

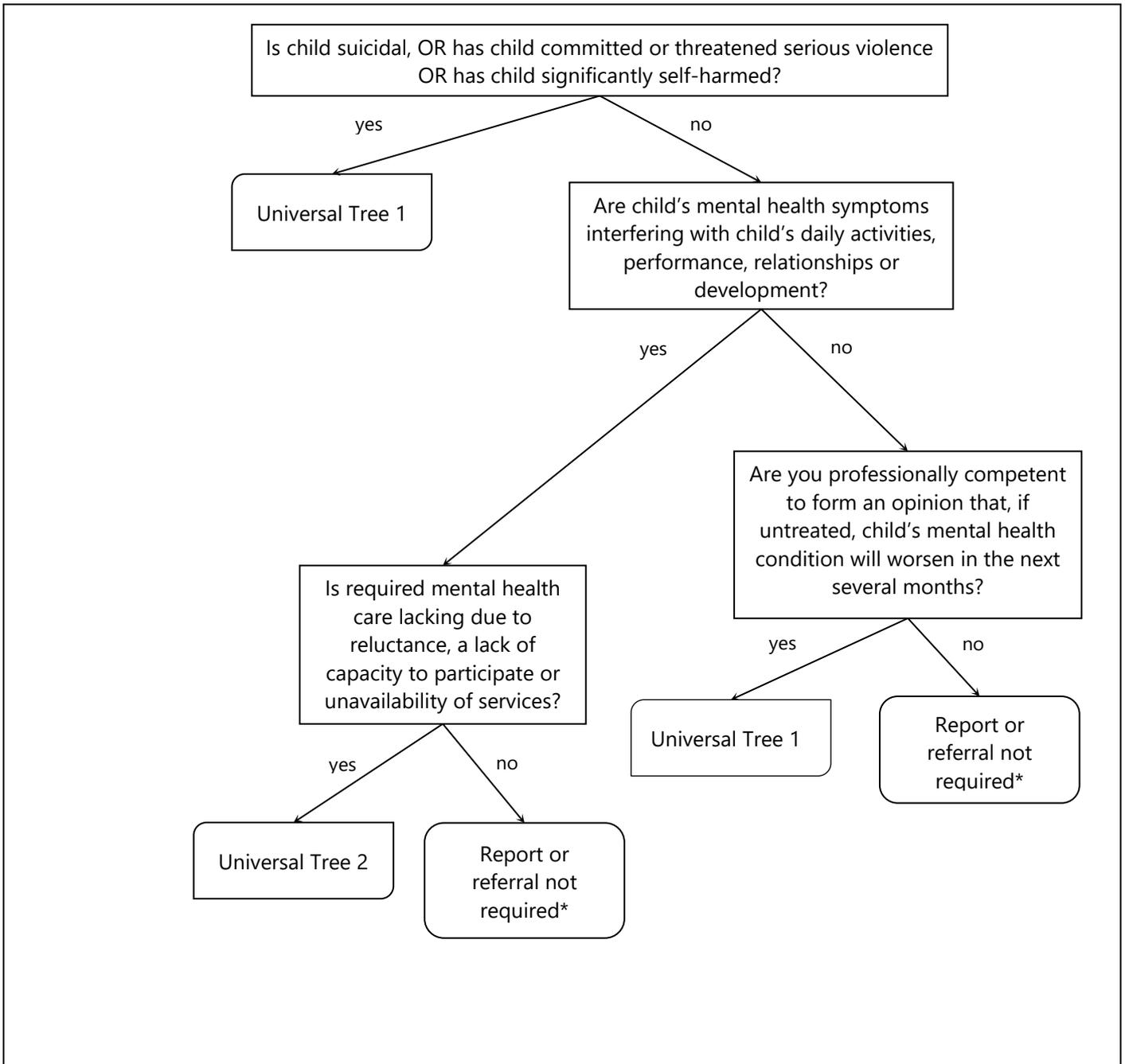
- Parent informs you that they do not plan to seek medical evaluation or follow a plan OR states they will do so, but after a reasonable period of time does not follow through.

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.

NEGLECT: MENTAL HEALTH



If needed, seek assistance from emergency services (police/ambulance/mental health). Do not leave child unattended. Ensure safety of others.

*Consider accessing services listed on [oneplace](#).

NEGLECT: MENTAL HEALTH DEFINITIONS

If needed, seek assistance from emergency services (police/ambulance/mental health). Do not leave the child unattended. Ensure the safety of others.

Is child suicidal, OR has child committed or threatened serious violence, OR has child significantly self-harmed?

Answer 'yes' if any of the following apply.

- 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 a child has a history of suicide attempts or has a friend or family member who has committed or attempted suicide, or the child has a mental health diagnosis or a current problematic alcohol or other drug use, answer 'yes' even if suicidal concerns are vague. If you are in doubt, discuss with CS-RIS 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 or 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, has problematic alcohol or other drug use, has access to weapons like guns and knives or expresses feeling victimised and left out. If in doubt, discuss with CS-RIS or mental health services.

- Child has significantly self-harmed. Child has self-inflicted injuries, or other self-inflicted physical or psychological damage, that require immediate medical or psychological intervention.

» *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 child serious physical or psychological damage. Serious damage requires immediate medical or psychological evaluation or intensive treatment (e.g. acute drug overdose).

Examples include the following.

- Child is using alcohol, illegal drugs, prescription drugs or other substances in ways that, based on child's age or on 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 child is losing weight, or child is forcing self to vomit.
- Child demonstrates persistent disregard for own safety in ways that have or are likely to result in serious injury or death.

Are child's mental health symptoms interfering with child's daily activities, performance, relationships or development?

Answer 'yes' if due to diagnosed or suspected mental health concern, child experiences one or more of the following.

- Activities. Child has stopped doing or significantly reduced participation in activities that the child previously enjoyed; OR child is no longer performing activities of daily living that were once achieved, so that hygiene or appearance has deteriorated; OR child is participating in increased risk taking or antisocial behaviour that is persistent and not modifiable 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. Child expresses inappropriate attachment or has withdrawn from relationships that were previously important; or child's behaviour jeopardises important relationships, including conflictual, manipulative or aggressive behaviours. Include family and non-family relationships (e.g. peers).

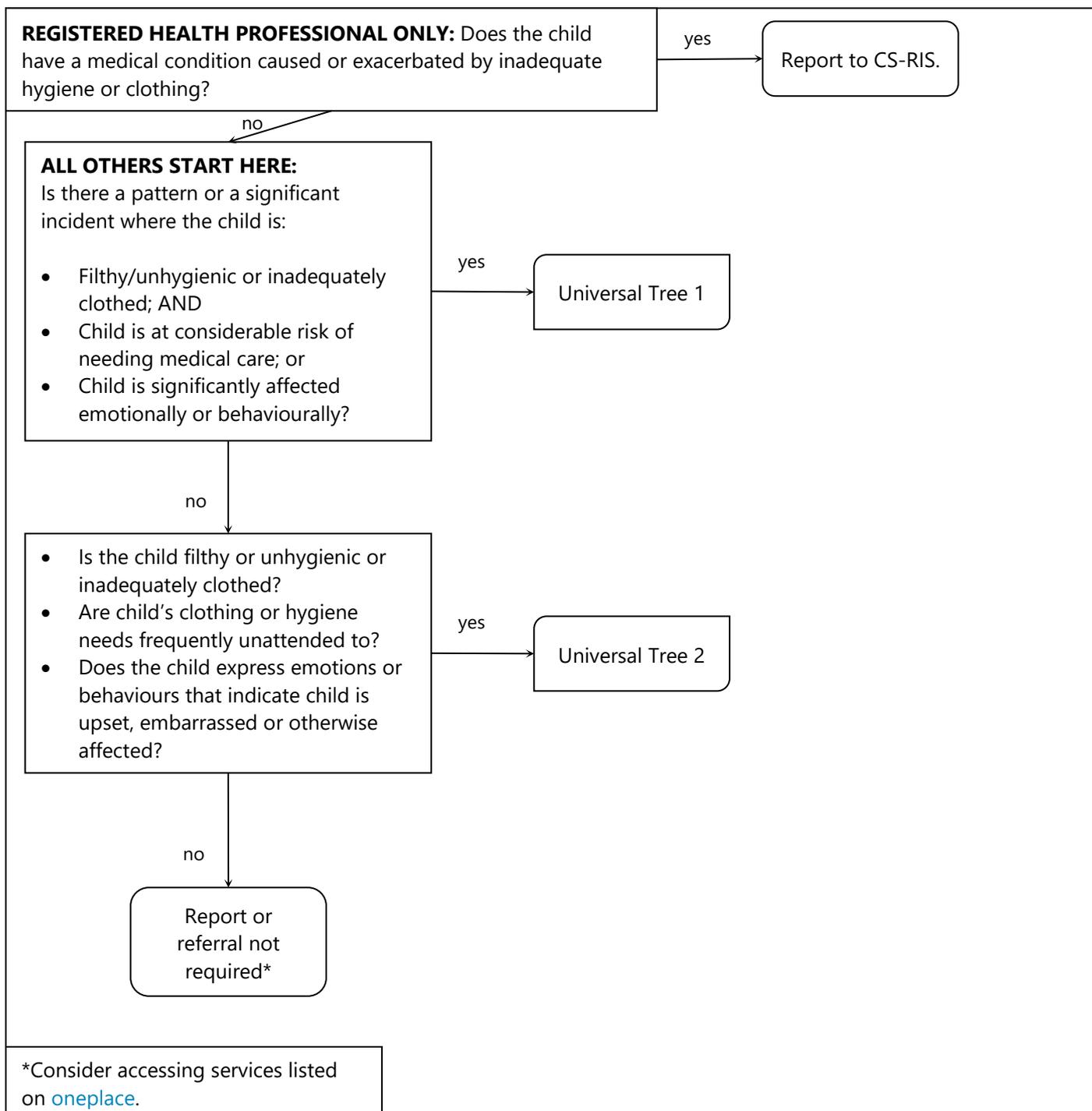
- Development. Child is no longer performing at a developmental level previously achieved. For example, child who was toilet trained is now soiling or wetting; OR child's withdrawal from relationships or activities has been prolonged to the extent that child is falling behind on developmental milestones.

Are you professionally competent to form an opinion that, if untreated, child's mental health condition 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.
- You have had the opportunity to assess the child.
- Child's mental health condition will most likely worsen in next several months if untreated.

NEGLECT: HYGIENE/CLOTHING



NEGLECT: HYGIENE/CLOTHING DEFINITIONS

REGISTERED HEALTH PROFESSIONAL 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 or injury resulted from or is made worse by poor hygiene or inadequate clothing.

Examples include the following.

- Recurrent skin infection or contact dermatitis, and a contributing factor may be unlaundered clothing.
- Recurrent urinary tract infections, and a contributing factor may be persistently soiled undergarments.
- Heat stroke or heat exhaustion, and a contributing factor was clothing too warm for known or predictable conditions.
- Hypothermia, and contributing factor was clothing that provided insufficient warmth for known or predictable conditions.

Answer 'no' if child has a medical condition unrelated to hygiene or clothing, or if child has no medical condition.

ALL OTHERS START 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 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 once, observations suggest that the condition has been present over an extended period of time.

- Filthy/unhygienic
 - » Child is dirty to a point where child's 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 or blistering, and parent is not changing the child adequately meaning that the child is left in a soiled nappy for long periods of time;
 - » The child has medical conditions attributable 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's hair is matted to the point that a comb cannot be run through it, has clumps of hair falling out or has a persistent untreated head lice infestation; or
 - » The child smells strongly of urine, faeces, menses or putrid scent suggestive of infection.

- 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, 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. hypothermia or heatstroke. Consider 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 somewhere with more moderate temperature.

AND if one or both of the following apply.

- Child is at considerable risk of needing 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

- Child is significantly affected emotionally or behaviourally. The child has one or more indicators from the 'Significant Adverse Effects' table that appear related to or exacerbated by hygiene or clothing concerns. For example, child is distressed due to persistent teasing or bullying related to dirty clothing. See Appendix B, Table B2.

Answer 'no' if all of the following apply.

- 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 being chilled due to minimal clothing in cool weather but not in danger of hypothermia.
- Child is not adversely affected emotionally.

Is the child filthy or unhygienic or inadequately clothed?

OR

Are child's clothing or hygiene needs frequently unattended to?

OR

Does the child express emotions or behaviours that indicate child is upset, embarrassed or otherwise affected?

Is the child filthy or unhygienic or inadequately clothed?

Answer 'yes' if either of the following apply.

- *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 unlaundered.

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 so large it is hard to keep on properly or so small it is uncomfortable.

Answer 'no' if either of the following apply.

- Child appears very dirty in situations that would be expected, such as during and shortly after outdoor play or activities.

OR

- Child is inadequately clothed because of choices the child has made rather than choices the parent has made, AND child is of developmental age and understanding to make this choice.

Are child's clothing or hygiene needs frequently unattended to?

Answer 'yes' if parent is inattentive to child's needs for hygiene or adequate clothing on a regular basis.

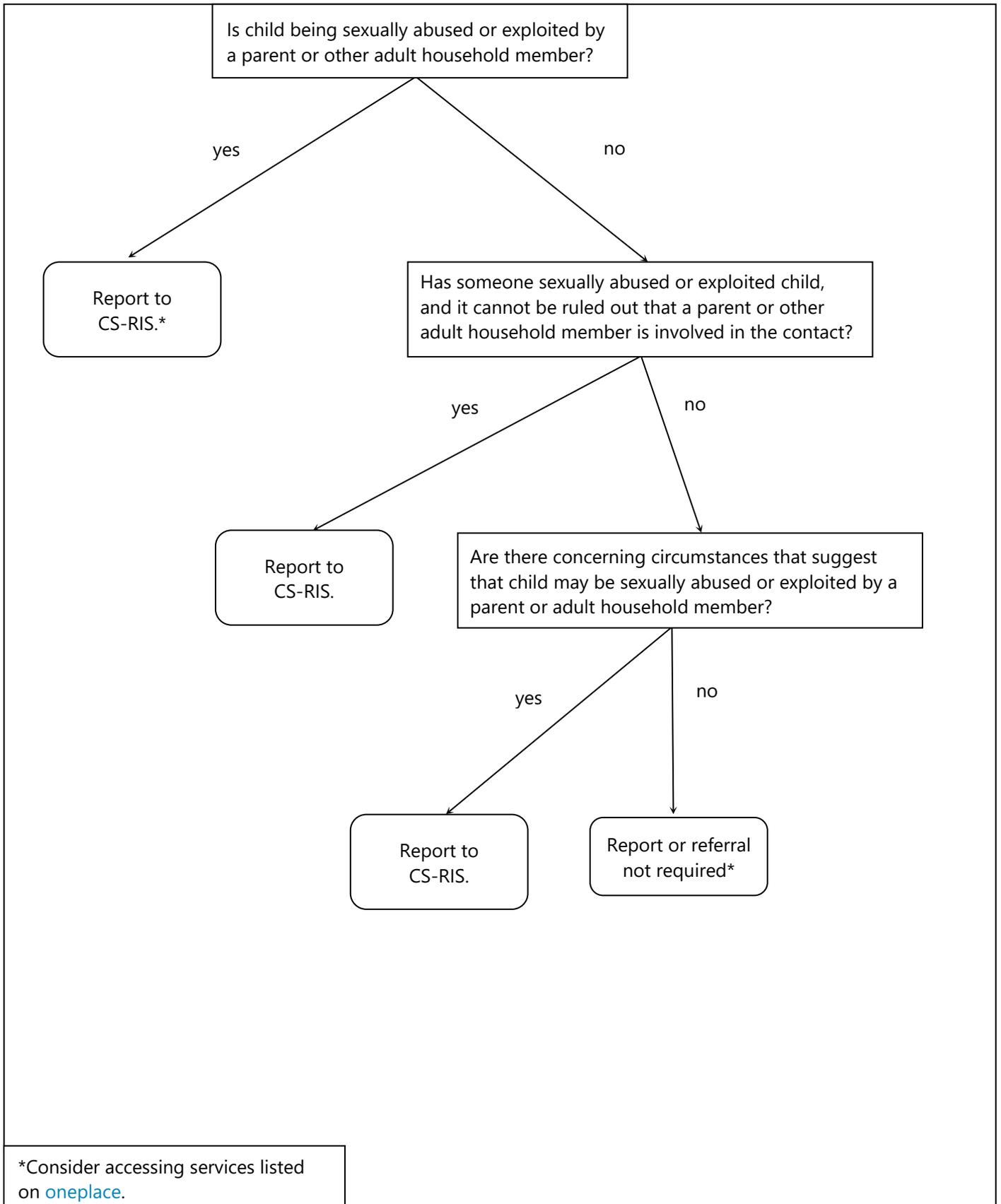
Answer 'no' if on rare occasions, parent has not ensured child is properly clothed and clean where the situation would require.

Does the child express emotions or behaviours that indicate child is upset, embarrassed or otherwise affected?

Answer 'yes' if the child expresses that child is upset or embarrassed by own 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 the child does not appear upset or embarrassed related to clothing or hygiene.

SEXUAL ABUSE



SEXUAL ABUSE DEFINITIONS

EDUCATION STAFF PRACTICE GUIDANCE

The following applies *only* to education staff.

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

If you know that at least one non-harming parent is willing and able to protect, you may not need to report.

For example: The sexual abuser was an unrelated person in the home, AND the parent will not allow further contact with child, AND the parent has demonstrated ongoing support of the child by arranging counselling or support services.

PRACTICE GUIDANCE

The following applies to all reporters.

Mandatory reporting applies to sexual abuse concerns based on the following guidance.

Also consider whether medical attention is required and whether a report to QPS is appropriate.

Is child being sexually abused or exploited by parent or other adult household member?

Review the tables for 'who' and 'what' and 'basis'.

Answer 'yes' if the 'who', 'what' and 'basis' tables each result in a 'yes'.

Answer 'no' if any of the 'who', 'what' or 'basis' tables result in a 'no'. If directed, refer the concern to other decision trees indicated.

Who	Child under 16	Child 16–18 Without Consent	Child 16–18 Consenting
Parent	yes	yes	yes
Adult household member	yes	yes	No if relationship is stable, has parent approval, and there is no power or coercion.* For all others, yes†.
<ul style="list-style-type: none"> Household child Non-household adult Non-household child 	<p>No. Consider whether the following apply.</p> <ul style="list-style-type: none"> Parent is protecting. If not, use neglect: supervision. Child sexual behaviour may indicate that child is a victim of unknown sexual abuse. If so, answer 'no' to this question and continue with this decision tree. Parent is obtaining necessary mental health intervention for a known victim of sexual abuse or exploitation. If not, use the Neglect: Mental Health decision tree. <p>A report to QPS may be required.</p>		

*For example:

- The relationship is legal; AND
- Parents approve of the relationship; AND
- Child is developmentally capable of understanding consent and the impact of the relationship.

†Examples include the following.

- Adult is significantly older, or is otherwise more powerful, so that child does not comprehend consent or the impact of the relationship.
- There is no meaningful relationship between child and adult apart from sexual contact.

What	Yes
Contact	<ul style="list-style-type: none"> Intercourse (vaginal or anal) Oral sex Penetration of vulva, vagina or anus with fingers or objects Any contact of child's genitals accompanied by force, violence, secrecy or indications that adult's intentions are sexual Any contact the child is directed to have with adult's genitals
Non-Contact	<ul style="list-style-type: none"> Recording child in sexual positions or actions, or for the purpose of sexual gratification Observing child for the purpose of sexual gratification of adult Causing child to observe live or depicted sexual positions or actions through force, violence, secrecy
Exploitation	<ul style="list-style-type: none"> Adult profits in any way from causing or permitting child to engage in sexual acts or to be recorded for the sexual gratification of others. Profit may be financial, material, physical or in any other forms. Adult manipulates or otherwise causes child to engage in activities in exchange for goods or services received by child or child's family (e.g. drugs, alcohol, clothing, housing).
Trafficking	<ul style="list-style-type: none"> Child is physically moved across borders, through deception, coercion or force, for the purpose of exploitation.

Basis	Yes
Clear statement by child	<p>Child told at least one person about one or more incidents of sexual abuse or exploitation. The child's statement may be verbal or with pictures or gestures. It is not necessary that the child provide details of time and place or specific actions, only that the child has made clear that a parent or adult household member is involved.</p> <p>PRACTICE GUIDANCE Once a child has made a statement, proceed based on that statement even if child later states that the sexual abuse or exploitation did not happen. Whilst it may not have happened, recantation is a common stage for children reporting sexual abuse. A trained forensic interviewer will need to speak with the child even if a statement was recanted.</p>
Witnessed	Reporter or another person (adult or child) saw one or more incidents of sexual abuse or exploitation involving child.
Confession	Parent or adult household member has told another person about one or more incidents of sexual abuse or exploitation involving child.
Documentary evidence	There is a photo, video, text or other recorded account of sexual abuse or exploitation.

Has someone sexually abused or exploited child, and it cannot be ruled out that a parent or other adult household member is involved in the contact?

Answer 'yes' if either of the following apply.

- Both the 'what' and 'basis' tables result in 'yes', but the 'who' table is unknown.
- A registered medical professional determined that there is medical evidence strongly suggesting sexual activity (e.g. pregnancy, syphilis or gonorrhoea; genital injury), AND one of the following applies.
 - » Child does not provide any statement (non-verbal child or child denies any sexual contact that would explain the medical evidence).
 - » Child describes sexual contact consistent with medical evidence but does not name the person involved.
 - » Child names a person other than a parent or adult household member; however, the account is implausible.

Answer 'no' if the following apply.

- Medical evidence strongly suggests sexual activity; or both the 'what' and 'basis' tables were yes, but the 'who' is unknown. However, all parents and adult household members have been ruled out.

OR

- The 'what' or 'basis' tables cannot be answered 'yes'.

Are there concerning circumstances that suggest that child may be sexually abused or exploited by a parent or adult household member?

Answer 'yes' if any of the following apply.

- Child is observed to act in ways that strongly suggest sexual abuse.
 - » For example, True has developed the Traffic Lights framework to help adults identify, understand and respond to children's sexual behaviour. This includes the Sexual Behaviours in Children & Young People brochure. (<http://www.true.org.au/Education/traffic-lights>) Red items in this brochure indicate a 'yes' answer.
- Child makes statements that strongly suggest sexual abuse. For example, 'I don't like how daddy touches me when mum isn't around, but I'm not supposed to tell.'
- A medical professional determines that child has indicators that are often associated with sexual abuse, AND there is no other plausible explanation.
- An adult living in the home has just been identified as having sexually abused another child in the past or present.
- An adult who is a registered sex offender has just moved into the home, or the adult's sexual offending history was not previously known. NOTE: Do not include adults who have completed treatment for prior sexual abuse and who are assessed by a professional specialising in treatment of sexual perpetrators to be low risk.

OR if two or more of the following apply.

- Child is observed to act in sexual ways that are not consistent with child's age or development or are unusual compared to child's prior behaviour.
 - » In True's Sexual Behaviours in Children & Young People brochure (<http://www.true.org.au/Education/traffic-lights>), amber items indicate a 'yes' answer.
- Child makes statements that vaguely suggest sexual abuse. For example, 'I don't like how daddy touches me'; OR 'I play a game with daddy when mum isn't around'; OR 'I have a secret, and daddy says I'm not supposed to tell.'
- A medical professional determines that child has indicators more commonly due to other causes but that can be due to sexual abuse.

- An adult living in the home has been charged but not convicted of a sexual offence or has previously been investigated for a sexual offence against children OR has completed treatment for prior sexual abuse and is assessed by a professional specialising in treatment of sexual perpetrators to be low risk.
- An adult living in the home acts in ways that suggest a combination of at least two the following.
 - » Having persistent secrecy with child.
 - » Lack of sexual boundaries around child such as walking around in the nude, or observing child whilst child is nude, beyond ages when required for daily care of child.
 - » Sexualising child by comments or actions.
 - » Similar actions that indicate potential sexualisation of the relationship with the child.
- Significant emotional or behavioural changes in child such as sleep or appetite disturbance, self-harming, unexplained significant change in school performance.
- Unexplained fear or dislike of an adult in the household or efforts to avoid being alone with an adult in the household.

NOTE: For non-verbal children (e.g. a child under age 3, or a child who is unable to speak due to a disability), a single indicator from the above list 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 any of the following apply.

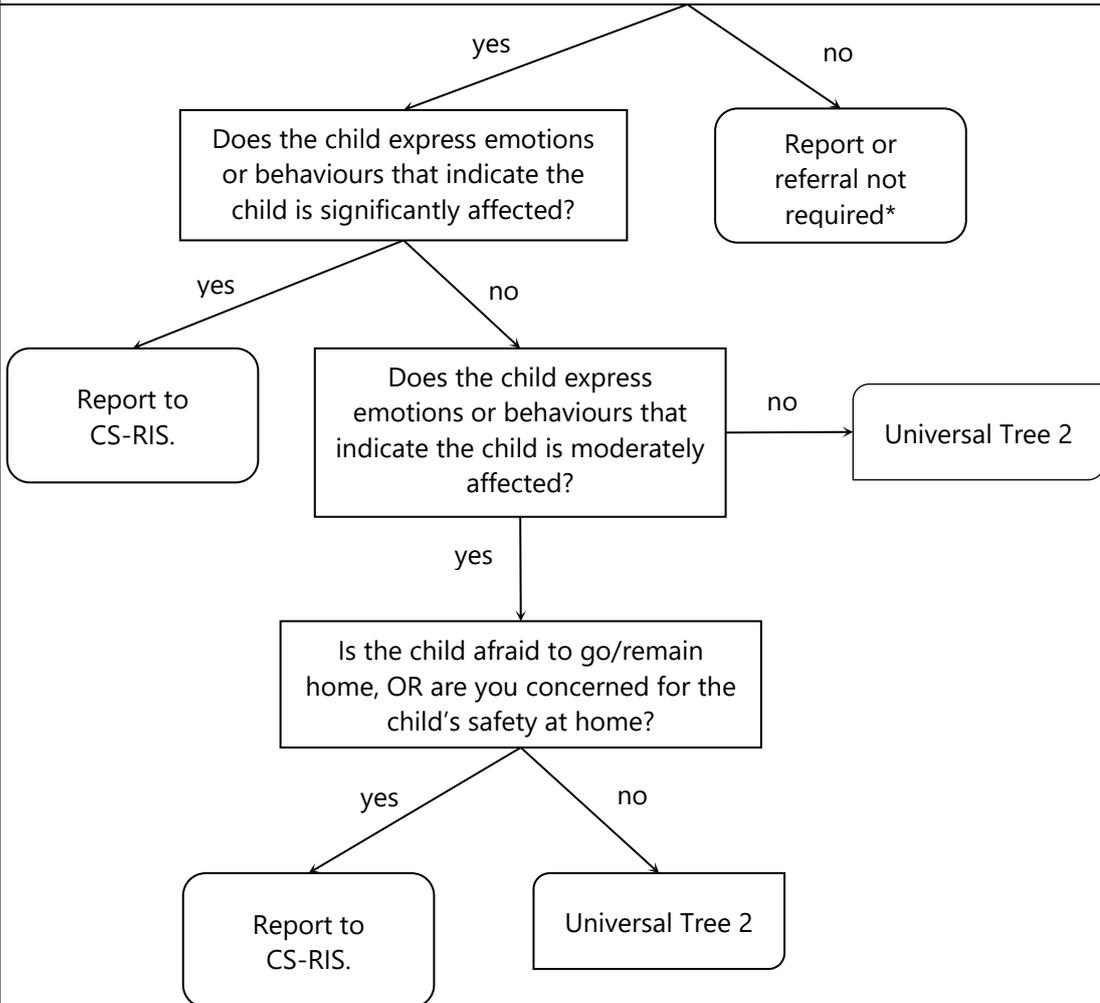
- Child's sexual behaviour is consistent with development.

For example, in True's Sexual Behaviours in Children & Young People brochure (<http://www.true.org.au/Education/traffic-lights>), green items indicate a 'no' answer.
- Child makes statements lacking any detail about whether there was any discomfort and where it is highly unlikely that the child means the contact was sexual. For example, 'Daddy touches me', OR 'I play a game with daddy.'
- Only a single concern is present from the list requiring two or more to be present, and none are present from the list requiring only one.

EMOTIONAL/PSYCHOLOGICAL HARM

Does the child experience any of the following?

- Severe or escalating domestic and family violence;
- Significant parental mental health or problematic alcohol or other drug use concerns;
- Parental behaviours that are persistent or repetitive and likely to cause emotional or psychological harm to the child;
- Parental criminal or corrupting behaviour; or
- Parental behaviour that deliberately exposes a child to traumatic events.



*Consider accessing services listed on [oneplace](#).

EMOTIONAL/PSYCHOLOGICAL HARM DEFINITIONS

Does the child experience any of the following?

- Severe or escalating domestic and family violence;
- Significant parental mental health condition or problematic alcohol or other drug use concerns;
- Parental behaviours that are persistent or repetitive and likely to cause emotional or psychological harm to the child;
- Parental criminal or corrupting behaviour; or
- Parental behaviours that deliberately expose a child to traumatic events.

Answer 'yes' if any of the following conditions are present in household.

- Severe or escalating domestic and family violence. Parent or other household member is violent or abusive to a person with whom they are, or have been, in an intimate personal relationship, family relationship or informal care relationship, and this is severe or escalating.
 - » *Violent*: On one or more occasions, one intimate partner physically assaulted another.
 - » *Abusive*: There is a pattern of verbal attacks, demeaning language, stalking or controlling behaviour (e.g. prevents contact with friends or family, restricts use of money).
 - » *Severe*: One or more incidents resulted in an injury to any participant or bystander that required medical care or involved use of a dangerous weapon (e.g. gun, knife, thrown object heavy enough to cause an injury requiring medical care).
 - » *Escalating*: There is a pattern of ongoing incidents that are not severe but are escalating in frequency or severity.
- Significant parental mental health condition or problematic alcohol or other drug use concerns. Parent has a diagnosed or suspected mental health concern or problematic alcohol or other drug use 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 or harm to pets.
- » Parent's behaviour is extremely erratic.
- » Parent fabricates or induces illness in child (commonly referred to as FIIIC, fabricated or induced illness by carer).
- Parental behaviours that are persistent or repetitive and likely to cause emotional or psychological harm to the child. 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* the single incident is severe and if you have no prior contact with family and are unlikely to have continuing contact.

Examples include the following.

- » *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.
- » *Scapegoating:* Blaming child for family circumstances that are not the child's fault or consistently accusing one child of fault for incidents caused by other household members.
- Parental criminal or corrupting behaviour. Parent engages in illegal behaviour and exposes or involves child in this behaviour.
- Parental behaviour that deliberately exposes a child to traumatic events. 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 express emotions or behaviours that indicate the child is significantly affected?

Answer 'yes' if either of the following apply.

- 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 Psychological Harm Indicators' in Appendix B, Table B1.

PRACTICE GUIDANCE

Whilst 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 express emotions or behaviours that indicate the child is moderately affected?

Answer 'yes' if the child has one or more indicators from the Table B3 in Appendix B.

PRACTICE GUIDANCE

Whilst 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 either of the following apply.

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

OR

- Explanations other than parental actions or inactions fully explain child emotions or behaviour.

Is the child afraid to go/remain home, OR are you concerned for the child's safety at home?

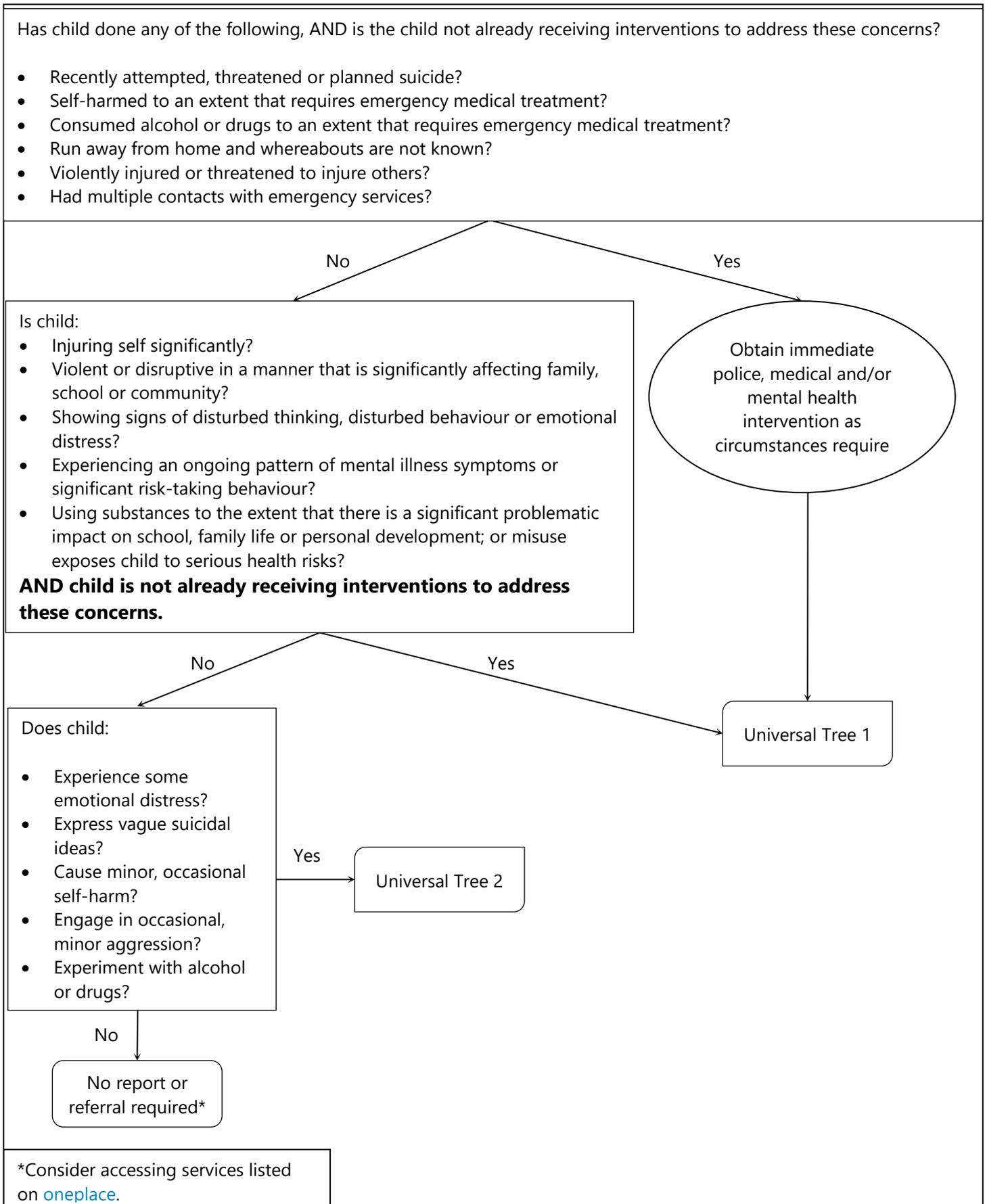
Answer 'yes' if either of the following apply.

- Child expresses concern that if child goes or remains home:

- » Child will be 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 or drugs, running away); OR
- » Parent will act 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 or remains home, child will be significantly harmed or will harm self or others. (for example, you spoke with parent by phone, and parent stated he would beat the child when child gets home).

Answer 'no' if child expresses feeling safe at home, AND there is no indication that child is in imminent danger. Child may be concerned about parent being angry or providing consequences for some child action, but there is no indication that anger is likely to be out of control and no indication that consequences will include physical or emotional harm.

CHILD IS A DANGER TO SELF OR OTHERS



*Consider accessing services listed on [oneplace](#).

CHILD IS A DANGER TO SELF OR OTHERS DEFINITIONS

Has child:

- **Recently attempted, threatened or planned suicide?**
- **Self-harmed to an extent that requires emergency medical treatment?**
- **Consumed alcohol or drugs to an extent that requires emergency medical treatment?**
- **Run away from home and whereabouts are not known?**
- **Violently injured or threatened to injure others?**
- **Had multiple contacts with emergency services?**

Answer 'yes' if any of the following apply.

- Recently attempted, threatened or planned suicide? Child recently² attempted, threatened or planned suicide. All attempts should be included, regardless of the method. Threats should be included where the threat is specific in terms of plan.
- Self-harmed to an extent that requires emergency medical treatment? Child deliberately injured self to the extent that emergency medical care was or is needed.
- Consumed alcohol or drugs to an extent that requires emergency medical treatment? Child used alcohol or drugs to an extent that emergency medical care was or is required.
- Run away from home and whereabouts are not known? Child has left home and cannot be located.
- Violently injured or threatened to injure others? Child is or recently³ has been acutely violent to the extent that child already caused injury to another person or animal or is threatening to injure or kill another person or animal in the immediate future. For example, child is brandishing a weapon.

² 'Recently' suggests that the action happened in the near past, typically within the past few hours to days. If you are aware of a circumstance that occurred in the more distant past; and to the best of your knowledge, there has been no intervention and child continues to be suicidal, violent, self-harming or problematic alcohol or other drug use; consider the incident to be recent.

³ Ibid.

- Had multiple contacts with emergency services? Child has a habit of running away from home, whereabouts are not known, AND there has been a history of child engaging in criminal or undesirable activities (e.g. drug-taking, sexual promiscuity or other self-harming behaviours).

PRACTICE GUIDANCE

Obtain immediate police, medical and/or mental health intervention as required by circumstances.

- **Police:** If child is injuring others or threatening to injure others, or if *child* needs to be restrained to prevent self-injury, or if child is missing and there are concerns for child's safety.
- **Medical:** If child or another person has been injured or child is unconscious.
- **Mental Health:** If child is suicidal (either overtly or covertly) or cannot be calmed.

Is child:

- **Injuring self significantly?**
- **Violent or disruptive in a manner that is significantly affecting family, school or community?**
- **Showing signs of disturbed thinking, disturbed behaviour or emotional distress?**
- **Experiencing an ongoing pattern of mental illness symptoms or significant risk-taking behaviour?**
- **Using alcohol or other drugs to the extent that there is a significant problematic impact on school, family life or personal development; or problematic use exposes child to serious health risks?**

AND child is not already receiving interventions to address these concerns.

Answer 'yes' if one or more of the following actions or conditions are observed in child.

- Injuring self significantly? Child has deliberately injured self, and even though medical care is not required, the injury was more than superficial (e.g. not cuts that bled but did not require stitches).
- Violent or disruptive in a manner that is significantly affecting family, school or community? Child is frequently aggressive so that one or more of the following are present.
 - » Family or household members have been injured or consistently fear injury by child.
 - » Family life is organised around protecting others from child.

- » Child is repeatedly suspended or expelled from school.
- » Child frequently absconds from school or home for duration that places child at risk.
- Showing signs of disturbed thinking, disturbed behaviour or emotional distress? Child is experiencing disturbed thinking, disturbed behaviour or emotional distress, including depression or other mental health concerns, to the extent that child is no longer able to participate in family, school or social life.
- Experiencing an ongoing pattern of mental health symptoms or significant risk-taking behaviour? Child has a history of a diagnosed mental health condition or participates in behaviours that indicate child may have an undiagnosed mental illness.
- Misusing substances to the extent that there is a significant impact on school, family life or personal development; or misuse exposes child to serious health risks? One or more of the following apply.
 - » Child is using alcohol or drugs to the extent that child:
 - Has stopped attending school;
 - Has little or no interest in activities other than drug or alcohol use; or
 - Is stealing or is engaging in prostitution, pornography or violent criminal behaviour.
 - » Child's use of substances has directly or indirectly led to impaired physical health. For example, you have received medical or professional advice that child's use of substances has led to malnutrition, weakened immune system, high blood pressure, liver damage, seizures.
 - » Child's use of substances has directly or indirectly led to impaired development. For example, you have received medical or professional advice that child's use of substances has led to memory loss, loss of concentration or cognitive impairment that persists even after the substances have cleared the system.
 - » Child is injecting illicit drugs, sharing needles or engaging in prostitution or other behaviours that will expose child to high risk of health issues such as HIV, hepatitis B or sexually transmitted diseases.

Does child

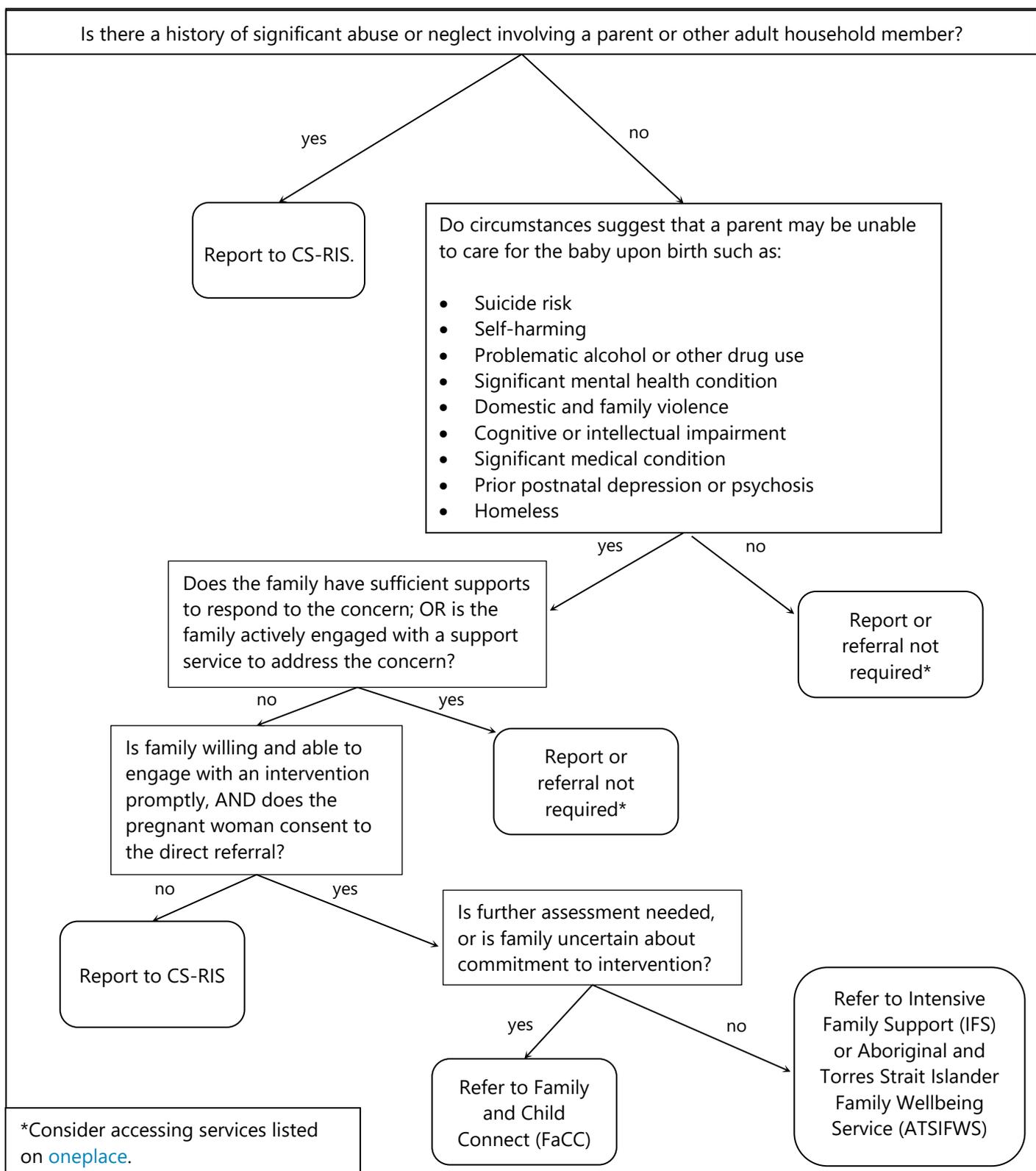
- **Experience some emotional distress?**
- **Express vague suicidal ideas?**
- **Cause minor, occasional self-harm?**
- **Engage in occasional, minor aggression?**
- **Experiment with alcohol or drugs?**

NOTE: These concerns may require treatment or intervention from a range of services, including police, medical or mental health. Depending on the circumstance, consider engaging with one or all of these services to address the risks identified.

Answer 'yes' if child does one or more of the following.

- Experience some emotional distress. Child has some symptoms of emotional distress, to the extent that these symptoms are interfering with normal activities. For example: child is having difficulty concentrating, having difficulty eating or sleeping, or losing interest in activities. See Appendix B, Table B1.
- Express vague suicidal ideas. Child has made statements or gestures or otherwise expresses ideas that indicate child may be thinking about suicide, even though child has not stated a specific plan.
- Cause minor, occasional self-harm. Child has deliberately caused superficial self-harm such as light scratches.
- Engage in occasional, minor aggression. Child gets into fights on a regular basis, frequently throws things in anger where others have been or could easily have been injured or is frequently engaged in reckless driving.
- Experiment with alcohol or drugs. Child is experimenting with alcohol or any drugs in a way that presents a risk to their development or well-being. Examples include the following.
 - » Primary school-age (or younger) child has used any drugs other than occasional sips of alcohol with parental supervision or for religious purposes.
 - » Child has used any drugs or alcohol on multiple occasions to the extent of altering behaviour.
 - » Child has used drugs or alcohol on multiple occasions to the extent that child may be developing a dependence.

PREGNANT WOMAN—UNBORN CHILD



PREGNANT WOMAN—UNBORN CHILD DEFINITIONS

NOTE:

- A pregnant woman may be a minor.
- An unborn child includes from the time of conception until the birth of the baby.

PRACTICE GUIDANCE

Whilst 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:

- Enable DCSYW and other agencies to mobilise services for the potential benefit of the pregnant woman and unborn child after birth; or
- Enable DCSYW to prepare appropriate statutory/protective intervention following the birth of the child.

Is there a history of significant abuse or neglect involving a parent or other adult household member?

Answer 'yes' if the pregnant woman or another adult who will be living with the baby after birth has previous abuse or neglect reports in which that adult is responsible for harm or risk of significant harm, AND the previous reports include at least one of the following.

- Death of a child.
- Serious injury or illness of a child.
- A child was removed and placed in the care of the Chief Executive.
- Multiple prior reports exist.

The victim may be any child, regardless of whether that child is part of the current household.

Do circumstances suggest that a parent may be unable to care for the baby upon birth such as:

- **Suicide risk**
- **Self-harming**
- **Problematic alcohol or other drug use**
- **Significant mental health condition**
- **Domestic and family violence**
- **Cognitive or intellectual impairment**
- **Significant medical condition**
- **Prior postnatal depression or psychosis**
- **Homeless**

Answer 'yes' if one or more of the following is present for any parent the child will be living with following 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.
- Problematic alcohol or other drug use. A parent is dependent on use of any illegal or prescription drugs or alcohol to the level of intoxication where one or both parents could be unresponsive to the needs of the infant upon birth.
- Significant mental health condition. A parent is experiencing significant symptoms of a mental health condition, including current postnatal depression or postnatal psychosis, to the extent that one or both parents are unable to provide care and protection for the infant upon birth. This includes situations in which either parent has been diagnosed with a mental health condition that requires medication or treatment that is not taken as prescribed (whether due to prescribed cessation during pregnancy or other reason) or parent has never been diagnosed and is showing significant symptoms. Significant symptoms include:
 - » 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 parent cannot focus attention on attending to an infant's needs; or
 - » Hearing voices, seeing things that are not there or having thoughts of unrealistic/unsupportable beliefs of persecution, etc. Especially concerning are hostile or negative expressions about the unborn child or denial of the pregnancy.

- Domestic and family violence. There is current domestic and family violence or threats of violence towards the pregnant woman that includes physical assaults that may involve a serious injury* or use of a weapon or isolating, coercive or controlling behaviour.

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

PRACTICE GUIDANCE

There is an increased risk of domestic and family violence towards women during pregnancy. This is often a time that violence in a relationship begins.

- Cognitive or intellectual impairment. A parent has limited ability to understand information 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. A parent has a significant medical condition or physical disability to the extent that one or both parents are unable to provide care and protection for an infant after the birth.
- Prior postnatal depression or psychosis. Mother experienced postnatal depression or postnatal psychosis following a previous birth.
- Homeless. The pregnant woman has no safe place to stay with baby after birth.

Does the family have sufficient supports to respond to the concern; OR is the family actively engaged with a support service to address the concern?

Answer 'yes' if at least one of the following applies.

- The incident or concern happened more than six months ago, AND the family has acted to change the situation, whether or not formal intervention was used.

AND

- » There have been no new incidents or recurrence of condition for at least three months.

OR

- » Parents have been able to describe what actions are occurring to address the concerns.
- The incident or concern happened within the past six months, AND the family recently began to work with a support service to take actions to address the area of concern.

PRACTICE GUIDANCE

It is not necessary to verify family's participation with a support service.

Answer 'no' if the incident or concern happened within the past six months, AND at least one of the following applies.

- The family does not have access to informal or formal supports to help them address the concerns.
- You have well-founded doubts that a family is working with a support service or has an adequate support network to respond to the concerns.
- The supports the family is accessing are not sufficient to address the concerns.

Is family willing and able to engage with an intervention promptly, AND does the pregnant woman consent to the direct referral?

An intervention can be formal or informal.

'Promptly' means that the intervention will commence before recurrence is likely. For an immediately concerning situation, 'promptly' may require commencement within 24 hours. For chronic concerns with minimal impact on the child expected in the interim, an appointment may be several weeks away and still be considered prompt.

Answer 'yes' if *all* of the following apply.

- The family recognises that there is a concern and agrees to work towards resolution.
- The family has an appointment or plan to commence intervention.
- The family has a plan for protecting the child until commencement of intervention.

AND

- When you explain the availability of Family and Child Connect (FaCC), IFS or ATSIFWS, the family states that you may refer them to one or more of these resources.

Answer 'no' if any of the following apply.

- There has been no contact with the family, and contact is not possible (may be for reporter safety concerns).
- The parent does not agree that there is a concern.
- The family states that they are unwilling to engage in any service or activity to address the area of concern.
- The family is willing but lacks the capacity or resources needed to successfully engage.
- The family is willing but has previously expressed willingness and not engaged successfully to resolve the area of concern.
- The pregnant woman does not consent to being referred to FaCC, IFS or ATSIFWS.

Is further assessment needed, or is family uncertain about commitment to intervention?

Answer 'yes' if any of the following apply.

- Family is not well known to reporter; or if family is well known, reporter is uncertain about family's support needs.
- Family is not opposing a referral but is ambivalent about accepting support services. This may be inferred by discussion of doubt that the support will work, barriers to accessing the support or prior agreements for support that ended in discontinuing support before completion.

Answer 'no' if both of the following apply.

- Family is well known, and the reporter has sufficient information to be confident that a referral to IFS or ATSIFWS is appropriate.

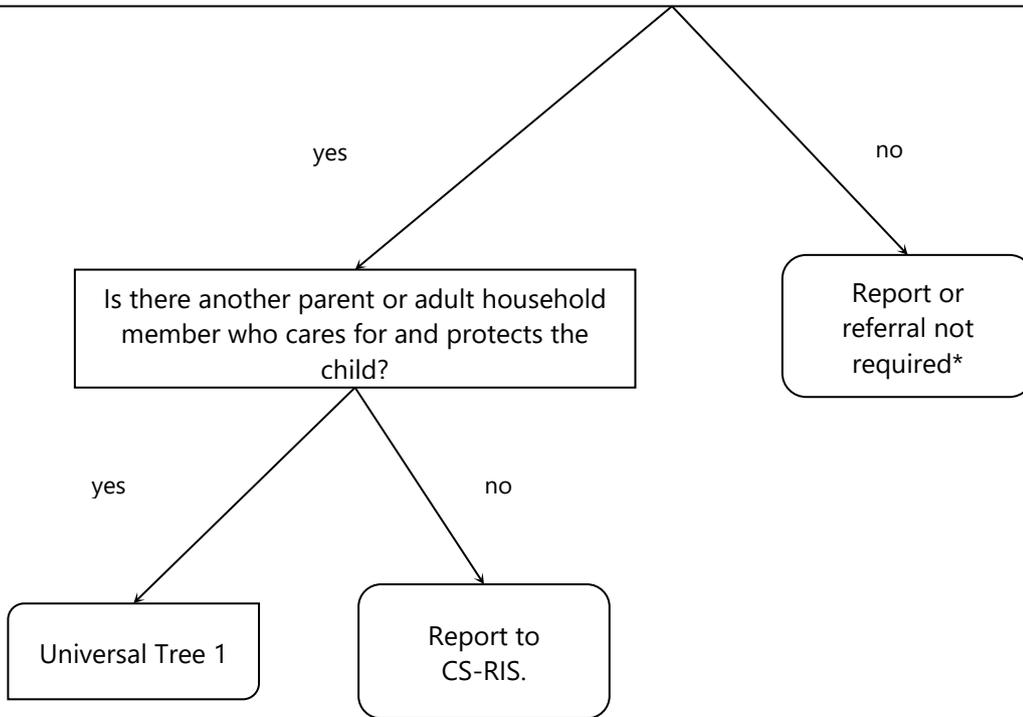
AND

- Family is committed to resolving the area of concern. This may be inferred by discussion of plans to begin a change process, the family taking at least one active step (e.g. calling for an appointment) or the family describing how life will be when the problem is resolved.

PARENT CONCERN: PROBLEMATIC ALCOHOL OR OTHER DRUG USE

Does the parent's problematic alcohol or other drug use impact, or is it likely to impact:

- Parent's ability to meet the child's needs; or
- Child's behaviour?



*Consider accessing services listed on [oneplace](#).

PARENT CONCERN: PROBLEMATIC ALCOHOL OR OTHER DRUG USE DEFINITIONS

PRACTICE GUIDANCE FOR QUEENSLAND HEALTH EMPLOYEES

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).

PRACTICE GUIDANCE FOR DEPARTMENT OF EDUCATION EMPLOYEES

If you are a DoE employee, consider consulting with a guidance officer or senior guidance officer.

Does the parent’s problematic alcohol or other drug use impact, or is it likely to impact:

- **Parent’s ability to meet the child’s needs; or**
- **Child’s behaviour?**

Answer ‘yes’ if both of the following apply.

- Parent is using alcohol or other drugs to the extent that it is having a negative impact on parent’s capacity to parent the child, parent’s 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.

The following table shows examples of problematic alcohol or other drug use indicators.

Examples of Indicators of Problematic Alcohol or Other Drug Use	
Type of Indicator	What You May Notice
Professional Assessment/Treatment	<ul style="list-style-type: none"> • Diagnosed by a professional as having an addiction to alcohol or other drugs. • Received or receiving treatment for addiction to alcohol or drugs.
Direct Observation of Use	<ul style="list-style-type: none"> • Observed parent use or possession of illegal drugs. • Observed parent consumption of alcohol to the point of intoxication.
Legal	Arrests for drink driving or other alcohol- or drug-related offences.
Work	<ul style="list-style-type: none"> • Excessive absences that may reflect hangover, withdrawal or active use. • Poor performance on the job because of impaired judgment.
Relationships	<ul style="list-style-type: none"> • Increasingly, relationships are limited to people with problematic alcohol or other drug use • Losing relationships with non-using friends and relatives.
Mood	<ul style="list-style-type: none"> • Increasing sadness. • Rapidly changing moods.

Examples of Indicators of Problematic Alcohol or Other Drug Use	
Type of Indicator	What You May Notice
Physical	<ul style="list-style-type: none"> • Whilst intoxicated or high: <ul style="list-style-type: none"> » Slurred speech » Poor coordination » Agitation » Pupils pinpoint or dilated • Long term: <ul style="list-style-type: none"> » Emaciated » Skin lesions » Tooth loss

AND

- One or more of the following is adversely impacted.
 - » Ability 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 or drugs; or parent's life is so organised around drug-seeking that parent is inattentive to child's needs. Consider child's age/developmental status. Older children are less dependent on their parent to meet basic needs, whilst infants and 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 the relevant neglect decision tree first and use this decision tree if you have already ruled out neglect.

- » Child's behaviour. Child is observed with indicators of emotional disturbance. Appendix B, Table B1 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 FaCC.

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

Is there another parent or other adult household member 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, does not engage in problematic alcohol or other drug use and provides care and protection appropriate to the child's needs including the following.

- Second parent is fully aware of the other parent's problematic alcohol or other drug use and impact or potential impact on the children.

AND

- Second parent provides a description of ways second parent is acting to protect the child.

Answer 'no' if any of the following apply.

- This is a single-parent family.

OR

- All adults engage in problematic alcohol or other drug use.

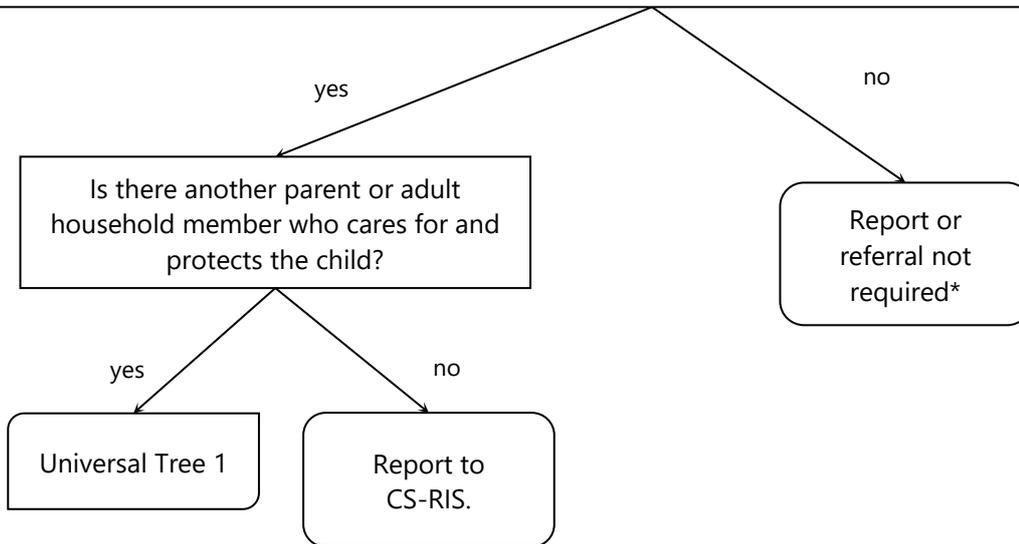
OR

- At least one adult does not engage in alcohol or other drug use 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.

PARENT CONCERN: MENTAL HEALTH

Does the parent's mental health concern impact, or is it likely to impact:

- Parent's ability to meet the child's needs;
- Ability to form a relationship with child; or
- Child's behaviour?



*Consider accessing services listed on [oneplace](#).

PARENT CONCERN: MENTAL HEALTH DEFINITIONS

If you have a parent concern and are a QH employee, consider consulting with a CPLO or CPA. If you are a DoE employee, consider consulting with a guidance officer or senior guidance officer or Principal Advisor—Student Protection.

Does the parent’s mental health concern impact or is it likely to impact:

- **Parent’s ability to meet the child’s needs;**
- **Ability to form relationship with child; or**
- **Child’s behaviour?**

Answer ‘yes’ if both of the following apply.

- 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 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).

The following table shows examples of mental health concern indicators.

Examples of Indicators of Mental Health Concerns	
Type of Mental Health Concern	What You May Notice
All	<ul style="list-style-type: none"> • Parent has been diagnosed with mental illness. • Parent is receiving therapy for mental illness. • Parent is on medication for mental illness.
Mood Disorders	<ul style="list-style-type: none"> • Suicide attempts, threats or preparations • Extremely sad for long periods of time and there is no obvious reason. May alternate with period of high activity. • 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	<ul style="list-style-type: none"> • Hears voices or sees things that others do not • Unfounded beliefs that others are conspiring against them • Beliefs that thoughts are being ‘planted’ • Unfounded beliefs of self-importance, powers
Compulsions/Obsessions	<ul style="list-style-type: none"> • Hoarding • Excessive hand washing, fear of germs
Personality Disorders	Completely focused on self and oblivious to the needs of others around

AND

- One of the following is adversely affected.
 - » Ability 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 are less dependent on their parent to meet basic needs, whilst infants and 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 the relevant neglect decision tree first and use this decision tree if you have already ruled out neglect.
- Do not include education non-attendance unless relevant.
- » Ability to form a relationship with their child. For example, mother is depressed (including postnatal depression) and not responsive to child. 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. Child's behaviour includes indicators of emotional disturbance. Appendix B, Table B1 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.

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 adult household member who cares for and protects the child?

Answer 'yes' if a second parent or another adult 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 the following.

- Second parent or adult household member is fully aware of the other parent's mental health issues and impact or potential impact on the children.

OR

- Second parent or adult household member provides a description of ways they are acting to protect the child such as ensuring that the parent with mental health concerns is never alone with the children.

Answer 'no' if any of the following apply.

- 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 due to family court orders).

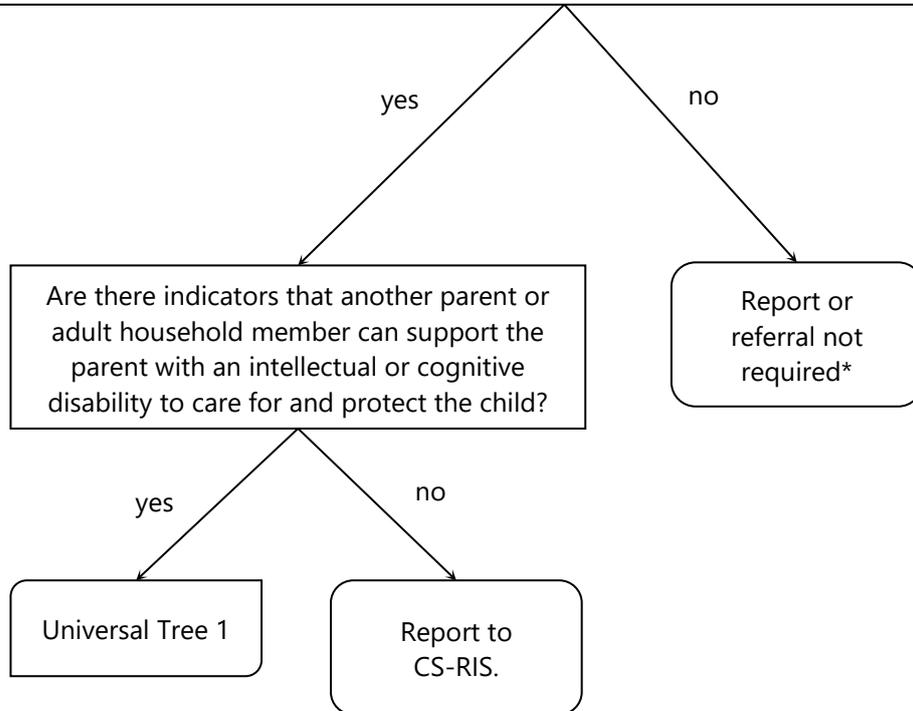
OR

- 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.

PARENT CONCERN: INTELLECTUAL OR COGNITIVE DISABILITY

Does the parent's intellectual or cognitive disability impact, or is it likely to impact:

- Ability to meet the child's needs;
- Ability to form a relationship; or
- Child's behaviour?



*Consider accessing services listed on [oneplace](#).

**PARENT CONCERN: INTELLECTUAL OR COGNITIVE DISABILITY
DEFINITIONS**

If you have a parent concern and are a QH employee, consider consulting with a CPLO or CPA. If you are a DoE 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:

- Ability to meet the child’s needs;
- Ability to form a relationship; or
- Child’s behaviour?

Answer ‘yes’ if both of the following apply.

- 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 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).

Indicators of Intellectual or Cognitive Disability or Learning Impairment	
	What You May Notice
Diagnosis and Early Intervention	<ul style="list-style-type: none"> • 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 child’s safety, despite access to the information and opportunities to learn.
Ability to Process Information	<ul style="list-style-type: none"> • 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 parent is able to meet the child’s developmental needs and ensure the child’s safety.

AND

- One or more of the following is adversely affected.

- » Ability 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 are less dependent on their parent to meet basic needs, whilst infants and 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 the relevant neglect decision tree first and use this decision tree if you have already ruled out neglect.
 - Do not include education non-attendance unless relevant.
- » Ability to form a relationship with child. 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. Child expresses symptoms of 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 a professional with expertise in this area.

Possible Impacts of Parent Intellectual Ability on Child	
	What You May Notice
Infants	<ul style="list-style-type: none"> • Parent engages in incorrect feeding practices and is unable to understand instructions regarding appropriate feeding. • Parent has ignored indicators of illness that should prompt medical attention. • Child is behind on developmental milestones.
Toddlers	<ul style="list-style-type: none"> • Falling behind on developmental milestones. • Allowed to play in dangerous situations.
School Age	<ul style="list-style-type: none"> • Parent is unable to provide supervision and support to assist the child meet daily school requirements, and the child may have delayed competencies in academic, social or emotional capacity compared to peers. • Child assumes responsibility for self and siblings.

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

Answer 'yes' if a second parent or adult household member is 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 the following.

- Second parent or adult household member 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 or adult household member provides a description of ways second parent is acting to protect the child such as ensuring that the parent with intellectual disability is never alone with the children where there is a risk of harm.

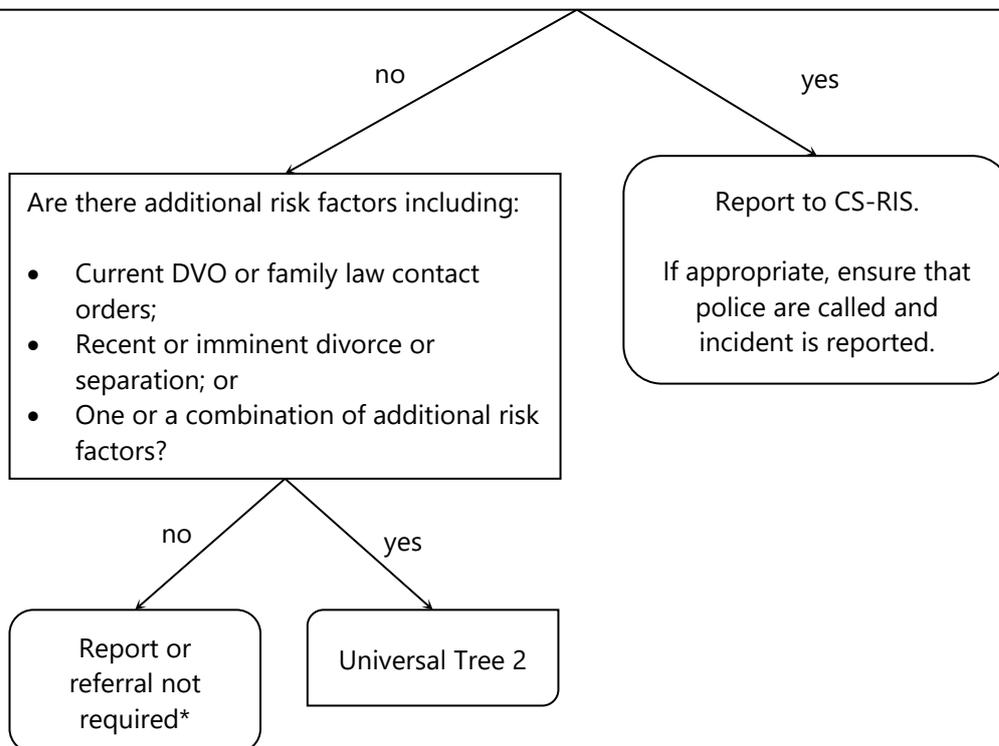
Answer 'no' if any of the following apply.

- 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, physically, financially or legally unable such as due to family court orders).

PARENT CONCERN: DOMESTIC AND FAMILY VIOLENCE

Has violence been perpetrated by an adult household member where one or more of the following occurred, AND a child normally resides in the home?

- Perpetrator
 - » Used a weapon (gun, knife, etc.) or has access to a weapon
 - » Attempted to strangle or suffocate
 - » Attempted to kill
 - » Caused serious injury to adult or pet
 - » Made a serious threat to harm child/adult/self/pet
 - » Made a threat to or harmed a pregnant woman or a woman who has recently given birth
 - » Is increasing severity or frequency of violence
 - » Is stalking, is extremely controlling or has sexually assaulted parent or other adult household member
 - » Has attempted suicide
 - » Is non-compliant with a court order
 - » Has significant mental health concerns or severe problematic alcohol or other drug use
 - » Is causing the victim or other household members to be very fearful for their safety
- Child
 - » Was physically injured
 - » Attempted to intervene
 - » Was in parent's arms or in close enough proximity to be hurt
 - » Was significantly emotionally/psychologically distressed
 - » Is the subject of a previous unborn child report related to domestic and family violence



*Consider accessing services listed on [oneplace](#).

PARENT CONCERN: DOMESTIC AND FAMILY VIOLENCE DEFINITIONS

Has violence been perpetrated by an adult household member where one or more of the following occurred, AND a child normally resides in the home?

- **Perpetrator**
 - » **Used a weapon (gun, knife, etc.) or has access to a weapon**
 - » **Attempted to strangle or suffocate**
 - » **Attempted to kill**
 - » **Caused serious injury to adult or pet**
 - » **Made a serious threat to harm child/adult/self/pet**
 - » **Made a threat to or harmed a pregnant woman or a woman who has recently given birth**
 - » **Is increasing severity or frequency of violence**
 - » **Is stalking, is extremely controlling or has sexually assaulted parent or other adult household member**
 - » **Has attempted suicide**
 - » **Is non-compliant with a court order**
 - » **Has significant mental health concerns or severe alcohol or drug abuse**
 - » **Is causing the victim or other household members to be very fearful for their safety.**

- **Child**
 - » **Was physically injured**
 - » **Attempted to intervene**
 - » **Was in parent's arms or in close enough proximity to be hurt**
 - » **Was significantly emotionally/psychologically distressed**

» **Is the subject of a previous unborn child report related to domestic and family violence**

Answer 'yes' if one or more of the following is occurring or has recently occurred.

Perpetrator

- *Used a weapon (gun, knife, etc.).* One or more parents or adults in the home used or has access to a weapon capable of causing significant injury, such as a gun, knife, blunt object such as a hammer, or a flammable liquid. Use means that the weapon was deployed (e.g. fired gun, slashed with knife, swung object, poured flammable liquid) or displayed in a threatening manner (e.g. pointed gun or showed it implying threat, held knife or blunt object in threatening manner).
- *Attempted to strangle or suffocate.* A parent or other adult household member attempted to cause harm by impeding the victim's ability to breathe, whether or not the victim was able to continue breathing.
- *Attempted to kill.* A parent or other adult household member intended to kill the victim by any means.
- *Caused serious injury to adult or pet.* A parent, other adult household member, or pet suffered a serious injury during the incident including but not limited to strangulation, sexual assault, fractures, internal injuries, disfigurement, burns, death or any injury that may require hospitalisation.
- *Made a serious threat to harm child/adult/self/pet.* Parent or adult household member threatened to harm child or another parent or adult, pet or self (e.g. threat to kill self, sexual assault, kidnap, hold hostage, murder, serious injury or harm; or parent killed or threatened to kill a pet).
- *Made a threat to or harmed a pregnant woman or a woman who recently gave birth.* Whilst a woman is pregnant, or shortly after a birth, a parent or adult household member made any threat to harm or caused any harm to the pregnant woman.
- *Is increasing severity or frequency of violence.* There is a significant increase in the number and severity of assaults. 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.

- *Is stalking, is extremely controlling or has sexually assaulted parent or other adult household member.* The perpetrator has been stalking (following; aggressive phone, email, text, mail contact; watching) the parent; OR the perpetrator 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; or repeatedly locking the victim in or outside the house); OR the perpetrator has forced sexual contact on parent.
- *Has attempted suicide.* The perpetrator attempted suicide in the recent past.
- *Is non-compliant with a court order.* There is a court order (i.e. domestic violence order or any other court order related to the perpetrator's behaviour) that is not being followed by the perpetrator.
- *Has significant mental health concerns or problematic alcohol or other drug use.* One or both of the following apply.
 - » Mental health concerns. Your awareness may be based on personal observations or credible statements by the child or another person. Include parents or adult household members 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 concerns include the following.

Examples of Indicators of Mental Health Concerns	
Type of Mental Health Concern	What You May Notice
All	<ul style="list-style-type: none"> • Parent has been diagnosed with mental illness. • Parent is receiving therapy for mental illness. • Parent is on medication for mental illness.
Mood Disorders	<ul style="list-style-type: none"> • Suicide attempts, threats or preparations. • Extremely sad for long periods of time, and there is no obvious reason. May alternate with period of high activity. • 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 interfere with daily life.
Psychotic Disorders	<ul style="list-style-type: none"> • Hears voices or sees things that others do not. • Unfounded beliefs that others are conspiring against the person. • Beliefs that thoughts are being 'planted'. • Unfounded beliefs of self-importance, powers.

Examples of Indicators of Mental Health Concerns	
Type of Mental Health Concern	What You May Notice
Compulsions/Obsessions	<ul style="list-style-type: none"> • Hoarding. • Excessive hand washing, fear of germs.
Personality Disorders	<ul style="list-style-type: none"> • Completely focused on self and oblivious to the needs of others around.

» Problematic alcohol or other drug use.

Examples of Indicators of Problematic Alcohol or Other Drug Abuse	
Type of Indicator	What You May Notice
Professional Assessment/Treatment	<ul style="list-style-type: none"> • Diagnosed by a professional as having an addiction to alcohol or drugs. • Received or receiving treatment for addiction to alcohol or drugs.
Direct Observation of Use	<ul style="list-style-type: none"> • Observed parent use or possession of illegal drugs • Observed parent consumption of alcohol to the point of intoxication
Legal	<ul style="list-style-type: none"> • Arrests for drink driving or other alcohol- or drug-related offences
Work	<ul style="list-style-type: none"> • Excessive absences that may reflect hangover, withdrawal or active use • Poor performance on the job because of impaired judgment
Relationships	<ul style="list-style-type: none"> • Increasingly, relationships are limited to people who also abuse alcohol or drugs • Losing relationships with non-using friends and relatives
Mood	<ul style="list-style-type: none"> • Increasing sadness • Rapidly changing moods
Physical	<ul style="list-style-type: none"> • Whilst intoxicated or high: <ul style="list-style-type: none"> » Slurred speech » Poor coordination » Agitation » Pupils pinpoint or dilated • Long term: <ul style="list-style-type: none"> » Emaciated » Skin lesions » Tooth loss

- *Is causing the victim or other adult household member to be very fearful for their safety.* The victim or other adult household member is very fearful for their safety because of threats or actions by the perpetrator.

Child

- *Was physically injured.* A child suffered physical injury whilst one parent or adult household member was assaulting another, 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 or evading the violence.
- *Attempted to intervene.* When one parent or adult household member was assaulting another, a child attempted to hold back the perpetrator or protect the victim or participated in assaulting the victim.
- *Was in parent or adult household member's arms or in close enough proximity to be hurt.* When one adult was assaulting another, either adult was holding a child in their arms, OR a child was near enough to the altercation that even though the child was not attempting to intervene, the course of the assault did or was likely to include the child's location.

NOTE: Consider the range of potential harm based on use of weapons and 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 scored 'yes'. If adults carried the altercation from room to room over many minutes to hours, a child being anywhere in the home should be scored 'yes'.

- *Was significantly emotionally/psychologically distressed.* During 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. This may include one or a combination of the behaviours in Appendix B, Table B1.
- *Is the subject of a previous unborn child report related to domestic and family violence.* You have information that whilst mother was pregnant with this child, a report was made to CS-RIS (whether accepted or not) because of concerns related to domestic and family violence; AND since that report, the violence has continued.

Are there additional risk factors:

- **Current domestic violence order (DVO) or family law contact orders;**
- **Recent or imminent divorce or separation;**
- **One or a combination of additional risk factors?**

Answer 'yes' if any of the following apply.

- Current DVO or family law contact orders. 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.
- Recent or imminent divorce or separation. 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.
- One or a combination of additional risk factors. None of the above are present, but one risk factor or a combination of several suggest that further violence is likely in the near future.

Examples of risk factors include the following.

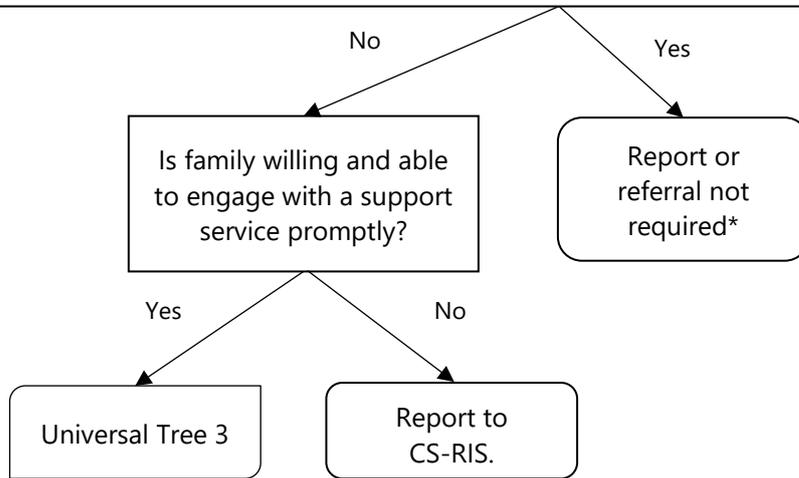
- » Parent or adult household member experiencing domestic and family violence is in a constant state of fear.
- » Parent or adult household member experiencing domestic and family violence fears for the child's safety.
- » Recent or prolonged unemployment is causing stress.
- » Severe financial stress
- » 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 or adult household member experiencing domestic and family violence is pregnant.
- » Cruel treatment of animals or 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 and family violence

UNIVERSAL TREE 1

Does the family have sufficient supports to respond to the concern;

OR

Is family actively engaged with a support service to address the concern?



*Consider accessing services listed on [oneplace](#).

UNIVERSAL TREE 1 DEFINITIONS

Does the family have sufficient supports to respond to the concern;

OR

Is family actively engaged with a support service to address the concern?

Answer 'yes' if at least one of the following applies.

- The incident or concern happened more than six months ago, AND the family has acted to change the situation, whether or not formal intervention was used.

AND

- » There have been no new incidents or recurrence of condition for at least three months.

OR

- » Parents have been able to describe what actions are occurring to address the concerns.
- The incident or concern happened within the past six months, AND the family recently began to work with a support service to take actions to address the area of concern.

PRACTICE GUIDANCE

It is not necessary to verify family's participation with a support service.
--

Answer 'no' if the incident or concern happened within the past six months, AND at least one of the following applies.

- The family does not have access to informal or formal supports to help them address the concerns.
- You have well-founded doubts that a family is working with a support service or has an adequate support network to respond to the concerns.
- The supports the family are accessing are not sufficient to address the concerns.

Is family willing and able to engage with a support service promptly?

An intervention may be a formal or informal intervention.

'Promptly' means that the intervention will commence before recurrence is likely. For an immediately concerning situation, 'promptly' may require commencement within 24 hours. For chronic concerns with minimal impact on child expected in the interim, an appointment may be several weeks away and still be considered prompt.

Answer 'yes' if *all* of the following apply.

- The family recognises that there is a concern and agrees to work towards resolution.
- The family has an appointment or plan to commence intervention.
- The family has a plan for protecting child until commencement of intervention.

Answer 'no' if any of the following apply.

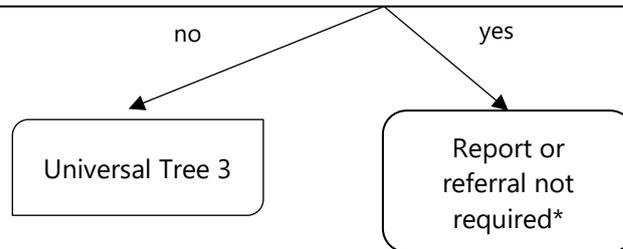
- There has been no contact with the family and contact is not possible (may be for reporter safety concerns).
- The parent does not agree that there is a concern.
- The family states that they are unwilling to engage in any service or activity to address the area of concern.
- The family is willing but lacks the capacity or resources needed to successfully engage.
- The family is willing but has previously expressed willingness and not engaged successfully to resolve the area of concern.

UNIVERSAL TREE 2

Does the family have sufficient supports to respond to the concern;

OR

Is family actively engaged with a support service to address the concern?



*Consider accessing services listed on [oneplace](#).

UNIVERSAL TREE 2 DEFINITIONS

Does the family have sufficient supports to respond to the concern;

OR

Is family actively engaged with a support service to address the concern?

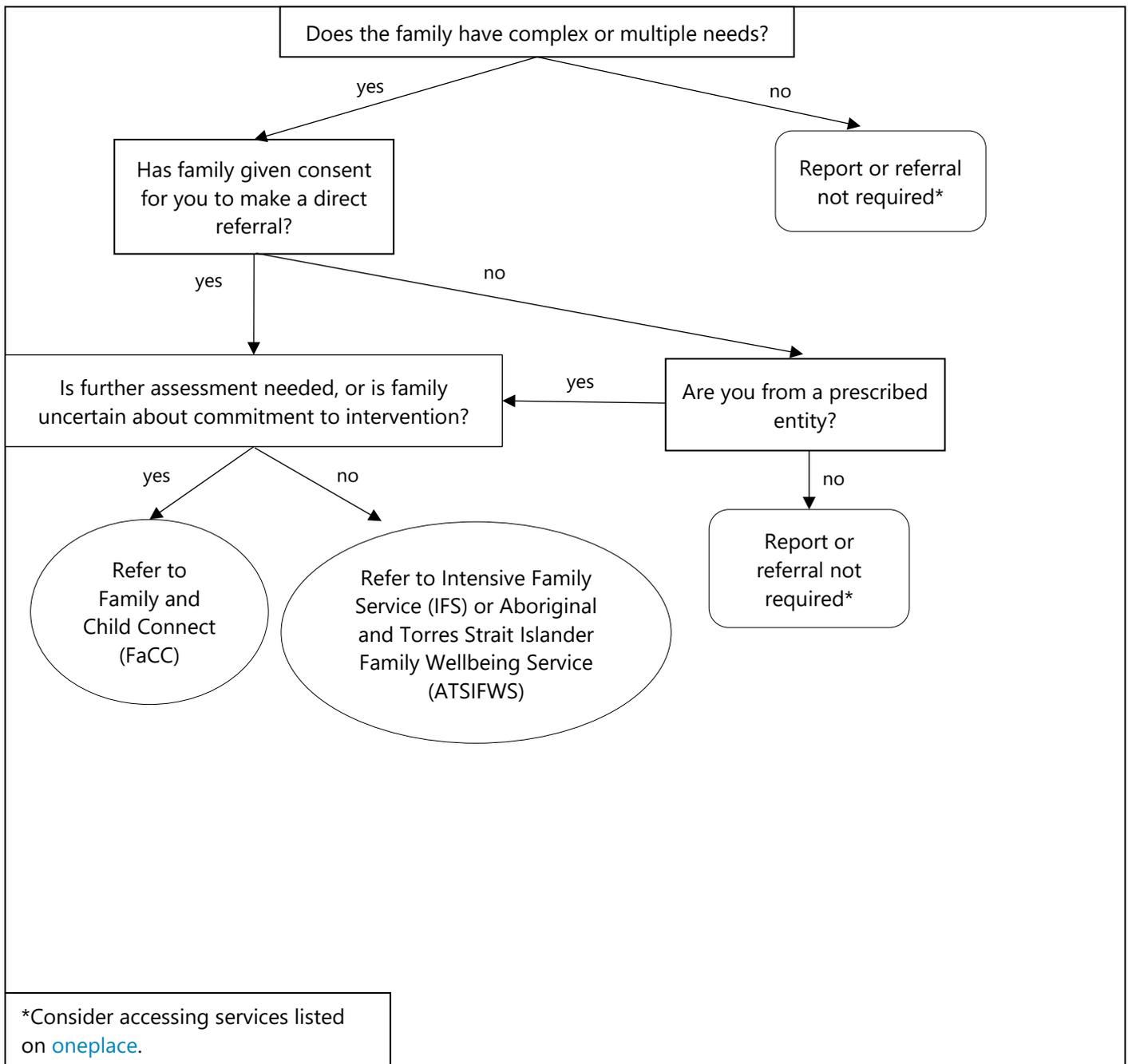
Answer 'yes' if at least one of the following applies.

- The incident or concern happened more than six months ago, AND the family has acted to change the situation, whether or not formal intervention was used, AND:
 - » There have been no new incidents or recurrence of condition for at least three months; OR
 - » Parents have been able to describe what actions are occurring to address the concerns.
- The incident or concern happened within the past six months, AND:
 - » The family recently began to work with a support service to take actions to address the area of concern

Answer 'no' if the incident or concern happened within the past six months, AND at least one of the following applies.

- The family does not have access to informal or formal supports to help them address the concerns.
- You have doubts that a family is working with a support service or has an adequate support network to respond to the concerns.
- The supports the family are accessing are not sufficient to address the concerns.

UNIVERSAL TREE 3



UNIVERSAL TREE 3 DEFINITIONS

Does the family have complex or multiple needs?

Answer 'yes' if at least one item from *each* of the following two lists applies.⁴

- At least one family member's behaviours or circumstances are having negative consequences for the family, particularly children. Consider if one or both of the following apply.
 - » A complex issue affecting the child or family's well-being. Examples of complex issues include but are not limited to family violence, mental illness, problematic alcohol or other drug use, learning difficulties, homelessness and poverty.
 - » More than one issue is affecting the child or family's well-being.

AND

- The concern has been present for more than six months without significant improvement; OR
- The family has substantial barriers to resolving the concern.

Answer 'no' if *all* of the following apply.

- There is one specific, clearly defined concern for which there is an appropriate service.
- The concern began within the past six months.
- The concern does not have a significant impact on family functioning.
- The family appears willing to engage with a service.

Has family given consent for you to make a direct referral?

Answer 'yes' if when you explain the availability of FaCC, IFS, or ATSIFWS, the family states that you may refer them to at least one of the resources.

Answer 'no' if either of the following apply.

⁴ For more information, refer to DCSYW Practice Manual 10.14.

- The family does not give consent.
- You have not been able to speak with the family to determine whether they consent.

Are you from a prescribed entity?

Answer 'yes' if you are from a prescribed entity defined at Section 159M of the Act. This includes *certain* professionals who are employees of the following.

- Adult corrective services
- Community services
- Disability services
- Education
- Housing services
- Public health
- Police
- Mater health services
- A health service as defined by *Hospital and Health Boards Act 2011*
- The principal of a school that is accredited, or provisionally accredited, under the *Education (Accreditation of Non-State Schools) Act 2001*
- A specialist service provider
- The chief executive of another entity that:
 - » Provides a service to children or families; and
 - » Is prescribed by regulation.

Specialist service provider means a non-government entity, other than a licensee or an independent Aboriginal or Torres Strait Islander entity for an Aboriginal or Torres Strait Islander child, funded by the State or the Commonwealth to provide a service to:

- A relevant child; or
- The family of a relevant child

Answer 'no' if you are not from a prescribed entity such as those listed above.

If you are unsure whether you are from a 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; or
- Monitoring the family.

Is further assessment needed, or is family uncertain about commitment to intervention?

Answer 'yes' if any of the following apply.

- Family is not well known to reporter; or if family is well known, reporter is uncertain about family's support needs.
- Family is not opposing a referral but is ambivalent about accepting support service. This may be inferred by discussion of doubt that the support will work, barriers to accessing the support or prior agreements for support that ended in discontinuing support before completion.

Answer 'no' if both of the following apply.

- Family is well known and the reporter has sufficient information to be confident that a referral to IFS or ATSIFWS is appropriate.
- Family is committed to resolving the area of concern. This may be inferred by discussion of plans to begin a change process, taking at least one active step (e.g. calling for an appointment) or describing how life will be when the problem is resolved.

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.

Attachment Theory

Attachment theory is a psychological model that attempts to describe the dynamics of long-term and short-term interpersonal relationships between humans. Attachment theory addresses only a specific facet of how human beings respond within relationships when hurt, separated from loved ones or perceiving a threat. Four different attachment classifications have been identified in children: secure attachment, anxious-ambivalent attachment, anxious-avoidant attachment and disorganized attachment. Attachment theory is a dominant theory used in the study of infant and toddler behavior and in the fields of infant mental health, treatment of children and related fields. It is also extended to Adult Attachment Theory.

Child

A person who has not reached their 18th birthday. This includes those defined in statute as child (up to age 16) and young person (age 16–17).

Child Exploitation Material

Child exploitation material means material that,⁵ 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:

- In a sexual context, i.e. engaging in a sexual activity;
- In an offensive or demeaning context; or
- Being subjected to abuse, cruelty or torture.

Developmental Delay

Developmental delay usually refers to a developmental lag, meaning that a child's cognitive abilities do not match the expectations for 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.

⁵ Section 207A *Criminal Code 1899*

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.

A guide to physical and cognitive developmental milestones can be accessed at <http://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/1-intake/resources> or <http://conditions.health.qld.gov.au/HealthCondition/home/topic/8/96/growth-and-development>.

Domestic and Family Violence

Domestic and family violence is violent or abusive behaviour by a person towards someone with whom they are or have been in an intimate personal relationship, family relationship or informal care relationship. 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 and Family Violence decision tree is intended for situations involving violence towards a child's parent or another adult in the child's household. Violence or abuse directed towards a child should be assessed using the Physical Abuse, Emotional/Psychological Harm or Sexual Abuse trees.

Domestic Violence Order

A 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 the other person, who is called the aggrieved, from further domestic and family violence in the future. For the court to make a DVO, the respondent and the aggrieved must be in an 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 towards the aggrieved and any named person and not commit further acts of domestic and family 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 that person's home or workplace.

In Queensland, there are three types of DVOs.

- Protection orders are the final order made by the court.
- Temporary protection orders are made whilst the court is still to hear and decide an application for a protection order.

- A police protection notice (PPN) is an application for a protection order; once issued by police, it provides short-term protection until a court can consider the need for ongoing protection. A PPN can contain the same conditions as a DVO or a temporary 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 CS-RIS. 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
- May not have a parent able and willing to protect the child from harm.

Section 9 of the Act defines 'harm' as follows.

- Harm to a child is any detrimental effect of a significant nature on the child's physical, psychological or emotional well-being.
- It is immaterial how the harm is caused.
- Harm can be caused by:
 - » Physical, psychological or emotional abuse or neglect; or
 - » Sexual abuse or exploitation.
- Harm can take place as:
 - » A single act, omission or circumstance; or
 - » 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 them. 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

A group of people who reside together. A child may be a member of more than one household such as when parents live separately. A household contains at least one parent who is legally responsible or has cultural responsibility for the child.

When a child is absent from such a household, such as due to having run away, the household to be considered for the purpose of the CPG should be the last such household where the child resided.

For example, if the child is staying with friends, his or her 'household' would be the parent's household or the last household caring for the child that included someone with cultural responsibility for the child. If the child is harmed in the friend's household, child protection reporting or referring decisions are based on whether the parent or culturally responsible person is protecting the child. The harm caused in the friend's house may be a police matter independently of whether there is a child protection concern.

Household Member

A household member is any person living with or having significant contact with the child in the residence. A residence includes where the child lives, AND, if parents do not live together, where each legally responsible parent lives.

This includes:

- Child's legal parents;
- Other adults or children who live in the child's residence; and
- Other adults who spend substantial time in the residence, e.g. an intimate partner who is at the residence most days of the week.

It excludes paid staff such as babysitters or nannies.

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 DCSYW and employees (if 18 or over) of approved Early Childhood Education and Care services or approved provider. An employee could be an educator or the nominated supervisor.

Note 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

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. Non-organic failure to thrive (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. A parent may neglect proper feeding of the infant because of preoccupation with the demands or care of others, their own emotional problems, problematic alcohol or other drug use, lack of knowledge about proper feeding or lack of understanding 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.

Non-registered Health Professional

Any health professional who is not registered through the Australia Health Practitioner Regulation Agency.

Parent

A parent of a child is defined as the child's mother, father or someone else (other than the chief executive) having or exercising parental responsibility for the child.⁶ 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.

Prescribed Entity

Answer 'yes' if you are from a prescribed entity defined at Section 159M of the Act. This includes *certain* professionals who are employees of the following.

- Adult corrective services
- Community services
- Disability services
- Education
- Housing services
- Public health
- Police
- Mater health services
- A health service as defined by *Hospital and Health Boards Act 2011*
- The principal of a school that is accredited, or provisionally accredited, under the *Education (Accreditation of Non-State Schools) Act 2001*

⁶ *Child Protection Act 1999*, Section 11

- A specialist service provider
- The chief executive of another entity that:
 - » Provides a service to children or families; and
 - » Is prescribed by regulation.

Specialist service provider means a non-government entity, other than a licensee or an independent Aboriginal or Torres Strait Islander entity for an Aboriginal or Torres Strait Islander child, funded by the State or the Commonwealth to provide a service to:

- A relevant child; or
- The family of a relevant child

If you are unsure whether you are from a prescribed entity or are a professional delegated to share information under section 159M, consult with your supervisor before referring a family without consent.

Registered Health Professional

Any health professional who is registered through the Australian Health Practitioner Regulation Agency.

REFERENCES

Bowlby, J. (1969). Attachment and loss. New York: Basic Books.

World Health Organization. (2018, January 31). Female genital mutilation. Retrieved from <http://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>

Appendix A

Supervision Levels

Examples of Circumstances and Appropriate Supervision Levels	
Oldest Child's Age/Developmental Age	Safe Circumstances
Infant/Toddler	<ul style="list-style-type: none"> • 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. playpen, child seat, protected area) whilst parent attends to other responsibilities, including self-care. • Child is left with appropriate adult supervision during the evening whilst parents are not at home.
Preschool Ages 5–7	<ul style="list-style-type: none"> • 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, generally within hearing or sight of an adult who is present. • Child is left with appropriate adult supervision during the evening whilst parents are not at home.
Ages 8–9	<ul style="list-style-type: none"> • 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 child is whilst parent attends to other responsibilities, including self-care for periods up to one hour. • Child is left with appropriate adult supervision during the evening whilst parents are not at home.
Ages 10–13	<ul style="list-style-type: none"> • There is a backup responsible adult available to child who is accessible, on call and able to assist for periods up to two hours. • Child is left with appropriate adult supervision during the evening whilst parents are not at home.
Ages 14–15	<ul style="list-style-type: none"> • There is a backup responsible adult available to child. • Child has demonstrated ability to self-supervise for periods of time up to 24 hours.
Ages 16–17	Assess safety based on child's capacity to live independently. Refer to Neglect: Physical Shelter/Environment decision tree if needed for periods of time more than 24 hours.
Child with a disability	Assess safety based on the level of disability and the nature of the child's care needs.

Appendix B

Psychological Impact on Child

The following tables are guides. Consider consultation with a professional with expertise in child mental health or CS-RIS or 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. If uncertain, follow your organisational consultation practice procedures.

Table B1			
Examples of Psychological Harm Indicators			
Infant	Toddler	School Age	Teen
<ul style="list-style-type: none"> • Not responding to cuddling • Not smiling or making sounds • Losing developmental milestones already achieved • Inconsolable • Head banging • Slow weight gain 	<ul style="list-style-type: none"> • Regression in toilet training, language or other skills • Head banging • Regressive behaviour • Difficulties sleeping 	<ul style="list-style-type: none"> • Bed wetting • Significant behaviour changes 	<ul style="list-style-type: none"> • Involved in violent relationships • Difficulty maintaining long-term significant relationships
<ul style="list-style-type: none"> • Upset by loud noises and quick movements, displays startle response. • Withdrawn, not playful or play imitates violence between parents. • Unusually extreme separation anxiety or no separation anxiety. 		<ul style="list-style-type: none"> • Self-harming/suicidal/social isolation. • Constant worry about violence/dangers. • Desensitisation to violence. • Decline in school performance. • Feels worthless about life and self. • Unable to value others or show empathy. • Lacks trust in people. 	
NOT APPLICABLE	<ul style="list-style-type: none"> • Loss of interest in previously pleasurable activities (not merely moving on to an interest in a new activity). • Poor school attendance. • Extreme anxiety, such as inability to sit still that is <i>not</i> 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 or submissive to adults. • Highly self-critical. • Feelings of hopelessness, misery, despair. • Significant change in child's personality or 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. 		
<ul style="list-style-type: none"> • More than occasional difficulty sleeping or eating, e.g. losing weight, becoming obese or having an eating disorder such as eating compulsively, anorexia or bulimia. • 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). 			

Table B2	
Age/Developmental Age of Child	Significant Adverse Effects (examples)
All	<ul style="list-style-type: none"> • Recurrent episodes of serious, unintentional injury or harm in circumstances where supervision has been an issue.
Infant/Toddler	<ul style="list-style-type: none"> • 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 parent. • Injuries and accidents related to lack of appropriate supervision.
Preschool	<ul style="list-style-type: none"> • Language delays with no other explanation. • Child is not learning age-appropriate self-care such as brushing teeth; cannot assist in dressing self.
5–9	<ul style="list-style-type: none"> • Child is not developing social skills. • Child is frequently out of control. • Child is extremely clingy with other adults.
10–13	<ul style="list-style-type: none"> • Child is getting involved in dangerous, risky or illegal behaviours. • School refusal.
14–17	<ul style="list-style-type: none"> • Illegal behaviour, high-risk sexual activity, alcohol or drug abuse and self-harm. • Disengagement from education or training.

Table B3	
Age/Developmental Age of Child	Moderate Adverse Effects (examples)
All Ages	<ul style="list-style-type: none"> • Reduced interest in previously pleasurable activities (i.e. not merely moving on to an interest in a new activity). • Declining school attendance. • Mild anxiety. • Below average interpersonal skills necessary for age-appropriate functioning. • Less secure than peers. • Trouble relating to adults or unusually compliant with adults. • Somewhat self-critical. • Feelings of sadness. • Noticeable change in child's personality/behaviour. • Seeks closeness to an adult other than parent. • Occasional difficulty sleeping or eating.
Infant/Toddler	<ul style="list-style-type: none"> • Play consistently imitates demeaning behaviour between parents. • Occasional or mild separation anxiety or no separation anxiety. • Difficulty self-soothing. • Less interested in play. • More timid or more aggressive than peers.
School age	<ul style="list-style-type: none"> • Some difficulty concentrating. • Unusually withdrawn.