Child Death Case Review Committee
Annual Report 2004–05

Reviews of child deaths in the Queensland child protection population

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28 October 2005

The Honourable Peter Beattie MP
Premier and Treasurer
Parliament House
George Street
Brisbane Qld 4000

Dear Mr Premier

I submit the first annual report for the Child Death Case Review Committee for the 2004–05 financial year.

This report outlines the Committee's key role and function and details its performance for 2004–05. It is made pursuant to section 89ZA of the *Commission for Children and Young People and Child Guardian Act 2000*.

This report includes data collected and information relating to child death case reviews that were conducted in the period from 1 July 2004 to 30 June 2005, identification of substantive issues and our recommendations made for improvement to the delivery of child protection services in Queensland.

Yours sincerely

Elizabeth Fraser
Chairperson
Child Death Case Review Committee

Glossary

BDMR Act	*Births Deaths and Marriages Registration Act 2003*
Blueprint	The Blueprint for implementing the recommendations of the CMC report, prepared by Peter Forster and released in March 2004
CAO	Court Assessment Order
CCYPCG Act	*Commission for Children and Young People and Child Guardian Act 2000*
CDCRC	Child Death Case Review Committee
child death case review	Incorporating both the original review conducted by the Department and the external review conducted by the CDCRC
child death case review process	The entire process for reviewing the Department's involvement with a child who has died, as provided for by Chapter 7A of the *Child Protection Act 1999* and Part 4A of the *Commission for Children and Young People and Child Guardian Act 2000*
CMC report	The January 2004 report of the Crime and Misconduct Commission *Protecting children: an inquiry into abuse of children in foster care*
Commission	Commission for Children and Young People and Child Guardian
Commissioner	Commissioner for Children and Young People and Child Guardian
Coroners Act	*Coroners Act 2003*
CP Act	*Child Protection Act 1999*
CPN	Child Protection Notification
CPO	Child Protection Order
Department	Department of Child Safety and also, where applicable, the former Department of Families
DVO	Domestic Violence Order
external review	Review carried out by the CDCRC pursuant to s89C of the *Commission for Children and Young People and Child Guardian Act 2000*
IA	Initial Assessment
IFS	Intensive Family Support
original review	Review carried out by the Department pursuant to s246A of the *Child Protection Act 1999*
QPS	Queensland Police Service
reporting period	1 July 2004 to 30 June 2005
SC	The child whose involvement with the Department was the subject of the child death case review (the subject child)

Message from the Chairperson

The death of a child is always a tragedy, but when the child was known to the child protection system, an independent process for reviewing the delivery of child protection services to that child provides an essential accountability mechanism.

Often it will be the case that nothing 'went wrong' (in terms of the child protection system meeting its service delivery obligations). This is because children known to the child protection system still die as a result of accidents and natural causes. However, a transparent process for reviewing the adequacy of the services provided to these children is still important to ensure continuous improvements to Queensland's child protection system.

The Child Death Case Review Committee (CDCRC) commenced its independent external reviews of the Department of Child Safety's child death case reviews on 1 August 2004. The CDCRC's reviews focus on identifying ways to improve the Department's service delivery to children and young people through the application of its 'review criteria'.

In recent times, child protection workers have faced an unprecedented level of scrutiny and, to date, the CDCRC's reviews have involved children known to the child protection system during a period of acknowledged systemic failings. As such, it should not come as a surprise that where deficiencies have been identified, in the main, they have related to the quality of risk assessments, record keeping and interagency cooperation arising from workloads, staffing issues and poor information management systems. However, given the scope and speed of recent reforms and the need for comprehensive monitoring of their effectiveness, I would expect new practice issues and challenges to be constantly presenting to the both the Department and the CDCRC over the coming years.

During the period 2004–05, the Department has submitted child death case reviews to the CDCRC of differing quality. Some reports have been of a high standard and have correctly identified where scope exists for significant improvements in child protection practice, while others have been of a lesser standard. It is clear that the Department has also been challenged in meeting the statutory timeframe for reporting, with only 50 per cent of its child death case reviews being submitted to the CDCRC within the required six months. Further work will also be required by the Department to ensure culturally appropriate input in future child death case reviews.

Given the current reform activities within the Department these outcomes are perhaps not surprising and I would expect that with the benefit of experience and the CDCRC's ongoing feedback, the overall quality of the Department's child death case reviews will improve. While these issues represent a significant challenge for the Department, there is evidence to suggest that gains can be made quickly.

The CDCRC looks forward to receiving responses from the Department to comments and recommendations it made in the eight child death case reviews completed in 2004–05, and more broadly in relation to the ongoing implementation of the CDCRC's recommendations.

I would like to offer my condolences and those of the CDCRC members to the families, carers and friends of the children and young people whose cases have come before the CDCRC. The premature death of anyone is a tragedy, but this is particularly so for a child or young person. Undoubtedly, the death of a client also has a significant impact on child protection professionals involved in the child's life.

I would like to acknowledge the hard work and motivation of my colleagues on the CDCRC. During the reporting period all eight reviews were completed within the three month statutory timeframe, allowing invaluable feedback and advice to be conveyed to the Department with minimal delay. Child protection is an extremely complex, sensitive and often challenging area of service delivery and I look forward to the CDCRC's ongoing and timely contribution to improving practice.

Finally, I would like to acknowledge the dedication and professionalism of the CDCRC's secretariat, which has provided high quality support throughout the reporting period.

Elizabeth Fraser
Chairperson
Child Death Case Review Committee

Child Death Case Review Committee Members

Ms Elizabeth Fraser (Chairperson)

Commissioner for Children and Young People and Child Guardian

BA, B Soc Wk, Grad Dip in Multicultural Studies, Cert Teaching

Elizabeth has worked at all levels of government, and lived and worked in a number of countries in roles providing direct services as well as in policy development and implementation. She has also been responsible for managing large scale organisational change and co-ordinating, overseeing and evaluating major policy and program reforms.

Elizabeth started her career as a social worker in public health and child welfare organisations in Canberra and later taught English as a foreign language in Australia, Hong Kong, Sweden and Nigeria. On her return to Australia, she managed non-government funding programs in the overseas aid program in Canberra, managed a review of the status of women in the aid program and oversaw an evaluation of government services to Queensland rural communities.

Before being appointed as Commissioner, Elizabeth was General Manager, Corporate and Executive Services in the former Department of Innovation and Information Economy, Sport and Recreation Queensland and Executive Director, Social Policy in the Department of the Premier and Cabinet. She has a long standing commitment to improving client services and outcomes, particularly for children and young people, and is committed to ensuring that relationships with key stakeholders are effective and contribute to good policy and practice.

Commissioner Robert (Bob) Atkinson

Commissioner of Police

Commissioner Atkinson has had a 36 year career with the Queensland Police Service (QPS). He has served throughout the State from Goondiwindi to Cairns performing a wide range of operational and managerial roles. He was a Detective for approximately 20 years and was in charge of regional Criminal Investigation Branch and Juvenile Aid offices. He was involved in the change management processes in the QPS post-Fitzgerald from 1990 and then later organisational change following the Public Sector Management Commission Review and Report Recommendations of the QPS in 1993. He is also a Graduate of the FBI National Academy in Quantico, Virginia.

Commissioner Atkinson was appointed as Commissioner of the QPS on 1 November 2000.

Mr Michael Barnes

State Coroner

BA, LLB, LLM

Michael is the inaugural State Coroner appointed on 1 July 2003. Prior to that he was Head, School of Justice Studies at Queensland University of Technology, a post he took up after nine years as the chief officer of the complaints section at the former Criminal Justice Commission.

Michael began his legal career in 1980 in a small suburban law firm in Brisbane. He was a partner in that firm for five years until he moved to the Aboriginal Legal Service. Michael became interested in coronial work when appearing for the relatives of people whose deaths were investigated by the Royal Commission into Aboriginal Deaths in Custody which highlighted the inadequacies of the coronial processes of that time.

He has since specialised in criminal and administrative law and undertakes research and teaching in corruption and organised crime investigation and alternative dispute resolution.

Michael was a member of the inaugural Biotechnology Advisory Council and is currently a member of the Police Education Advisory Council and the Community Expert Reference Group for Suicide Prevention.

Dr Colin Brennan

MBBS(Qld) FRANZCP, MRC Psych (London), DPM (Melb), FRACMA, FAIM, FAFPHM (RACP), FRIPH

Colin is a senior consultant psychiatrist and senior public health physician. He has extensive experience at senior levels across the Queensland and Commonwealth public sector as well as the academic sector in Queensland.

Colin has served in multiple roles and positions at all levels in the Queensland hospital system; and in the Queensland Psychiatry Directorate; and also as Deputy Director-General of Health and Medical Services for Queensland. He has served as Chairman of the Queensland Public Service Board.

As well as his current private and public practice in general adult psychiatry and forensic psychiatry practice, Colin has a special ongoing interest in family, child and adolescent psychiatry with particular interests in child and young persons protection; and optimal service delivery to such persons by the Queensland public sector and the non-government sector.

Ms McRose Elu

McRose was born on Saibai Island in the top western region of Torres Strait. She spent most of her childhood at Seisia on Cape York Peninsula. McRose has a Bachelor of Arts majoring in Anthropology and a double major in Political Science. She is currently doing her Masters on Customary Law. She was the first Torres Strait Islander to receive an Overseas Study Award in 1995, to undertake a Masters research on Hanai, Hawaiian Child Rearing Practices, at the University of Hawaii. She speaks four languages and several dialects.

McRose is a delegate of various committees and boards including the Pacific History Association, Association for Social Anthropology in Oceania, World Indigenous Peoples' Education, Pacific Educational Conference, Torres Strait Islander National Seminar/Workshop, Torres Strait Islander Anglican Ministry Brisbane, Torres Strait representative on Indigenous Cultural Heritage Group, Multicultural Faith Committee, Women's Group, SEQ Aboriginal and Torres Strait Islander Legal Service, National Aboriginal and Torres Strait Islander Anglican Consultative Committee, Indigenous Australia Postgraduate Association and Working Party Member of the Kupai Werem Torres Strait Islander Child Rearing Practices.

McRose is currently employed in the Department of Communities in the area of Public Relations. Her career interests are in law both customary and European, Politics, cross cultural awareness programs, religion and theology.

McRose is the CDCRC's Torres Strait Islander representative.

Mr Barry Salmon
Assistant Commissioner
Commission for Children and Young People and Child Guardian
Dip Teaching, BA, B Ed, M Ed St, FAIM

Barry began his career as a primary teacher and has over 25 years experience in supporting young people, teachers and administrators in Queensland schools. He has worked in a range of policy positions in Education Queensland, managing the Effective Learning and Teaching Unit and leading the development of the Year 2 Diagnostic Net to assess literacy and numeracy levels, which is still used today. Before joining the Commission, Barry was Assistant Director of the Queensland School Curriculum Council, managing the Preschool to Year 10 (P-10) curriculum development program, and achieved an outcomes-based approach to the curriculum.

In 2001, Barry was appointed as Executive Director of the Commission, with responsibility for the employment screening, community visitors and complaints functions. After acting in the role of Commissioner for six months in 2004, he was appointed to the new role of Assistant Commissioner in February 2005, with responsibility for the Commission's Child Guardian functions. Barry is committed to strengthening children's and young people's primary relationships to improve their wellbeing.

Ms Trudi Sebasio

Trudi is a descendent of the Yimen and Gungulu people of Central Queensland. Trudi has extensive work experience in the field of social, emotional and mental wellbeing in Aboriginal and Torres Strait Islander communities.

Trudi has been formally trained as a social worker and has worked in the following areas since graduating from the University of Queensland ten years ago:

- Grief and loss counsellor with the 'Deaths In Custody – Family Support Program'
- Program Development Officer at the (previously known) John Oxley Secure Mental Health Hospital (Wolston Park)
- First Chairperson of Gallang Place – Aboriginal and Torres Strait Islander counselling service, Brisbane, and
- Coordinator, Indigenous Mental Health Program, Far North Queensland.

Trudi currently holds the position of Principal Project Officer, Indigenous Mental Health Policy. She is responsible for the 'Furthering the Implementation of the Queensland Health Mental Health Policy Statement, Aboriginal and Torres Strait Islander People'.

Trudi is the CDCRC's Aboriginal representative.

Dr Neil Wigg
MBBS, FRACP, MPol Admin

Neil is a paediatrician and holds the following appointments: Executive Director, Community Child Health Service, Royal Children's Hospital and Health Service District, Queensland Health; Associate Professor, Discipline of Paediatrics and Child Health, University of Queensland; and President, Paediatrics and Child Health Division, The Royal Australasian College of Physicians.

Neil has over twenty years of experience in child health service management and in clinical practice in child disability. Neil's interests include child health policy, advocacy and child public health.

Ms Jennifer Wiltshire
BSocWork, MAASW

Jennifer is a social worker with twenty five years experience in child protection including case work, supervision, training, policy development and case consultation. She was an inaugural member of the Queensland Child Protection Council and is currently a member of the Children Services Tribunal and a private practitioner specialising in child protection and child and family welfare.

Proxy members

Proxy member of the CDCRC for the State Coroner:

Mr Michael Bice
Registrar
Office of the State Coroner
LLB, BCom, Accredited Mediator

Michael is the Registrar for the Office of the State Coroner appointed on 31 January 2005. He is also an Acting Magistrate. Prior to his current appointment, he was a Registrar in the Magistrates Court Office (Charters Towers and Pittsworth), a post which he served in for more than eight years. Michael has 21 years experience in multiple roles and positions relating to justice administration within the Queensland court system.

Proxy members of the CDCRC for the Commissioner of Police:

Mr Peter Swindells
Assistant Commissioner
Queensland Police Service

Assistant Commissioner Swindells is the Assistant Commissioner, State Crime Operations Command. This position has the responsibility of State investigative groups, including the Child Safety and Sexual Crime Group.

Assistant Commissioner Swindells is a graduate of the Australian Institute of Police Management.

Mr Ross Barnett
Detective Superintendent
Queensland Police Service

Detective Superintendent Barnett is the Director of Child Safety for the Queensland Police Service (QPS). He is also the Superintendent in Charge of the Child Safety and Sexual Crime Group which overviews all reportable child death investigations conducted by the QPS.

Detective Superintendent Barnett has 29 years operational policing experience and has served on secondment with two Commissions of Inquiry, the National Crime Authority, the Queensland Crime Commission and the Australian Crime Commission. He is also a Graduate of the FBI National Academy in Quantico, Virginia.

Mr Rob Weir

Detective Inspector
Queensland Police Service

Detective Inspector Weir is based in the State Crime Operations Command and is responsible for the Child Sexual Assault Investigation Unit and is the State Deputy Juvenile Aid Bureau Coordinator. He has been an investigator since 1987, working at Criminal Investigation Branches in Mount Isa and Townsville. He has been involved in Suspected Child Abuse and Neglect Teams since 1992 and held the position of Officer in Charge of the Townsville Juvenile Aid Bureau. Detective Inspector Weir has worked closely with the former Department of Families and current Department of Child Safety since 1992. He has also worked in a number of indigenous communities including Mornington Island, Doomadgee and Palm Island.

Chapter 1:

Chapter 1: Introduction

This report has been prepared by the Queensland Child Death Case Review Committee (CDCRC) for tabling in Parliament, pursuant to section 89ZA of the *Commission for Children and Young People and Child Guardian Act 2000* (the CCYPCG Act)[1].

The CDCRC has been charged with the responsibility of considering the adequacy of reviews completed by the Department of Child Safety (the Department) when a child dies who was known to the Department in the three years before their death.

This inaugural annual report provides an account of the events leading to the creation of the CDCRC in 2004 as well as an overview of the child death case review processes that exist in Australia and internationally.

This report also describes the purpose and functions of the CDCRC, and seeks to inform Parliament of the work undertaken during the 2004–05 reporting period, including the recommendations made for improving the delivery of child protection services.

Lastly, this report identifies anticipated issues and challenges to be faced by the CDCRC during the 2005–06 reporting period.

The report is structured as follows:

Chapter 2 provides an historical overview of the key reports and inquiries that lead to the creation of the CDCRC. It describes how the CDCRC was established and provides a summary of child death case review processes in other Australian states and internationally.

Chapter 3 provides an overview of the responses and responsibilities of various public sector agencies when a child dies in Queensland and describes the child death case review process that is carried out by the Department and the CDCRC.

Chapter 4 provides information about the child deaths that occurred in Queensland in 2004–05 where the child's involvement with the Department was, or will be, the subject of a child death case review.

Chapter 5 contains an analysis of the quality of the original reviews conducted by the Department and reviewed by the CDCRC in 2004–05. It identifies substantive issues concerning the quality of child protection services provided by the Department to those children, as well as recommendations that were made by the CDCRC to the Department to address those issues.

Chapter 6 examines the work and challenges that the CDCRC will face in 2005–06.

1 Information on financial matters relevant to the functioning of the CDCRC is contained within the Commission for Children and Young People and Child Guardian Annual Report 2004–05.

Chapter 2:

Chapter 2:
Child death review processes and the Child Death Case Review Committee

What led to the creation of the Child Death Case Review Committee in Queensland?

Department of Families' internal reviews

In September 2001 the former Department of Families (the Department)[2] introduced new policies and procedures for conducting a review where a child who had been the subject of departmental interventions died or suffered serious injury. The reviews focused on departmental systems, practices and procedures that applied to the child.

The nature of the review that was undertaken depended on the actual circumstances of the child's death. In cases where the death of the child was considered to be 'accidental', the policy provided for an internal review completed by a senior departmental officer. External reviews, by an appropriately qualified child protection practitioner external to the Department, were conducted in cases where the child's death related to one or more of the following circumstances:

- suspected non-accidental death or illness
- suicidal or self injurious behaviours
- a death associated with a child protection matter where there was a pattern of contact with the Department based on similar concerns
- a SIDS death where there had been previous contact with the Department relating to the neglect or physical abuse of the child, and
- where there were contentious circumstances or significant external criticism in relation to prior management of the case.

Ombudsman report

In October 2003 the Queensland Ombudsman tabled a report in Parliament titled *'An investigation into the adequacy of the actions of certain government agencies in relation to the safety, well being and care of the late baby Kate, who died aged 10 weeks'* (the Baby Kate report). The report highlighted, among other things, the inadequacy of the internal review conducted by the Department in relation to its handling of Baby Kate's case. The Baby Kate report recommended that a body external to the Department be established in Queensland to monitor and review the investigation of the deaths of all children known to the Department. Further, the report recommended that the Commissioner for Children and Young People and Child Guardian be appointed Chairperson of the body, and that it should report annually to Parliament.

In response to this recommendation, the Department advised that 'consideration of whether or not to establish a body as described in these recommendations is a major public policy issue ... as such the decision on whether or not to accept this recommendation sits with Cabinet'. The Department further advised that it would 'progress a submission to Cabinet in due course'.

2 Since replaced by the Department of Child Safety (responsible for child protection) and the Department of Communities.

Crime and Misconduct Commission inquiry and report

In 2003 the Crime and Misconduct Commission (CMC) undertook an independent public inquiry into concerns that the child protection system had failed to prevent children placed in foster care from being abused and neglected.

The CMC's January 2004 report, *Protecting Children: an inquiry into abuse of children in foster care*, made significant recommendations for extensive structural and organisational reforms to the child protection system in Queensland. As well as recommending the creation of the new Department of Child Safety (the Department), the CMC report recommended that an independent child death review mechanism be established in Queensland to include:

- a statutory requirement that the Department conduct a review of its involvement with children who die and were known to the Department in the three years before their death
- an independent Child Death Case Review Committee, chaired by the Commissioner for Children and Young People and Child Guardian, to monitor the review (consistent with the recommendations of the Baby Kate report), and
- a child death research role for the Commission for Children and Young People and Child Guardian (the Commission), including maintaining a register of child deaths, preparing an annual report to Parliament making recommendations for the prevention of child deaths and providing secretariat support to the Child Death Case Review Committee.

Blueprint for Implementing the Recommendations of the CMC Report

The Blueprint for Implementing the Recommendations of the CMC Report was prepared by external consultant Peter Forster and released in March 2004. The Blueprint identified the legislative amendments required to establish the Child Death Case Review Committee and expand the Commission's functions to include those outlined in the CMC report recommendations.

Child safety legislative amendments

The *Child Safety Legislation Amendment Act 2004* amended a range of legislation to implement the CMC report's recommendations. To establish a two-tiered process for child death case reviews, the amendments included:

- a new 'Chapter 7A – Child Deaths' in the *Child Protection Act 1999* (CP Act), which established a legislative framework for the Department's role in conducting case reviews for child deaths, and
- a new 'Part 4A – Child Deaths' in the *Commission for Children and Young People and Child Guardian Act 2000* (CCYPCG Act), which established the Child Death Case Review Committee (CDCRC) and included provisions relating to its functions, membership, conduct of business and its reviews and reports. (This part also outlines the Commission's new child death functions including maintaining a child death register and researching ways to reduce and prevent child deaths).

These provisions commenced on 1 August 2004. The new child death case review process does not apply to child deaths that occurred before this date.

How was the Child Death Case Review Committee established?

Following commencement of the provisions establishing the CDCRC, a recruitment process was conducted to obtain appropriately qualified and suitable persons to be appointed as members of the CDCRC.

To ensure a multidisciplinary child death case review process, the legislative provisions require that the CDCRC includes the Commissioner for Children and Young People and Child Guardian and the Assistant Commissioner and five to seven members appointed by the Premier who have expertise in the fields of paediatrics and child health, forensic pathology, mental health, investigations or child protection, or members who can otherwise make a valuable contribution. The CDCRC membership must also include at least one Aboriginal member and one Torres Strait Islander. Appointments to the CDCRC are for a term of no more than three years.

The following people were appointed to the CDCRC in 2004:

- Ms Elizabeth Fraser, Commissioner for Children and Young People and Child Guardian
- Mr Barry Salmon, Assistant Commissioner, Commission for Children and Young People and Child Guardian
- Mr Robert (Bob) Atkinson, Commissioner of Police
- Mr Michael Barnes, State Coroner
- Dr Colin Brennan, psychiatrist
- Ms McRose Elu, Torres Strait Islander representative
- Ms Trudi Sebasio, Aboriginal representative
- Dr Neil Wigg, paediatrician
- Ms Jennifer Wiltshire, social worker

The Commissioner is responsible for ensuring that the CDCRC has the administrative support services required to carry out its functions effectively and efficiently.

The following administrative support has been provided to the CDCRC in the reporting period 2004–05:

- management of the administrative processes for the recruitment, selection and appointment of CDCRC members
- drafting of confidentiality agreements between the members of CDCRC and the Commission
- preparation and presentation of induction materials for the CDCRC's inaugural meeting on 9 December 2004
- drafting and, following approval by the members, gazettal of the CDCRC's review criteria
- drafting of procedures to assist the CDCRC to perform its functions
- coordination of monthly meetings and workflow planning to ensure the CDCRC meets its statutory timeframes, and
- preparation of quality briefing materials to assist CDCRC members to conduct reviews and development of CDCRC report templates.

- liaison with the Department about procedures for the provision of original review reports and materials and exchange of information relevant to the child death review process, and
- development of guidelines and processes for collection, storage, retrieval and destruction of highly confidential and sensitive child death case review information.

What child death case review processes exist in other Australian states?[3]

New South Wales

In New South Wales the Ombudsman is responsible for reviewing and reporting on the deaths of certain children and young people under the age of 18. While the focus of these reviews is largely on systemic issues, the NSW Ombudsman has the responsibility to not only consider issues relating to the system, but also to review, when necessary, the circumstances of individual child deaths.

The NSW Ombudsman details its work relating to child death reviews in an annual report.

Victoria

In Victoria there is a two-tiered child death case review process similar to the system recently introduced in Queensland.

The Victorian Department of Human Services (DHS) conducts 'case practice reviews' of deaths of children and young people who were current or recent (within three months of case closure) clients of child protection services. The reviews are conducted within 45 days of a death to establish the facts and determine whether DHS adhered to standards, guidelines and protocols. An officer of DHS who is not associated with the region where the death occurred undertakes the review.

The Victorian Child Death Review Committee (VCDRC), a multidisciplinary advisory committee of members from health, welfare, police, legal and academic fields, externally reviews the reports prepared by DHS officers and advises the Minister of its deliberations. The VCDRC identifies particular types of child deaths that may benefit from further investigation or research, and analyses any themes, trends or patterns that emerge. It also comments on service and system responses to children and families and receives feedback on the implementation of reforms.

The VCDRC produces an annual report about its work and findings.

3 Apart from child death case review processes, various jurisdictions (including Queensland) have child death review teams or similar bodies that are responsible for collecting and analysing data and conducting research relating to all child deaths and making recommendations for reducing and preventing child deaths in the future (as distinct from conducting individual reviews of particular child deaths that occur in the child protection population). This report does not seek to identify these bodies. For further information, refer to the Commission for Children and Young People and Child Guardian's Annual Report: Deaths of Children and Young People in Queensland 2004–05.

Western Australia

In Western Australia the WA Child Death Review Committee (WACDRC) was established to facilitate accountability in the Department of Community Development (DCD), by providing additional quality assurance in certain cases where children have died.

The WACDRC reviews the operation of relevant DCD policies, procedures and organisational systems when a child dies who was known to DCD within 24 months of their death.

The WACDRC has a responsibility to identify 'best practice' and effective systems as well as any variance in practice that may have impacted on the service provided by DCD. In addition the WACDRC identifies particular classes of child deaths or related issues that may benefit from further investigation and research.

The WACDRC reports annually to Parliament.

South Australia

The South Australian Child Death and Serious Injury Review Committee (CDSIRC) was established in 2005 by the Minister for Families and Communities to review the deaths and serious injuries of children aged from birth to 18 years.

Legislation enabling the CDSIRC to review individual child deaths and serious injuries and to obtain information from relevant sources, the *Children's Protection (Keeping them Safe) Amendment Bill 2005*, was before the Parliament of South Australia at the time of publishing this report.

Under the proposed legislation, the CDSIRC will conduct detailed reviews of cases of child death or serious injury if the death or injury was due to, or 'suspicious' of, abuse or neglect. The CDSIRC will also review cases in which death or serious injury may have been prevented by some kind of systemic change, or the child was in custody, detention or in the care of a government agency. Deaths or injuries will also be reviewed if the case was referred to the CDSIRC by the State Coroner.

The purpose of a child death case review by the CDSIRC will be to identify legislative or administrative means to avoid similar incidents in the future, to make recommendations for reducing preventable deaths or serious injuries, and to monitor the implementation of these recommendations.

The membership of the CDSIRC includes experts in child forensics, psychology, advocacy, health and justice, and is assisted by a small secretariat located within the South Australian Department of Families and Communities.

Australian Capital Territory, Tasmania and Northern Territory

The Australian Capital Territory, Tasmania and the Northern Territory currently have no child death case review committees or other external, independent, multidisciplinary processes for conducting reviews of cases where children in care or protection have died.

While the departments responsible for child protection may carry out their own case reviews of child deaths or critical incidents, reviews are not based on statute and are not mandatory.

What child death case review processes exist internationally?

New Zealand

The New Zealand Child Youth and Family Agency (responsible for child protection) conducts a review of its involvement in each case where a child dies who was known to the agency in the two years before they died. These reviews focus on the case work and services provided by the agency and do not investigate the death or cause of death.

The New Zealand Office of the Commissioner for Children is notified of deaths and receives a copy of the agency's report. The Commissioner considers the agency's child death review, comments on the resulting report, and may request additional information or action. In some circumstances, the Office of the Commissioner for Children conducts its own investigations (for example, where there was extensive historical as well as current involvement with the family at the time of a child's death).

United Kingdom

The United Kingdom (UK) has a long history of reviewing child abuse fatalities. Until recently, child death case reviews took a public inquiry approach that differs significantly from multidisciplinary review systems. Between 30 and 40 public child death inquiries have been conducted in the UK since 1945.

A number of these inquiries and other UK child death research and inquiry processes have, in their findings, advocated for the introduction of independent, multidisciplinary child death review teams to review all child deaths.

Since 1989, the UK has implemented a formal system of conducting child death reviews. Under this system, when a child dies and abuse or neglect may have been a factor in the death, the Local Area Child Protection Committee conducts a review into the child and family's involvement with agencies and professionals. The purpose of the review is to ensure the protection of siblings and to identify and act upon any lessons learned about the way local professionals and agencies work together to safeguard children.

In 2005, the UK introduced legislation to establish a new review process to replace Local Area Child Protection Committees. Local authorities will operate Local Safeguarding Children Boards, which are required to establish local screening teams responsible for reviewing child deaths and responding quickly to unexpected deaths. The guidance relating to the functioning of these teams is still under development and has yet to be consulted on. Therefore, it is as yet unclear what review mechanisms will be established.

United States of America

In the United States of America, the Inter-Agency Council on Child Abuse and Neglect's (ICAN's) National Center on Child Fatality Review (NCFR) is responsible for developing and promoting a nationwide system of child fatality review teams to improve the health, safety and wellbeing of children and reduce preventable child fatalities and severe injuries. NCFR establishes and supports a national network of multi-agency, multidisciplinary review teams at the local, regional and state level. In 2005 all states, with the exception of Idaho, have some type of local or state review team in operation.

While these teams were developed largely in response to the critical need for systematic evaluation and case management of suspicious child deaths, most teams have expanded into a public health model that reviews all forms of intentional and preventable deaths, including child suicides, accidents, and deaths from natural and undetermined causes.

Canada

Child death case review teams or other review mechanisms currently exist in eight of the 13 Canadian provinces and territories. The composition of the teams and the duties they perform varies across jurisdictions.

National guiding principles for ideal practice in case reviews have been developed as part of widespread moves towards establishing multidisciplinary teams. These principles aim to create independent, external review teams with statutory powers for accessing information, making recommendations, monitoring compliance with recommendations and making public reports.

Chapter 3:

Chapter 3: Responses to and reviews of child deaths in Queensland

What is the current response when a child dies in Queensland?

When a child dies in Queensland, a number of public sector agencies respond in various distinct ways.

Commission for Children and Young People and Child Guardian

The Commission for Children and Young People and Child Guardian (the Commission) has certain responsibilities regarding child deaths under the new 'Part 4A – Child Deaths' of the *Commission for Children and Young People and Child Guardian Act 2000* (CCYPCG Act).

In particular, the Commission has a statutory obligation to keep a Child Death Register of all deaths of children and young people under 18 in Queensland, including information about the cause of death, demographic information and other relevant factors.

The Commission analyses information in the register and conducts research to identify and report on patterns and trends in child mortality. The Commission then makes recommendations to improve legislation, policies, procedures and practices that apply to children and to reduce risk factors associated with deaths that were considered preventable. The Commission reports on its findings and recommendations annually to Parliament.

To support the establishment and maintenance of the Child Death Register, amendments to the *Coroners Act 2003* (Coroners Act) and the *Births Deaths and Marriages Registration Act 2003* (BDMR Act) requires the Office of the State Coroner and the Registry of Births Deaths and Marriages (the Registry) to advise the Commissioner of a child's death.

The Commission also provides secretariat and administrative support and research assistance to the Child Death Case Review Committee (CDCRC).

Apart from these specific child death functions, the Commission also has certain statutory powers and obligations in relation to referral and investigation of child protection concerns, which can arise as a result of the death of a child.

If the Commission receives information in relation to a child death that raises concerns about the safety and wellbeing of the child's surviving siblings (including foster siblings) and, based on these concerns, the Commission considers a child may be in need of protection under the *Child Protection Act 1999* (CP Act), the Commission must refer the matter to the Department of Child Safety (the Department) or the Queensland Police Service (QPS)[4].

The Commission also has a discretionary power in certain circumstances to conduct investigations in relation to a service provided to a child in the child safety system[5]. Information received in relation to the death of a child may give rise to the exercise of this discretion. An investigation may include consideration of the delivery of services to children by the Department or by other public or private service providers.

4 Section 20 of the CCYPCG Act.
5 Section 42 of the CCYPCG Act.

Registry of Births, Deaths and Marriages

The Registry sits within the Department of Justice and Attorney General and is legislated by the BDMR Act.

The Registry must be informed of all child deaths in Queensland. Information is supplied by the doctor who completes the cause of death certificate, the next of kin or family member who supplies personal information, and the funeral director who provides burial or cremation details. If the death is a 'reportable death' (under the Coroners Act, discussed below), the Registry also receives an Autopsy Certificate regarding the cause of death.

Office of the State Coroner

The Office of the State Coroner sits within the Department of Justice and Attorney General and is established under the Coroners Act.

The Office and position of State Coroner provide a consistent and coordinated system of reviewing deaths occurring in circumstances where further explanations are needed. The State Coroner is responsible for overseeing and coordinating other coroners. All Queensland magistrates can act as coroners. The State Coroner issues directions and guidelines about the conduct of coronial investigations.

Coroners may investigate 'reportable deaths'[6], which include deaths that were violent or unnatural, that occurred in suspicious circumstances, or that occurred in care or in custody. Deaths in care include deaths of children in foster care or under guardianship of the Department[7]. Deaths in custody include deaths of children in detention under the *Juvenile Justice Act 1992*[8]. Coroners' powers of investigation are extensive and the process must include an autopsy.

The State Coroner notifies the Commissioner of all reportable child deaths. The information includes:

- Police Report of Death to a Coroner (Form 1), which includes a narrative summary of the circumstances surrounding the death
- autopsy and toxicology reports, and
- Coroner's findings and comments[9].

A Memorandum of Understanding with the Office of the State Coroner also enables the Commissioner to access investigation documents including police briefs of evidence. Investigation documents frequently provide details of the circumstances surrounding a death and help identify risk factors associated with child deaths that may have been preventable.

Coronial information is used to supplement data from the Registry to inform the Commission's Child Death Register and assist in the analysis of major categories of child deaths.

6 Section 8 of the Coroners Act.
7 Section 9 of the Coroners Act.
8 Section 10 of the Coroners Act.
9 Coroner's findings are the findings of coronial investigations and should confirm the identity of the person, how, when and where the person died, and what caused the death. Coroner's comments are comments that may arise from an inquest that relate to public health or safety, the administration of justice or ways to prevent future deaths.

Queensland Police Service

If the QPS receives a report about a 'reportable death' or otherwise becomes aware of a death that appears to be a reportable death, the QPS must advise the Coroner in writing of the death[10]. This is done by the completion of a Police Report of Death to a Coroner (Form 1).

In June 2005 the QPS implemented a new operational policy in relation to the investigation of 'reportable' child deaths. The new policy requires that all reportable child deaths are to be managed by a senior and experienced police investigator. First response officers are required to contact the Department's Crisis Care Unit to establish whether the death was a 'death in care' or whether the child was otherwise known to the Department. Specific operational policy and procedures apply to the investigation of child reportable deaths. The QPS Child Safety Director is required to review the investigation of all child reportable deaths to identify and respond to any training, policy or operational issues.

In addition, the QPS, in partnership with the Office of the State Coroner, has revised the Police Report of Death to a Coroner (Form 1) to improve the type and consistency of initial information provided to assist in determining the cause of death.

Reviews by the Department of Child Safety

What is the Department required to review?

The Department must carry out a review about its involvement with a child if that child dies and, within three years before the child's death[11], the Department became aware of alleged harm or alleged risk of harm to the child or took action under the CP Act in relation to the child.

What is the scope of the Department's reviews?

The Director-General must decide the extent of the review and the terms of reference for the review. The Act provides that the terms of reference may include (but are not limited to):

- finding out whether the Department's involvement with the child and the child's family complied with legislative requirements and the Department's policies (including guidelines, procedures, protocols, standards and systems)
- considering the adequacy and appropriateness of the Department's involvement with the child and the child's family
- commenting on the sufficiency of the Department's involvement with other entities in the delivery of services to the child and the child's family
- commenting on the adequacy of legislative requirements and the Department's policies relating to the child, and
- making recommendations regarding the above issues and suggesting strategies to put into effect the recommendations.

10 Section 7 (Duty to Report Deaths) of the Coroners Act.
11 This includes a child who was born during this period and, before they were born, the Department reasonably suspected that the child might be in need of protection after they were born.

Are other entities involved in the review process?

The Department may ask another entity for information about the child that was relevant to the child's protection or welfare while the child was alive. Such entities may include police, health and education.

How does the Department report on its reviews?

The Department must complete the review and prepare a report about the review 'as soon as practicable'. In any case, the Department must give a copy of the report and any documents obtained by the Department and used for the review to the CDCRC within six months after the Department became aware of the child's death.

If the review concerns the Department's involvement with a child whose death is a reportable death under the Coroners Act, the Department must give a copy of the report to the State Coroner. This report may then be used by a coroner to help in an investigation under the Coroners Act.

Reviews by the Child Death Case Review Committee

What are the responsibilities of the CDCRC in relation to child death case reviews?

The CDCRC is an important mechanism for ensuring the external accountability of the Department's child death case reviews. The core responsibility of the CDCRC is to conduct external reviews of the Department's original reviews and make recommendations to:

- improve the Department's policies (including guidelines, procedures, protocols, standards and systems) for the delivery of services to children and families, and
- improve relationships between the Department and other entities involved with children and families.

The CDCRC is also responsible for making recommendations about whether disciplinary action should be taken against officers or employees of the Department in relation to the Department's involvement with a child.

Additionally, the CDCRC is required to monitor the implementation of its recommendations and, if requested, provide the Premier with information about particular reviews or classes of reviews carried out by the CDCRC.

Is the CDCRC independent?

The CDCRC must act independently and is not under the control or direction of any other entity, including the Premier or the Commissioner for Children and Young People and Child Guardian.

Is anyone else involved in the conduct of CDCRC reviews?

The CDCRC may obtain help from anyone whom the CDCRC considers to be appropriately qualified to help. This may include, for example, the seeking of expert opinion from persons in relevant fields including mental health and disability services.

How does the CDCRC conduct its reviews?

The CDCRC convenes meetings, chaired by the Commissioner, to conduct its reviews. The CDCRC must meet certain quorum requirements including a requirement that, if the review concerns an Aboriginal or Torres Strait Islander child, at least one CDCRC member present must be an Aboriginal person or a Torres Strait Islander respectively.

The CDCRC must keep minutes of its meetings.

How does the CDCRC decide matters?

A question at a CDCRC meeting is decided by a majority of the votes. If votes are equal, the presiding member also has a casting vote.

What if a CDCRC member has a conflict of interest?

A conflict of interest may occur where, for example, a CDCRC member had prior involvement with the child or departmental officers involved in the case, either in a personal or professional capacity.

The Act provides that, if a CDCRC member has a direct or indirect interest in an issue being considered, and the interest could conflict with the proper performance of the member's duties, the member must disclose the nature of the interest as soon as practicable.

Unless the CDCRC decides otherwise, the member must not be present when the issue is considered or take part in a decision about the issue. This does not affect the quorum of the CDCRC for considering or deciding the issue.

The disclosure must be recorded in the CDCRC's minutes and any relevant report prepared by the CDCRC about the review.

What matters does the CDCRC consider when carrying out its reviews?

The Act requires the CDCRC to develop review criteria to be used in carrying out its functions. In developing the review criteria, the CDCRC must consult the Director-General of the Department and other entities the CDCRC considers have a sufficient interest.

In the reporting period the CDCRC developed and utilised the following review criteria:

CDCRC Review Criteria

The CDCRC must determine whether the original review[12]:

1. Was conducted in accordance with statutory and common law requirements.
2. Was conducted in accordance with all relevant policies and procedures of the Department (including any joint policies and protocols which the Department may have with other entities).
3. Had appropriate terms of reference and the extent of the review was appropriate in the circumstances.
4. Demonstrated that:
   a) an adequate review and/or investigation plan was developed for the purpose of conducting the review
   b) all necessary information about the child that was relevant to the child's protection or welfare while the child was alive was obtained and considered as part of the review or reasonable efforts were made to obtain the information for the purpose of conducting the review
   c) any information obtained and considered as part of the review was obtained in a lawful, ethical and culturally sensitive manner, and
   d) cultural and Indigenous issues were addressed in the composition of the review team and the conduct of the review.
5. Had findings and recommendations that were logical and reasonable in that they:
   a) considered the application and adequacy of the relevant legislation, policies and procedures that applied or should have applied to the child and their family by all entities
   b) identified deficiencies or gaps in service delivery to the child and their family by all entities and solutions to remedy any deficiencies or gaps
   c) considered whether the relationships and interactions between the Department and other relevant entities ensured that the welfare and best interests of the child were paramount, and
   d) considered whether disciplinary action should be taken against any officers or employees of the Department in relation to its involvement with the child and their family.
6. Was comprehensive, independent, impartial and transparent, including whether it considered:
   a) any systemic failings that may have contributed to the death(s)
   b) any failings, actions or inactions of individual officers that may have contributed to the death(s), and
   c) any risk factors associated with the death(s).
7. Was timely.

12 'Original review' is a review carried out by the Department under Part 7A of the CP Act.

In addition, the CDCRC will consider whether:

8. The Department developed an appropriate action plan to give effect to any recommendations of the original review.
9. The Department's action plan should be altered, revoked or substituted with a new action plan.
10. Information on the outcome of the original review was conveyed to all relevant persons and entities.

To remove any doubt, the above criteria do not limit the functions of the CDCRC under the CCYPCG Act.

What materials does the CDCRC review?

The CDCRC examines the Department's original review report and any documents obtained by the Department and used it for the review. It may also request that the Department provide a supplementary report about the original review.

The CDCRC may also consider reports provided by the Office of the Queensland Ombudsman[13] that relate to the child whose involvement with the Department is the subject of the review.

How does the CDCRC report on its reviews?

The CDCRC must give a copy of its report to the Department and to the Commissioner within three months after receiving the original review report.

The CDCRC's report may recommend that the Department takes certain action within a stated time that is reasonable in the circumstances.

The CDCRC's report must not include any information that identifies, or is likely to lead to the identification of, any individual. However, the CDCRC may include a separate document that allows the Department to identify individuals.

What powers does the CDCRC have if the Department does not comply with the recommendations contained within a CDCRC report?

The CDCRC may ask the Department to notify the CDCRC, within a reasonable stated time, of the steps taken to give effect to the recommendations contained in its report and, if no steps have been taken, the reasons for this.

If, after considering the Department's response, the CDCRC considers that no steps have been taken to give effect to the recommendations or the steps taken are inadequate or inappropriate, the CDCRC may report on the matter to the Premier and the Minister for Child Safety.

13 Under section 57B of the *Ombudsman Act 2000*.

Chapter 4:

Chapter 4: Child deaths in 2004–05

Deaths of children known to the Department of Child Safety

During the period from 1 July 2004 to 30 June 2005, the deaths of 482 children were registered in Queensland with the Registry of Birth, Deaths and Marriages.

The Department of Child Safety's (the Department's) legislative obligation for conducting child death case reviews commenced on 1 August 2004. As such, the Department is only required to conduct reviews in relation to deaths that occurred after this date[14]. From 1 August 2004 to 30 June 2005, 33 children who died in Queensland were known to the Department either at the time of, or within the three years before, their death.

During the reporting period, the Department completed 14 original reviews, involving a total of 15 child deaths. The CDCRC reviewed eight of the 14 original reviews. The review processes for both the Department and the CDCRC are described in chapter three of this report.

Table 4.1 provides a demographic profile of the 33 deaths of children known to the Department. Cases marked with an asterisk (*) refer to the nine children whose child death case reviews were reviewed by the CDCRC (two of these children died in the same incident and were the subject of a joint review).

Table 4.1 Deaths of children known to Department

Subject child	Age bracket	Gender	Indigenous status	Region	Cause of death
SC1	Under 1 yr	Female	Not Indigenous	Metropolitan	Acquired disease/illness
SC2*	1–4 yrs	Female	Aboriginal	Regional	Acquired disease/illness
SC3*	15–17 yrs	Male	Not Indigenous	Regional	Acquired disease/illness
SC4	Under 1 yr	Male	Aboriginal	Remote	Not yet determined
SC5*	5–9 yrs	Male	Not Indigenous	Regional	Acquired disease/illness
SC6*	15–17 yrs	Female	Not Indigenous	Regional	External causes
SC7	Under 1 yr	Male	Torres Strait Islander	Regional	Acquired disease/illness
SC8*	Under 1 yr	Male	Not Indigenous	Regional	Sudden Infant Death Syndrome (SIDS)
SC9*	1–4 yrs	Female	Aboriginal	Remote	External causes
SC10*	1–4 yrs	Male	Aboriginal	Remote	External causes
SC11	1–4 yrs	Female	Not Indigenous	Remote	Acquired disease/illness
SC12*	10–14 yrs	Male	Not Indigenous	Regional	External causes
SC13*	Under 1 yr	Female	Not Indigenous	Regional	Acquired disease/illness
SC14	Under 1 yr	Male	Aboriginal	Regional	Acquired disease/illness
SC15	5–9 yrs	Female	Not Indigenous	Regional	Acquired disease/illness
SC16	15–17 yrs	Male	Not Indigenous	Interstate	External causes
SC17	15–17 yrs	Male	Not Indigenous	Remote	External causes
SC18	1–4 yrs	Female	Aboriginal	Remote	Acquired disease/illness
SC19	Under 1 yr	Male	Unknown	Regional	Non-accidental trauma
SC20	1–4 yrs	Male	Not Indigenous	Regional	Non-accidental trauma
SC21	10–14 yrs	Male	Not Indigenous	Regional	External causes
SC22	15–17 yrs	Male	Unknown	Metropolitan	Acquired disease/illness
SC23	1–4 yrs	Male	Unknown	Metropolitan	Acquired disease/illness
SC24	5–9 yrs	Male	Aboriginal	Regional	Acquired disease/illness
SC25	1–4 yrs	Female	Aboriginal	Remote	Acquired disease/illness
SC26	1–4 yrs	Male	Not Indigenous	Remote	External causes
SC27	15–17 yrs	Female	Not Indigenous	Regional	Acquired disease/illness
SC28	Under 1 yr	Male	Aboriginal	Metropolitan	Not yet determined
SC29	5–9 yrs	Male	Not Indigenous	Remote	Acquired disease/illness
SC30	1–4 yrs	Female	Not Indigenous	Remote	Acquired disease/illness
SC31	5–9 yrs	Male	Not Indigenous	Metropolitan	Not yet determined
SC32	1–4 yrs	Female	Aboriginal	Remote	External causes
SC33	10–14 yrs	Male	Aboriginal	Remote	External causes

14 *Child Safety Legislation Amendment Act 2004 No. 13* (Qld) s 16.

Age and gender

Of the 33 children who died, over half (57 per cent) were aged between birth and four years. More males than females died (64 per cent and 36 per cent respectively).

Table 4.2 Age and gender of children

	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Female	2	7	1	0	2	12
Male	6	4	4	3	4	21
Total	**8**	**11**	**5**	**3**	**6**	**33**

Aboriginal and Torres Strait Islander status

Twelve Aboriginal or Torres Strait Islander children died during this reporting period, accounting for 36 per cent of deaths of children known to the Department.

Geographical distribution

The large majority of the children who died resided in regional or remote areas (82 per cent).

Table 4.3 Areas where children resided

Area	Number of children
Metropolitan*	5
Regional**	15
Remote***	12
Interstate	1

** The metropolitan area refers to Brisbane city and surrounding suburbs.*
*** The regional area refers to inner and outer regional locations in Queensland.*
**** The remote area refers to rural and minor towns in Queensland.*

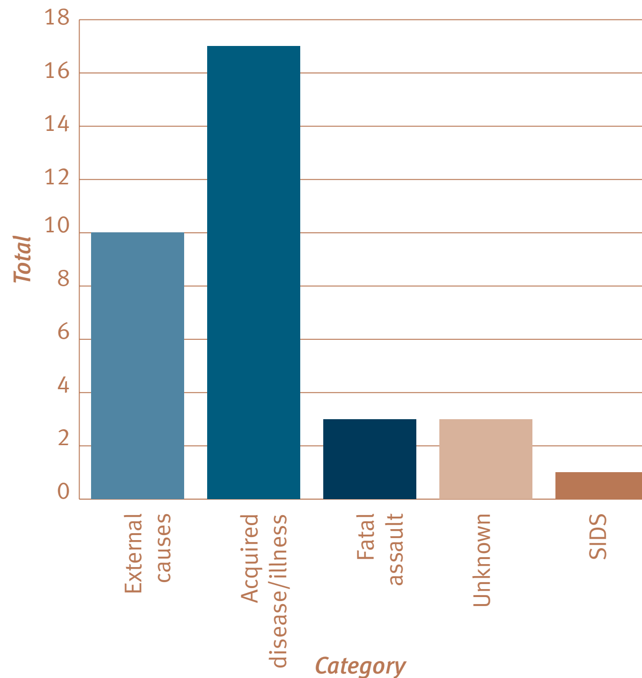
Categories of death

The Commission's Child Death Register categorises cause of death according to the World Health Organisation's *International Classification of Diseases and Related Health Problems (ICD)* 10th revision.

In the reporting period 'acquired disease/illness' was the main cause of death of children known to the Department. This category includes deaths resulting from significant disabilities and/or long-term illnesses.

External causes accounted for 10 deaths of children known to the Department and included car accidents, drowning and house fires.

Figure 4.1 Categories of death of children



Child death case reviews

This section provides an overview of the original reviews undertaken by the Department and externally reviewed by the CDCRC during the reporting period.

It also provides a description of the key characteristics of the children and families who were the subject of the reviews, including an outline of the nature of the Department's contact with these children and families.

Completed reviews

From 1 August 2004 to 30 June 2005 the Department completed 14 original reviews involving 15 children who died.

The CDCRC reviewed eight of the Department's original review reports concerning nine children.

Compliance with legislative timeframes

The Department

Once the Department has been notified of a child's death it must, as soon as practicable, complete a review of its involvement with the child. A copy of the original review report and relevant documents must be provided to the CDCRC within six months[15].

As set out in Table 4.4, the Department completed seven of its 14 original reviews within its six month statutory timeframe, with two provided to the CDCRC five days early. Of those that were provided outside the timeframe, the delay varied from one month to two and a half months. Four original review reports were outstanding as at 30 June 2005.

15 Section 246D of the CP Act.

Table 4.4 Due dates and dates of receipt of original review reports

Original review report	Due date	Date received
Report 1	09/02/2005	09/02/2005
Report 2	08/03/2005	27/05/2005
Report 3	13/03/2005	31/03/2005
Report 4	21/03/2005	18/04/2005
Report 5	25/02/2005	29/03/2005
Report 6	27/02/2005	27/02/2005
Report 7	21/04/2005	20/06/2005
Report 8	05/04/2005	03/06/2005
Report 9	18/04/2005	18/04/2005
Report 10	13/04/2005	13/04/2005
Report 11	15/04/2005	Outstanding as at 30/06/2005
Report 12	02/05/2005	03/05/2005
Report 13	21/05/2005	Outstanding as at 30/06/2005
Report 14	20/05/2005	Outstanding as at 30/06/2005
Report 15	17/05/2005	17/05/2005
Report 16	08/06/2005	03/06/2005
Report 17	08/06/2005	03/06/2005
Report 18	25/06/2005	Outstanding as at 30/06/2005

The Department advises the CDCRC of any revised due dates and provides preliminary reports when it is unable to meet the statutory timeframe for completing the review. However, these preliminary reports provide only limited information including a brief outline of the facts, the terms of reference and the review status.

The CDCRC

The CDCRC is required to give a copy of its review reports to the Department within three months after receiving the Department's original review report[16].

The CDCRC complied with its three month statutory timeframe for each of its eight reviews completed in 2004–05. Two reports were provided to the Department on the due date. One report was provided six weeks early and the remaining five reports were provided between five days and three weeks early.

Child and family characteristics

The following child and family characteristics were identified in the eight reviews completed by the CDCRC during the reporting period.

Age and gender

Five of the nine children were aged under four years, one was aged five to nine years and three were aged 15 to 17 years. Five children were male and four were female.

16 Section 89U of the CCYPCG Act.

Table 4.5 Age and gender of children

	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total
Female	1	2	0	0	1	4
Male	1	1	1	0	2	5
Total	**2**	**3**	**1**	**0**	**3**	**9**

Aboriginal and Torres Strait Islander status

Three of the nine children who died were of Aboriginal or Torres Strait Islander origin.

Care arrangements at the time of death

Table 4.6 represents the care arrangements in place at the time of the nine deaths. Five of the children were placed in alternative care at the time of their death.

Table 4.6 Care arrangements at the time of death

Two parent families		Single parent families		Alternative care			Total
Biological Parents	Grandparent and biological parents	Biological mother	Biological father	Extended family/ friends	Foster family	Hospital	
1	0	3	0	2	3	0	9

Parental characteristics

Consideration needs to be given to external factors when assessing the risk of harm to a child. Parental issues such as substance abuse, family violence, transience, mental illness, child protection history and intellectual disability impact on the parent's capacity to provide adequate care and protection to their child. Table 4.7 summarises the presence of these characteristics in the families of the eight children.

Table 4.7 Overview of parental characteristics

Parental characteristics	Cases where characteristic identified
Family violence	4 (50%)
Substance abuse	3 (37.5%)
Mental illness	2 (25%)
Corrective services history	2 (25%)
Transience	1 (12.5%)
Intellectual disability	0

Parental substance abuse and family violence were identified in the majority of families. A transient lifestyle was noted in one of the cases and parental mental illness was identified in two cases. In most cases where specific parental characteristics were evident, families presented with more than one of the characteristics described above (83 per cent). The most commonly combined parental characteristics were substance abuse and family violence, substance abuse and mental illness, and family violence and corrective services history.

Nature of contact with the Department

When the Department receives information about a child or young person an ‘intake’ is recorded. If the information leads the Department to reasonably believe that a child has suffered harm or is at risk of suffering harm, a ‘child protection notification’ (CPN) is recorded. If the level of harm is considered to be significant the Department will carry out an ‘initial assessment’ to determine the protective needs of the child. If the level of harm is not considered to be significant the Department will provide ‘protective advice’ to the notifier but will not make any contact with the family involved[17].

Table 4.8 shows the child protection status at the time of the child’s death and the child’s and their family’s history of involvement with the Department.

Overall, five of the nine children were subject to current departmental intervention when they died, two were not subject to current intervention, and in the other two cases the level of intervention at the time of the child’s death cannot be established due to the Department’s poor recordkeeping.

17 The nature and extent of these responses is currently the subject of significant reform as a result of the CMC inquiry.

Table 4.8 Child protection status and history of departmental involvement

Subject child	Age bracket	Gender	Indigenous status	Area	Cause of death	Child protection status at time of death	History of previous departmental involvement
SC2	1–4 years	Female	Aboriginal	Regional	Acquired disease/ illness	SC was under a Child Protection Order (CPO) since 2001 (extended in 2003) and was placed with departmental carers.	One Child Protection Notification (CPN) in relation to SC resulted in substantiated physical harm in 2001 and two CPNs regarding the SC's siblings in 2003–04 were unsubstantiated.
SC3	15–17 years	Male	Not Indigenous	Regional	Acquired disease/ illness	SC was not subject to any departmental orders or departmental intervention.	SC and his siblings were the subject of nine CPNs and three intakes in 1992–03. Two of these CPNs resulted in alternative placement of SC and his siblings, three resulted in substantiated harm or risk of harm, one was responded to by protective advice and three were not completed. A protective supervision order was granted in 1994 and released in 1998.
SC5	5–9 years	Male	Not Indigenous	Regional	Acquired disease/ illness	SC was under a short-term CPO since 2003 (extended in 2004) and was residing with foster carers.	SC was subject of two CPNs from 2002–04. At the time of death the Initial Assessment (IA) following the CPN recorded in 2004 had not been completed and no outcome had been recorded in the Department's database.
SC6	15–17 years	Female	Not Indigenous	Regional	External causes	SC was not subject to any departmental orders or departmental intervention.	SC was the subject of a CPN in 2004 which was responded to with protective advice.
SC8	Under 1 year	Male	Not Indigenous	Regional	Sudden Infant Death Syndrome (SIDS)	SC and his family were involved in Intensive Family Support (IFS) with a 28 day approval for placement of SC with parental consent.	SC and his siblings were subject to one CPN in 2004 which resulted in substantiated risk of harm. A Temporary Assessment Order (TAO) was made followed by a Court Assessment Order (CAO). When the CAO expired, an IFS case was opened.

Table 4.8 Child protection status and history of departmental involvement *continued*

Subject child	Age bracket	Gender	Indigenous status	Area	Cause of death	Child protection status at time of death	History of previous departmental involvement
SC9	1–4 years	Female	Aboriginal	Remote	External causes	SC was assigned an Early Intervention and Prevention Worker (EIPW).	SC and her siblings were the subject of nine CPNs and two intakes in 1995-2004. Three CPNs were substantiated, three were substantiated at risk, two were unsubstantiated and one was recorded with no outcome. Four CPNs resulted in a referral to an EIPW.
SC10	1–4 years	Male	Aboriginal	Remote	External causes	SC was assigned an EIPW.	SC and his siblings were subject to nine CPNs and two intakes in 1995–2004. Three CPNs were substantiated, three were substantiated at risk, two were unsubstantiated and one was recorded with no outcome. Four CPNs resulted in a referral to an EIPW.
SC12	15–17 years	Male	Not Indigenous	Regional	External causes	Unclear whether IFS intervention was provided to SC's family due to poor record keeping.	SC and his siblings were subject to two CPNs in 2003–04. The first CPN was unsubstantiated and the second was substantiated.
SC13	Under 1 year	Female	Not Indigenous	Regional	Acquired disease/ illness	Unclear whether IFS intervention remained open to SC's family due to poor record keeping.	SC and her siblings were subject to one CPN in 2004 which resulted in a substantiated risk. As a result, an IFS case was opened.

Chapter 5:

Chapter 5: Reviews conducted by the Child Death Case Review Committee in 2004–05

This chapter discusses in detail the findings from the eight reviews carried out by the CDCRC in 2004–05.

The first part of the chapter examines the quality of the original reviews conducted by the Department. The second part examines the quality of child protection services provided to the children who were the subject of the reviews.

Quality of the Department's original reviews

It is important to assess the quality of the Department's original reviews to identify opportunities for future improvement. The CDCRC, in making the following observations, is seeking to strengthen and promote confidence in the Department's child death case review process.

Table 5.1 sets out the issues identified by the CDCRC against the particular review criterion that specifically require the CDCRC to assess the quality of the Department's reviews[18].

Overall, the key concerns about the Department's original reviews in 2004–05 were:

- failure to complete reviews within the six month statutory timeframe
- limiting the extent of reviews to 'desktop reviews'
- inadequate terms of reference
- lack of an adequate review or investigation plan
- lack of an adequate action plan to give effect to the review's recommendations
- failure to observe the rules of procedural fairness
- failure to consider the adequacy of the legislative and policy requirements that applied or should have applied to the child, and
- failure to consider whether disciplinary action pursuant to s87(1)(a) of the *Public Service Act 1996* (PS Act) or referral to the Crime and Misconduct Commission (CMC) pursuant to s38 of the *Crime and Misconduct Act 2001* (CM Act) was warranted.

18 Review criterion one to four, five(d), seven, eight and ten. The remaining review criterion relate to the adequacy of the review's findings and recommendations about the Department's involvement with the subject child. These are considered in the second part of this chapter.

Table 5.1 Issues identified about the quality of the Department's original reviews

CDCRC review criteria used to determine whether the original review:	Issues concerning the quality of the original reviews	Number of original reviews where issue was identified	Recommendations/action by CDCRC
1. Was conducted in accordance with statutory and common law requirements.	Reviews provided to CDCRC outside the statutory timeframe.	4	The CDCRC is engaged in ongoing discussions with the Department about this issue, as this failure impacts on the quality and value of the child death case review process.
	Failure to observe natural justice.	2	The CDCRC recommended that the Department include a section in its child death case review policy that requires the rules of procedural fairness to be observed in the review process.
2. Was conducted in accordance with all relevant policies and procedures of the Department (including any joint policies and protocols which the Department may have with other entities).	The Department has not yet formalised its child death case review policies and procedures. However, on 19 October 2004 it provided the CDCRC with a draft policy and procedure document. The CDCRC has considered whether reviews were conducted in accordance with this draft policy. No issues were identified.	0	Not applicable.
3. Had appropriate terms of reference (TOR) and the extent of the review was appropriate in the circumstances.	Drawing the TORs directly from the examples in s246B(2) of the CP Act without considering the specific circumstances of the case or ensuring that the TORs define an appropriate scope and focus for the review.	8	The CDCRC recommended that the Department provide the CDCRC with a draft policy/statement outlining its intended policies and procedures for deciding the TORs for each original review.
	Failure to include a specific TOR requiring the original review to consider whether the Department's service delivery adequately addressed particular health and/or developmental issues or other special needs of the child.	1	The CDCRC recommended that the Department ensure that for any original reviews where it is known that the child had significant health or developmental issues or other special needs, the review has a specific TOR requiring the review to consider whether the Department's involvement with the child included adequate assessments of whether the child's protective needs were being met in the context of these special needs.
	Limiting the extent of a review to a desktop review.	3	The CDCRC recommended that the Department provide the CDCRC with a draft policy/statement outlining its intended policies and procedures for determining the extent of original reviews, particularly addressing the concerns raised by the CDCRC in relation to the use of desktop reviews.

Table 5.1 Issues identified about the quality of the Department's original reviews *continued*

CDCRC review criteria used to determine whether the original review:	Issues concerning the quality of the original reviews	Number of original reviews where issue was identified	Recommendations/action by CDCRC
4. Demonstrated that: a) an adequate review and/or investigation plan was developed for the purpose of conducting the review	Lack of an adequate review and/or investigation plan.	7	The CDCRC recommended that the Department ensure that all original reviews are conducted in accordance with a documented review and/or investigation plan that is linked directly to the review's TORs.
b) all necessary information about the child that was relevant to the child's protection or welfare while the child was alive was obtained and considered as part of the review and/or reasonable efforts were made to obtain the information for the purpose of conducting the review	Review focussed on gathering general information about the siblings rather than information that was relevant to the welfare and protection of the subject child.	1	The CDCRC recommended that, for the purpose of original reviews, information about the subject child's family and/or siblings should only be considered to the extent that it was relevant to the services provided by the Department to the subject child.
	Inconsistencies in the response of Queensland Health (QH) facilities to requests by the Department for medical records to inform the review.	1	The CDCRC recommended that the Department consult with QH to develop a memorandum of understanding or other form of agreement to ensure that QH facilities take a consistent approach to requests for information made by the Department pursuant to s246C of the CP Act.
	Individual departmental officer's handwritten notes and/or notebooks did not appear to have been obtained and considered as part of the review.	1	The CDCRC is engaged in ongoing discussions with the Department about this issue.
c) any information obtained and considered as part of the review was obtained in a lawful, ethical and culturally sensitive manner, and	No issues identified.	0	Not applicable.

Table 5.1 Issues identified about the quality of the Department's original reviews *continued*

CDCRC review criteria used to determine whether the original review:	Issues concerning the quality of the original reviews	Number of original reviews where issue was identified	Recommendations/action by CDCRC
d) cultural and Indigenous issues were addressed in the composition of the review team and the conduct of the review.	No issues identified.	0	Not applicable.
5. Had findings and recommendations that were logical and reasonable in that they: ... d) considered whether disciplinary action should be taken against any officers or employees of the Department in relation to its involvement with the child and their family.	Failure to consider whether disciplinary action pursuant to s87(1)(a) of the PS Act or referral to the CMC under s38 of the CM Act was warranted.	2	The CDCRC recommended that the Department's child death case review policy be amended to include a section on the process to be followed if possible misconduct (as defined by the PS Act) or suspected official misconduct (as defined by the CM Act) is identified. This process should require that the reports prepared for the CDCRC: • state whether information or conduct identified in the course of a review has been referred to either the Department's Ethical Standards Unit or the CMC, • identify the reason for the referral, and • state the outcome of any disciplinary or misconduct investigation, if known.
7. Was timely.	See review criterion one (above) in relation to failure to meet the statutory timeframe.	4	As above.
8. The Department developed an appropriate action plan to give effect to recommendations, if any, of the original review.	Failure to develop an adequate action plan to give effect to the review's recommendations.	8	The CDCRC is engaged in ongoing discussions with the Department about this issue and has recommended that the Department alters its action plans to ensure that they: • provide a detailed explanation of how the Department intends to carry out each of the actions and who is responsible for carrying out the actions • prescribe the timeframes for carrying out the actions • provide a mechanism for ensuring that the actions are carried out, and • identify how the outcomes of the actions will be measured and/or reported upon.

Table 5.1 Issues identified about the quality of the Department's original reviews *continued*

CDCRC review criteria used to determine whether the original review:	Issues concerning the quality of the original reviews	Number of original reviews where issue was identified	Recommendations/action by CDCRC
9. The Department's action plan should be altered, revoked or substituted with a new action plan as a result of findings and/or recommendations arising from the CDCRC's review of the original review.	See review criterion eight (above).	7	As above.
10. Information on the outcome of the original review was conveyed to all relevant persons and entities.	Failure to disseminate the findings of the original review to all relevant persons and entities.	3	The CDCRC recommended that the Department ensure that its child death case review policies and procedures for the dissemination of review findings reflect the following: • that where findings and/or recommendations from a review relate to an individual officer, the Department ensures that the rules of procedural fairness have been complied with in relation to that individual • the Department should assess on a case by case basis which of the review's findings and recommendations (particularly those relating to an individual officer) should be disseminated, and • that relevant findings and recommendations from the reviews may also need to be conveyed to other relevant persons or entities, which may include external stakeholders such as families, caregivers and agencies, as well as various internal stakeholders such as training and policy units.

Failure to observe the rules of procedural fairness[19]

In conducting an original review, the rules of procedural fairness require the Department to:

- inform people of the substance of any allegations made against them or grounds for adverse comment about them
- provide people with a reasonable opportunity to express their case
- hear all relevant parties and consider submissions
- make reasonable inquiries or investigations before making a decision
- ensure that no person decides a case in which they have a direct interest
- act fairly and without bias, and
- conduct the review without undue delay.

Case study

The following comments were made about W7 by interviewees during an original review and reported in the Department's original review report[20]:

'W7 was terrible, was condescending, at times abusive, made value statements about our profession and having a lack of professional knowledge that he/she was better educated then we were…used to stereotype people…. and making offensive jokes, smutty, sexual, and inappropriate.'

'W7 is an extrovert, a dominant personality who liked to run the show…he/she was dismissive and not understanding of working in a community and with a families and strengths-based approach.'

'W7 is very unreliable, takes weeks to provide services and we can't rely on what he/she tells us over the phone, and they have to wait for written reports each time.'

The CDCRC considered the departmental review team's interview notes and was unable to locate any record of an interview with W7. It appears that W7 was not given an opportunity to respond to the above comments made by other parties to the review, which were clearly adverse to W7. Furthermore, it is not clear whether or not W7 was given an opportunity to respond to the following adverse finding that was made in the Department's original review report:

'In essence, W7 has inappropriate interpersonal skills and mannerisms that others interpret as an arrogant and dismissive orientation. For his/her part, W7 believes that he/she has been unfairly placed on the periphery by Department staff.'

As noted in Table 5.1 the CDCRC has recommended that the Department include a section in its child death case review policy to require that the rules of procedural fairness be observed in the review process.

19 Also known as the rules of 'natural justice'.
20 These comments have been altered to ensure that neither the officer nor the case can be identified.

Limiting the extent of a review to a desktop review

The Department determines at the start of the review process whether it will conduct a 'full review' or a 'desktop review'. The information used to inform a full review includes interviews with relevant departmental officers and, where appropriate, officers from other entities and an analysis of all relevant documentation. In comparison, a desktop review is limited to an analysis of the documentation.

In the eight child death case reviews considered in the reporting period, it was evident that the Department's decision to undertake a desktop review was based on:

- the extent of its involvement with the child and their family, and/or
- the nature of the child's death.

The CDCRC has concerns about these two reasons, given that:

- section 246A of the CP Act requires the Department to review all child death cases where the child was known to the Department in the three years before their death, regardless of the level of involvement, and
- the child death review function is aimed at promoting the Department's accountability and facilitating ongoing learning and improvement in the delivery of services to children and families. The focus of the review is on the adequacy and appropriateness of departmental interventions, policies, procedures and interactions with other agencies as they related to a child who died. The cause of death is irrelevant.

The CDCRC is also concerned about the Department's use of desktop reviews generally, given their inherent limitations, namely:

- they do not allow for the provision of contextual or other information not contained within departmental files. For example, often departmental officer's handwritten notes and/or notebooks do not form part of the Department's official records.
- it has been recognised that the Department has historically experienced significant problems in relation to the quality of its record keeping. As such, the reviews could be based on flawed information.
- they do not necessarily allow for and/or may restrict the provision of procedural fairness to persons who may be adversely named in a review report.

The following two case studies illustrate how a desktop review may adversely impact on the quality of a review.

Case study

The original review stated that the decision to limit the review to a desktop review was 'due to the limited departmental involvement with this family, that is a period of approximately five months, and the accidental nature of the subject child's death'.

However, the CDCRC identified that the Department had been involved in the case for 17 months not five months as stated in the reasons for conducting a desktop review.

The factual circumstances of the case highlighted a concern that, although a child's death may be described as 'accidental', there may be evidence that parental/caregiver negligence or inadequate supervision was a factor in the accident. This may then raise concerns as to the adequacy of the Department's assessment of whether the child's protective needs were being met by the parents/caregivers.

The CDCRC therefore cautioned the Department to exercise particular care when considering the nature of the child's death to determine the extent of a review.

Case study

An original review involved a child who was found at birth to have no gag or swallow reflexes and was unable to take any feeds by mouth. The child also had generalised hypertonia/developmental delay, very significant sight and hearing impairments and developed seizures. The child's medical needs included feeding via a gastronomy 'button', nasopharyngeal or oral suctioning every few days for secretion control and anti-seizure medication.

The cause of the child's death was certified as a seizure disorder secondary to global neurological deficit and prenatal hypoxaemia.

An original review was conducted as a desktop review 'due to limited departmental involvement with this family and the nature of the child's death (that is due to existing medical condition)'.

The CDCRC formed the opinion that in a case where the child's death was the result of a medical condition, it may be necessary to consider whether the Department properly assessed the child's protective needs were being met in the context of their medical condition.

The CDCRC again cautioned the Department to exercise particular care when considering the nature of the child's death to determine the extent of a review.

Delivery of child protection services

The CDCRC's core function is to make recommendations to improve the Department's delivery of child protection services to children and families.

The review process is an opportunity to analyse and evaluate the service delivery and system responses with the potential to improve outcomes for children.

The CDCRC aims to ensure that its child death case reviews identify issues that may indicate broader systemic problems. This allows it to make recommendations to assist the Department to address these systemic issues.

The scope for identifying systemic issues and making recommendations for improvement during the reporting period 2004–05 has been limited by the following:

- the necessarily small number of child death case reviews completed in the reporting period (due to the fact that the statutory child death case review process only relates to deaths occurring after 1 August 2004 and the length of time allowed for the conduct of the reviews by the Department)
- this being the CDCRC's inaugural year and the lack of comparative data from previous years
- the significant child protection reform processes currently underway that are expected to address a number of the issues identified in the child death case review process, and
- the fact that the reviews concern children with whom the Department was involved during the period prior to these reforms.

The CDCRC notes that, within the eight child death case reviews, issues that were identified by the CMC inquiry and Ombudsman Baby Kate report were clearly evident in the delivery of child protection services to these children. Particularly, the reviews identified evidence of:

- poor record keeping
- deficiencies in the use of Suspected Child Abuse and Neglect (SCAN) Teams
- inadequate risk assessment
- failure to give proper consideration to cultural and Indigenous issues
- delay in beginning and completing assessments
- inadequate interagency collaboration and exchange of information
- inadequate case management of children in care, and
- poor professional practice generally.

Current and ongoing reform processes are intended to address these significant systemic issues. As such, the CDCRC did not make further recommendations regarding these concerns.

However, in a number of its reports the CDCRC requested that the Department takes steps to ensure that the broader reform process addresses the particular issues identified in the eight child death case reviews. The CDCRC considers the review process to be an important external mechanism for checking the progress and effectiveness of the reform process.

For the above reasons, the CDCRC considers that it would be unhelpful to identify and report on systemic issues or themes arising from its reviews. Instead, this section identifies specific issues that arose in the eight individual child death case reviews that lead the CDCRC to make a recommendation[21].

Sexualised behaviours of children and young people with a disability

One child death case review identified that a child with severe disabilities in the care of the Department was reported to have exhibited significant, age-inappropriate sexualised behaviours which may have been indicators of sexual abuse. The original review identified that the Department failed to record a child protection notification or conduct further investigations in relation to the behaviours. The CDCRC further identified that this failure may have been due to a lack of understanding by departmental staff about the significance of sexualised behaviours in children, which was further compounded by a lack of understanding of the capabilities and appropriate behaviours of children with severe disabilities.

The CDCRC concluded that the Department should provide appropriate training and guidance to alert staff to the indicators of sexual abuse, specifically for children with a disability.

The CDCRC made the following recommendation:

> **The CDCRC recommends that the Department evaluates its training programs and practice standards to determine whether sufficient information is provided to:**
>
> - **assist staff to identify what types of behaviours exhibited by children and young people, specifically those with a disability, may be indicators of sexual abuse; and**
> - **enable staff to properly assess whether or not there are serious child protection concerns.**

21 The report's discussion of these issues (below) includes occasions when the Department 'did not endorse' a recommendation of the original review. The Department's internal child death case review process requires the original review report to be provided to an internal management committee for review and comment, before being provided to the CDCRC. When the CDCRC receives the original review report, it also receives an attachment containing the comments of the Department's internal committee against each of the original review's recommendations, including an indication of whether the internal committee endorsed, conditionally endorsed or did not endorse the recommendation.

Case management of terminally ill children in care

One child death case review concerned a child who was in the care of the Department under a short-term child protection order and was residing with foster carers. In the three months before his death, the child had been receiving palliative care following deterioration in his medical condition. The original review identified a number of deficiencies in the Department's involvement with end of life decision-making and its use of the SCAN Team.

The original review recommended that a specific policy be developed to support case management regarding terminally ill children in care, covering the following issues:

- clarification of the Department's role/legislative obligations for medical decision-making (including delegations, custody and guardianship issue, collaborative decision-making with parents)
- child's ability to participate in decision-making (Gillick competence)
- specific decision-making around end of life issues such as withdrawal of life support, persistent vegetative state, palliative care, and do not resuscitate (DNR) orders, and
- collaborative consideration of cultural and religious beliefs with relevant key stakeholders.

The Department did not endorse this recommendation because 'the Director-General has the delegated responsibility to make end of life decisions and has delegated this to the Deputy Director-General and the on-call executive officer in the event this decision needs to be made outside work hours'.

The CDCRC formed the view that this response was inadequate because:

- while the recommendation requires the development of a policy to support case management issues regarding terminally ill children in care, the Department's response only addresses one specific issue – who has the delegated responsibility to make end of life decisions (the CDCRC noted that in this case, the Department did not have any statutory responsibility to make end of life decisions and the deficiencies identified in the original review related to case management issues rather than delegated end of life decision-making)
- the Department's response did not address what information, support and/or training is available to staff regarding the Department's role or legislative obligations in end of life decisions or regarding case management of terminally ill children in care, and
- the response did not identify how the departmental decision-maker or case worker will inform themselves to ensure the decision or case management is in the best interests of the child. Specifically, the Department did not identify what consultation or collaboration will occur, what information will be sought, the extent to which the child will have input into the decision-making or case management process, or whether cultural and religious beliefs of key stakeholders will be considered.

The original review also recommended that where a child's condition has been diagnosed as terminal, the case should be immediately referred to a SCAN Team, which will allow:

- the appointed SCAN Team paediatrician to provide an external objective opinion regarding treatment
- the Queensland Police Service (QPS) (through its SCAN Team representative) to have advance notice of the child's condition and conduct mandatory investigations in an appropriately sensitive manner after the child has died, and
- early consultation with key stakeholders to ensure case planning decisions (including instructions to carers) comply with legislation.

The Department did not endorse this recommendation because it 'supports collaborative planning between the Department and Queensland Health to meet health needs of children in care. This recommendation is inconsistent with the role of SCAN Teams as outlined in the legislation. It is not the role of SCAN Teams to provide an external objective review or opinion in relation to the treatment recommendations'.

The CDCRC acknowledged that it is not the role of SCAN Teams to provide an external objective review or opinion in relation to a treatment recommendation. However, the CDCRC believed that the response otherwise failed to recognise the value of referral of such cases to SCAN Teams, namely:

- to allow the appointed SCAN Team paediatrician or other health representative to ensure appropriate coordination and collaboration with other agencies and individuals regarding the child's health care and appropriate action at the time of the child's death (eg. notification to the QPS and reporting of the death to the State Coroner)
- to provide the QPS with advance notice of the child's condition to facilitate timely and appropriate police investigations at the time of the child's death, and
- to ensure participation of all key stakeholders in a coordinated case management approach for the entire period of the child's illness.

The CDCRC therefore recommended that the Department implement the original review's recommendations in relation to these issues in their entirety.

Intensive Family Support policy

One child death case review raised concerns about the Department's Intensive Family Support (IFS) policy, which limits the time the Department can work with a family on a voluntary basis. The policy states that after three months of voluntary involvement the Department must apply for a child protection order if ongoing intervention is required for the child's safety.

The child death case review identified that the Department had continued to engage with the family after the three month period without applying for a child protection order.

The CDCRC was of the opinion that the circumstances of the case did not necessarily indicate the need for a child protection order, and that the case was an example of the need for child protection casework to be flexible and take into account the best interests of the child. The CDCRC expressed a concern that policy should support good casework rather than dictate what the casework should be.

The CDCRC considered that the case demonstrated a need for a review of the Department's IFS policy, particularly in relation to timeframes, to ensure that casework is not terminated prematurely and departmental officers are not compelled to apply for child protection orders in circumstances where such orders may not be in the best interests of the child.

The CDCRC therefore made the following recommendation:

> **The CDCRC recommends that the Department review its current IFS policy, with a particular focus on the adequacy of timeframes, to ensure it allows for case management decisions to be made in the best interests of the child in all circumstances.**

Referrals by hospital staff to the Department

The CDCRC identified in one child death case review that a decision by hospital staff to refer serious child protection concerns to the Department was not agreed to by all staff involved in the matter. Significantly different assessments were made by nursing staff and the senior medical practitioner about the risks to the child's safety and wellbeing.

The CDCRC formed the view that risk assessment and referral of child protection concerns by hospital staff may require further attention to ensure a consistent approach by various medical professions/streams and by hospitals generally, as well as to ensure compliance with statutory obligations for notifying the Department of child protection concerns.

The CDCRC made the following recommendation:

> **The CDCRC recommends that the Department consult with the Child Safety Directorate, Queensland Health (QH), to assess the need for implementing measures (such as ongoing education or training) to ensure that QH officers' approach to child protection issues (specifically, risk assessments and referrals to appropriate entities) is consistent across professions/streams and facilities and is compliant with any statutory obligations.**

Poor record keeping

Poor record keeping by departmental staff was identified as an issue in a number of the child death case reviews. The CDCRC acknowledges that the reform process intends to address this systemic issue and therefore did not make a broader recommendation about this issue.

However, the CDCRC formed the view that, as an outcome of any child death case review where poor record keeping was identified, it would be good practice for the Department to correct any erroneous departmental records. The CDCRC considers that this will assist the Department to ensure that departmental records are accurate and that a full history is available if the family and/or any relevant individuals come into contact with the Department in the future.

The CDCRC made the following recommendation:

> **The CDCRC recommends that the Department ensures that it undertakes the correction/inclusion of all record keeping errors/omissions identified during the conduct of a child death case review. The CDCRC further recommends that for any corrections that are made subsequent to a review, it should be made clear on the departmental record the date of the correction, the reason for the correction and the identity of the officer responsible for the correction.**

Sudden Infant Death Syndrome education/information

A child death case review concerning a child aged seven weeks who died while in the care of his parents, and whose death was attributed to Sudden Infant Death Syndrome (SIDS), identified that the child's parents may not have received any education or information from hospital staff or other professionals in relation to SIDS risk reduction strategies, due to him being removed from his parents' care immediately upon his birth for a period of one month.

The original review recommended that the Department develop a policy/practice paper that requires staff to provide culturally and educationally appropriate SIDS risk reduction information (either verbal, written or by video) to families with children under two years of age, before the child is reunited with his/her family.

The Department did not endorse this recommendation because 'the development of educational material in relation to SIDS is a QH responsibility and not the role of the Department. However, it is acknowledged that departmental staff have a role in ensuring parents are informed about the availability of such information and are encouraged to access this information from QH'.

The CDCRC formed the view that the original review's basis for making this recommendation was sound. The CDCRC was also of the opinion that the reason given by the Department for not endorsing this recommendation was insufficient. The CDCRC noted that although the Department's response may be correct in principle, it failed to address what happens in practice and, particularly, what happened in this case.

The CDCRC therefore made the following recommendation (to adopt and improve on the original review's recommendation):

> **The CDCRC recommends that the Department develops a policy/practice paper that requires staff to ensure that families who have a child/children under two years of age, and may not be aware of SIDS risks, are connected with the QH, Child Health Service to receive culturally and educationally appropriate SIDS risk reduction information (for example, through a visit by a Child Health Nurse to the family home). Additionally, where the child/children have been removed from the family, staff ensure that SIDS information be communicated before reunification of the child/children with the family.**

Access to historical information

A child death case review identified that the Department failed to access or take into account extensive historical information which detailed significant concerns about the mother's care of the child's older sibling, who had been placed in long term care.

The original review recommended that the Department put in place mechanisms to ensure that in cases where newborns have a sibling in care, staff:

- critically analyse the past file material
- seek real evidence of change during case planning and management
- thoroughly assess the role and abilities of new partners
- understand the benefit of consistency of allocation of case workers, and
- validate information (in recognition that the mother/parent may present as compliant to minimise the level of departmental intervention).

The CDCRC formed the opinion that this recommendation had merit, but considered that it failed to address the significant amount of time it may sometimes require for staff to read and analyse past file material and the difficulty this poses when urgent assessments are required.

Therefore, the CDCRC made the following recommendation:

The CDCRC recommends that the Department consider the merit of developing a specific mechanism to operate within its Integrated Case Management System (ICMS), encompassing the following:

- **That where a child becomes the subject of a long term child protection order, staff create a 'Summary of Significant Historical Concerns' record containing a succinct but comprehensive summary of the history of departmental involvement, any risk factors and other concerns identified during this involvement, and the reason for the long term child protection order. (The CDCRC notes that this information could be readily sourced from the court application documents).**
- **That this record be linked to the name of the parent/s and/or any other individuals of concern.**
- **That the ICMS has an 'alert' system that ensures that, if the Department's attention is drawn to any of these individuals in the future (eg subsequent birth of another child), departmental staff are alerted to the 'Summary of Significant Historical Concerns' record and are required to take into account this record as part of any current or future assessments or decision-making.**

The CDCRC notes that the record should not be used as a substitute for past file material. Rather, it is intended as an aid in circumstances where departmental staff would not otherwise be able to reasonably access information contained in the past file material in a timely manner for the purpose of informing urgent decision-making.

The CDCRC acknowledges that the Department would need to independently assess the appropriateness and viability of this or a similar mechanism. The CDCRC therefore requests that the Department specifically respond to this finding if it believes that such a mechanism is not appropriate or viable.

Disciplinary action

One of the CDCRC's functions is to make recommendations to the Department about whether disciplinary action should be taken against officers or employees of the Department in relation to the Department's involvement with the child[22].

The CDCRC acknowledges that a child death case review is not intended to be an ethical standards or disciplinary investigation and may only provide limited information about possible disciplinary issues. However, in order to discharge its function under the Act, the CDCRC must be satisfied that any information that may provide grounds for disciplinary action against departmental officers has been dealt with appropriately by the Department.

The CDCRC has taken the position that if possible misconduct[23], suspected 'official misconduct'[24] or code of conduct breaches[25] are identified during an original review, such matters should be referred without undue delay to an appropriate body such as the Department's Ethical Standards Unit or the CMC. As a minimum requirement, the original review report should then:

- state whether information or conduct identified in the course of the original review has been referred to either the Ethical Standards Unit or the CMC
- identify the reason for the referral, and
- if known, state the outcome of any disciplinary or misconduct investigation.

A number of the original reviews contained evidence of serious deficiencies in individual professional decision-making and conduct and failed to adequately identify these deficiencies or refer such information to an appropriate body or recommend that this occur.

The CDCRC therefore made the following recommendation in these child death case reviews:

> **The CDCRC recommends that the Department give further consideration to whether [certain departmental officers] performed their duties carelessly, incompetently or inefficiently and whether disciplinary action should be imposed under s87(1)(a) of the PS Act.**

22 Section 89C(b)(iii) of the CCYPCG Act.
23 As defined under the PS Act.
24 As defined under the CM Act.
25 Breach of a code of conduct may constitute grounds for disciplinary action under the PS Act.

Chapter 6:

Chapter 6: The Year Ahead

This chapter examines the work and challenges that are anticipated to be faced by the CDCRC in the year 2005–06.

Monitoring Child Death Case Review Committee recommendations

During the 2004–05 reporting period the CDCRC carried out only eight child death case reviews and provided six of the eight reports to the Department on 24 June 2005. The other two reports were provided earlier than this but, as at 30 June 2005, the Department's responses to these reports were under consideration and subject to possible further discussions. The CDCRC is therefore unable to provide any meaningful information about the Department's response to its reports and recommendations made in 2004–05.

In the coming year the CDCRC looks forward to monitoring the implementation of its recommendations to the Department in relation to these and future child death case reviews

Liaison with stakeholders

The CDCRC acknowledges the need to engage in an effective and meaningful way with the Department in relation to the conduct of child death case reviews. The CDCRC will continue to work collaboratively with the Department, particularly through the following:

- ongoing meetings between the CDCRC's secretariat staff and staff of the Department's Case Review Unit, to assist in the conduct of child death case reviews
- direct consultation with the Department, including briefings and presentations by relevant departmental staff to the CDCRC, to ensure that it remains informed of the progress of the Department's ongoing reforms and the implementation of new systems, policies and procedures
- constructive dialogue between the CDCRC and the Department about the implementation of the CDCRC's recommendations, and
- development of strategies for building the capacity of the Department to conduct high quality child death case reviews.

The CDCRC also recognises the value of exchanging information with relevant agencies about systemic issues. The CDCRC hopes to improve communication about these issues by:

- making recommendations to improve the relationships between the Department and other entities involved with children and families
- ensuring effective participation of persons from key agencies in the child death case review process through membership of the CDCRC, including the Queensland Police Service, the Office of the State Coroner and Queensland Health
- providing the Commissioner for Children and Young People and Child Guardian with a copy of CDCRC reports to inform the Commission's monitoring and oversight functions[26], and

26 Section 89U(1) of the *Commission for Children and Young People and Child Guardian Act 2000* provides that the CDCRC must give a copy of its report to the Commissioner.

- ensuring that the Department complies with its requirement to provide a copy of the CDCRC's report to the State Coroner, where the report concerns the Department's involvement with a child whose death is a 'reportable death'[27].

Reforms to the child protection system

The CDCRC has been established during a time of significant reforms to Queensland's child protection system.

The January 2004 CMC report highlighted systemic failures within the former Department of Families over a number of years, and concluded that the child protection system in Queensland had failed many children.

The CMC report called for urgent, comprehensive reforms to the child protection system to ensure that all children at risk from harm, abuse or neglect were properly protected, cared for and supported. These reforms have been and are currently still being implemented, and include the creation of the Department of Child Safety, which is exclusively focused upon protecting children.

Measures to achieve the Department's goal of delivering a world class child protection system, including the implementation of the CMC report's recommendations, have required and will continue to require fundamental structural, organisational and practice reform.

It is in this context that the CDCRC is now charged to conduct reviews of the Department's original reviews. The CDCRC is committed to providing a means for the Department to be open and accountable through an independent, multi-disciplinary external review process.

In the next year, the CDCRC looks forward to assisting the Department to achieve its primary aim of improving the lives of Queensland children who have been harmed or are at risk of harm.

Conduct of child death case reviews

In Queensland, about 500 children die each year. The Department estimates that about 50 to 60 of those children will have been known to the Department within three years of their deaths. The Department's involvement with those children will therefore be reviewed by the CDCRC.

Sadly, as these figures show, the CDCRC has an extremely busy time ahead.

The CDCRC acknowledges that when a child in the child protection population dies, there is a strong need for an explanation as to what occurred and for some reassurance, if the death is seen as 'preventable', that the same will not happen again. However, the CDCRC also recognises that the majority of the deaths of children in the child protection population are due to medical conditions or accidents.

Nevertheless, the CDCRC considers that every child death case review, regardless of the cause of death, is an important opportunity to gain valuable insight into how the child protection system is working and to make a significant contribution to improving child protection practice in Queensland.

27 Section 246H of the *Child Protection Act 1999* provides that the Director-General must give a copy of its original review and the CDCRC's report to the State Coroner for use by the coroner if it concerns a 'reportable death' under the *Coroners Act 2003*.

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