

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.

5

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.