

# Chapter 3:

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

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## 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)<sup>4</sup>.

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<sup>5</sup>. 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’<sup>6</sup>, 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<sup>7</sup>. Deaths in custody include deaths of children in detention under the *Juvenile Justice Act 1992*<sup>8</sup>. 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<sup>9</sup>.

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.

<sup>6</sup> Section 8 of the Coroners Act.

<sup>7</sup> Section 9 of the Coroners Act.

<sup>8</sup> Section 10 of the Coroners Act.

<sup>9</sup> 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<sup>10</sup>. 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<sup>11</sup>, 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.

<sup>10</sup> Section 7 (Duty to Report Deaths) of the Coroners Act.

<sup>11</sup> 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<sup>12</sup>:

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.

<sup>12</sup> '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<sup>13</sup> 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.

<sup>13</sup> Under section 57B of the *Ombudsman Act 2000*.