

Chapter 5:

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

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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 reviews¹⁸.

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. Failure to observe natural justice.	4 2	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. 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. 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. Limiting the extent of a review to a desktop review.	8 1 3	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. 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. 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	<p>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:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • 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 fairness¹⁹

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 report²⁰:

'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 than 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.

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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 gastrostomy '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 recommendation²¹.

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 child²².

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 misconduct²³, suspected 'official misconduct'²⁴ or code of conduct breaches²⁵ 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.