

# Appendix 1: CDCRC members during 2006–07

## Members

**Ms Elizabeth Fraser (Chairperson)**  
**Commissioner for Children and Young People and Child Guardian**  
*BA, BSocWk, GradDip in Multicultural Studies, CertTeaching*

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 managing policy development and implementation. She has also been responsible for leading large-scale organisational change and coordinating, overseeing and evaluating major policy and program reforms.

After graduating from the University of Queensland, Elizabeth worked for 19 years as a social worker in child health and welfare in Canberra, interspersed with short breaks to look after children and travel overseas, teaching English as a foreign language in Hong Kong, Sweden and Nigeria. After this she worked in the Australian Government's overseas aid program, managing a number of policy and funding reforms.

In 1992 Elizabeth returned to Brisbane, where she started work with the Queensland Government public service, initially to undertake a program review of the Office of Rural Communities. After that review was completed, she held a range of policy and program management positions, including General Manager, Corporate and Executive Services in the former Department of Innovation and Information Economy, Sport and Recreation Queensland and Executive Director, Social Policy and also Implementation in the Department of the Premier and Cabinet.

Elizabeth has a long-standing commitment to improving government service delivery, particularly for children and young people, and is committed to working closely with key stakeholders to achieve appropriate policy and program outcomes.

**Mr Bob Atkinson APM**  
**Commissioner of Police**

Commissioner Atkinson has had a 38-year career with the Queensland Police Service, having been sworn in as a Constable on 30 October 1968. 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 country Criminal Investigation Branch and Juvenile Aid Bureau offices. He was involved in the change management processes in the QPS post-Fitzgerald from 1990 and then later in terms of further organisational

change after the Public Sector Management Commission Review and Report Recommendations of the Queensland Police Service in 1993.

In 1989 he attended the three-month FBI National Academy Course at Quantico, Virginia, USA. That program is aligned with the nearby University of Virginia. He again attended the FBI Academy during 2002 for the National Executive Institute Program. He holds several graduate-level qualifications.

Bob Atkinson was appointed Commissioner of the Queensland Police Service on 1 November 2000.

### **Dr Colin Brennan**

#### **Senior Consultant Psychiatrist and Senior Public Health Physician**

*MBBS (Qld), FRANZCP, MRCPsych (London), DPM (Melb.), FRACMA, FAIM, FAFPHM (RACP), FRIPH*

Colin has extensive experience in multiple senior roles across the Queensland public sector, as well as the Commonwealth public sector and the academic sector in Queensland.

He has served in numerous roles and positions to the most senior levels in the Queensland hospital system, in the Queensland Psychiatry Directorate and as Deputy Director-General of Health and Medical Services for Queensland. He has also served as Chairman of the Queensland Public Service Board and Permanent Head (CEO) of the (then) Department of the 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/young person protection, and facilitating optimal service delivery to such people by the Queensland public sector and the non-government sector. He sees his current membership of the CDCRC as a special opportunity to participate, and to help facilitate the Queensland Government's major reforms in the area of child protection and related service delivery to children and young people and the community generally. Colin has a long-standing interest in public sector organisational review and renewal, together with professional development of relevant officers.

### **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. In 1995 she was the first Torres Strait Islander to receive an Overseas Study Award, to undertake PhD 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 as a Resource Officer with Youth Family Support Services, Department of Communities. Her career interests are in law (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**  
*DipTeaching, BA, BEd, MEdSt, 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 and managerial positions with Education Queensland. 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 for state, Catholic and independent schools in Queensland.

In 2001, Barry was appointed Executive Director of the Commission, with responsibility for the employment screening, Community Visitors and complaints functions. He was appointed to the new role of Assistant Commissioner, with responsibility for the Commission's Child Guardian functions, in February 2005. Barry is committed to the view that strengthening children and young people's primary relationships will improve their wellbeing.

**Ms Trudi Sebasio**

Trudi is a descendant of the Yimen and Gungulu people of Central Queensland. She 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 titled) John Oxley Secure Mental Health Hospital (Wolston Park)
- Inaugural Chairperson of Gallang Place – Aboriginal and Torres Strait Islander counselling service, Brisbane
- 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’ and has provided strategic advice and planning to a number of statewide Queensland Health – Mental Health initiatives in the following capacities:

- Member, Statewide Child Safety Therapeutic Teams
- Member, Statewide Homelessness and Mental Health Teams
- Member, Statewide Mental Health Clinical Network
- Project Manager for developing ‘Protocols for the Scope of Practice’, Indigenous Mental Health Worker 004/102
- Chairperson of Indigenous Mental Health Workforce Forums in Queensland.

Trudi is the CDCRC’s Aboriginal representative.

### **Dr Neil Wigg**

*MBBS, FRACP, MPolAdmin*

Neil 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, Royal Australasian College of Physicians.

Neil has over 20 years experience in child health service management and in clinical practice in child disability. His interests include child health policy, advocacy and child public health.

### **Ms Jennifer Wiltshire**

*BSocWk, MAASW*

Jennifer is a social worker with 25 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 members for the Commissioner of Police

**Mr Peter Crawford**  
**Detective Superintendent**  
**Queensland Police Service**

Detective Superintendent Crawford is the Director of Child Safety for the Queensland Police Service. He also manages and leads the Child Safety and Sexual Crime Group in providing statewide, national and international responses to child protection related investigations and is responsible for overseeing all reportable child death investigations conducted by the Queensland Police Service.

Detective Superintendent Crawford has over 20 years policing experience, working predominantly in a variety of operational roles, including as a criminal investigator, as a specialist child abuse investigator and as a police Suspected Child Abuse and Neglect (SCAN) Team representative. Since January 2003 he has performed a range of management roles within the Child Safety and Sexual Crime Group and has been heavily involved in the implementation of child protection reforms from a whole-of-government and Queensland Police Service perspective. In 2004 he received the Queensland Child Protection Award in the public sector category.

**Mr Cameron Harsley**  
**Detective Inspector**  
**Queensland Police Service**

Detective Inspector Harsley is currently appointed as the Officer in Charge of the Child and Sexual Assault Investigation Unit within the State Crime Operations Command and also holds the position of Deputy State Coordinator for the Child Protection and Investigation Units (CPIU) which operate throughout the state. He has been involved with child protection as an investigator since 1991 and held positions as Officer in Charge of CPIU, Criminal Investigation Branch as well as a dedicated Child Abuse Unit in Logan. He has been a Suspected Child Abuse and Neglect (SCAN) Team member and also has extensive experience in investigation of general crime.

Detective Inspector Harsley worked within the Department of Child Safety during the reform period and has also worked on projects within the Commission for Children and Young People and Child Guardian.

## Appendix 2: Review criteria

### Commission for Children and Young People and Child Guardian Act 2000

#### Section 89S

#### Review Criteria for Child Death Case Review Committee 5 August 2005

The review criteria to be used by the Child Death Case Review Committee (CDCRC) in reviewing an ‘original review’<sup>56</sup> are to determine whether the original review:–

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 of Child Safety (including any joint policies and protocols which the Department of Child Safety 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 and/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 that should have applied to the child and their family by all entities; and
  - 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; and

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<sup>56</sup> ‘Original review’ means a review carried out by the Department of Child Safety under Part 7A of the *Child Protection Act 1999*.

- c) Considered whether the relationships and interactions between the Department of Child Safety and other relevant entities ensured that the welfare and best interests of the child were paramount; and
  - d) Identified any evidence of broader systemic issues for the Department of Child Safety's consideration.
6. Was comprehensive, independent, impartial and transparent, including whether it:
    - a) Identified any failings, actions or inactions of individual officers or employees of the Department of Child Safety that may warrant referral to an appropriate entity for possible investigation and/or disciplinary action; and
    - b) Identified any failure, action, inaction or other matter within the scope of the Department of Child Safety's involvement with the child and their family that may have impacted directly or indirectly on the child's health and well-being
  7. Was timely.

In addition, the CDCRC will consider whether:

8. The Department of Child Safety developed an appropriate action plan to give effect to the recommendations, if any, of the original review.
9. The Department of Child Safety'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.
10. Information on the outcome of the original review was conveyed to all relevant persons and entities.
11. To remove any doubt, the above criteria do not limit the functions of the CDCRC under the *Commission for Children and Young People and Child Guardian Act 2000*.

## Appendix 3: Abbreviations and dictionary

CCR	Child Concern Report
CCYPCG Act	<i>Commission for Children and Young People and Child Guardian Act 2000</i>
CDCRC	Child Death Case Review Committee
CM Act	<i>Crime and Misconduct Act 2001</i>
CMC	Crime and Misconduct Commission
child death review	The internal review conducted by the department under Chapter 7A of the <i>Child Protection Act 1999</i>
child death case review	The entire process for reviewing the department's involvement with a child who has died, as provided for by Chapter 7A of the <i>Child Protection Act 1999</i> and Part 4A of the <i>Commission for Children and Young People and Child Guardian Act 2000</i>
Child Guardian Key Outcome Indicators	Eight outcomes used by the Child Guardian to gather, assess and report information about the effectiveness of the child safety system
the Commission	Commission for Children and Young People and Child Guardian
the Commissioner	Commissioner for Children and Young People and Child Guardian
Coroners Act	<i>Coroners Act 2003</i>
CP	Child Protection
CP Act	<i>Child Protection Act 1999</i>
CPN	Child Protection Notification
CPO	Child Protection Order
CSAHSC	Child Safety After Hours Service Centre
CSD	Child Safety Director
CSDN	Child Safety Directors' Network
CSO	Child Safety Officer
CSSC	Child Safety Service Centre
the department	The Department of Child Safety and also, where applicable, the former Department of Families
desktop review	A paper-based review process that explores limited avenues of inquiry (for example, no interviews are conducted)
DVO	Domestic Violence Order
DSQ	Disability Services Queensland

external causes	Pertaining to environmental events and circumstances that cause injury, such as motor vehicle accidents, drowning and poisoning
external review	Review carried out by the CDCRC pursuant to s. 89C of the <i>Commission for Children and Young People and Child Guardian Act 2000</i>
fatal assault	The death of a child or young person from acts of violence perpetrated by another person, including cases where death is the sequel of a fatal assault that occurred some time earlier
IA	Investigation and Assessment
IFS	Intensive Family Support
internal review	Original review carried out by the department pursuant to s. 246A of the <i>Child Protection Act 1999</i>
MIR	Monthly Implementation Report
non-accidental trauma	Physical trauma that has been intentionally inflicted, such as fatal assault and suicide
Ombudsman	Office of the Queensland Ombudsman
PS Act	<i>Public Service Act 1996</i>
QH	Queensland Health
QPS	Queensland Police Service
reporting period	1 July 2006 to 30 June 2007
SC	The child whose involvement with the department was the subject of the child death case review (the 'subject child')
SCAN Team	Suspected Child Abuse and Neglect Team
SDM	Structured Decision-Making
SIDS	Sudden Infant Death Syndrome
suicide	A self-inflicted injury that is accompanied by the intention of the individual to die as a result of the action taken
suspected suicide	Where no coronial findings are available, but other factors and information raise suicide as a possible cause of death; relevant evidence and factors include QPS opinions, previous statements of intent by the deceased, the presence of a suicide note, witnesses to the event, prior suicide attempts or any precipitating factors
TAO	Temporary Assessment Order
TOR	Terms of reference
unknown/pending (cause of death)	Includes the following causes of death: 'Autopsy Notice given – cause of death not yet determined', 'Not yet determined pending test results' and 'Not yet established, tests required'
year ahead or next year	The 2007–08 financial year

## Appendix 4: Detail about the Queensland child death review process and other jurisdictions

### Commission for Children and Young People and Child Guardian

The Commission for Children and Young People and Child Guardian (the Commission) has significant responsibilities in relation to child deaths. First, it is required by the *Commission for Children and Young People and Child Guardian Act 2000* to provide administrative (secretariat) support to the CDCRC. Second, the Act also makes the Commissioner and Assistant Commissioner standing members of the CDCRC. Under the Act, the Commissioner is the permanently appointed chairperson. Therefore, for all practical purposes, the Commission is the administrative conduit between the CDCRC and other agencies and entities.

The Commission also has a broader statutory obligation to keep a register of the deaths of all children and young people under 18 that occur in Queensland, including information on cause of death, demographic information and other relevant factors. This information is collected and collated by the Commission in the Child Death Register.

The Commission analyses information in the Child Death Register and conducts research to identify and report on patterns and trends of child mortality, including those relating to the child protection population. On the basis of this analysis and research, the Commission makes recommendations that are focused on reducing risk factors associated with deaths that were preventable. The Commission reports annually to the Premier on its findings and recommendations.

To support the establishment and maintenance of the Child Death Register, the Office of the State Coroner and the Registry of Births, Deaths and Marriages advise the Commissioner of child deaths.

### Registry of Births, Deaths and Marriages

All child deaths in Queensland are required to be notified to and registered by the Registry of Births, Deaths and Marriages. Information needed for this purpose 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 2003*, discussed below), the Registry also receives an Autopsy Certificate in relation to the cause of death.

## Office of the State Coroner

The Office of the State Coroner and the position of State Coroner provide a consistent and coordinated system that reviews deaths occurring in circumstances where further explanations are needed.

Coroners may investigate ‘reportable deaths’, which include deaths that were violent or unnatural or happened in suspicious circumstances, and deaths that occurred in care or in custody.<sup>57</sup> Deaths in care include deaths of children in foster care or under guardianship of the Department of Child Safety.<sup>58</sup> Deaths in custody include deaths while in detention under the *Juvenile Justice Act 1992*.<sup>59</sup> Coroners’ powers of investigation are extensive and the investigative process must include an autopsy.

The *Coroners Act 2003* imposes an obligation on the State Coroner to notify the Commission of all ‘reportable’ child deaths. The information provided by the State Coroner to the Commission is recorded in the Child Death Register and includes:

- Police Report of Death to a Coroner (Form 1), which includes a narrative providing a summary of the circumstances surrounding the death
- autopsy and toxicology reports, and
- the Coroner’s findings and comments.<sup>60</sup>

## Queensland Police Service

If the Queensland Police Service (QPS) receives a report about a ‘reportable death’ or otherwise becomes aware of a death that appears to be a reportable death, it must advise the Coroner in writing of the death.<sup>61</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 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.

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<sup>57</sup> Section 8 of the *Coroners Act 2003*.

<sup>58</sup> Section 9 of the *Coroners Act 2003*.

<sup>59</sup> Section 10 of the *Coroners Act 2003*.

<sup>60</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.

<sup>61</sup> Section 7 of the *Coroners Act 2003*.

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.

## The Queensland child death review process

### The department's internal review process

A child death case review process begins when the department becomes aware of a death of a child and, within three years before the child's death,<sup>62</sup> the department became aware of alleged harm or alleged risk of harm to the child or took action under the *Child Protection Act 1999* in relation to the child. The department then notifies the CDCRC<sup>63</sup> of the death of the child.

The department must decide the extent of its review and terms of reference. The department may also ask another entity for information about the child that was relevant to the child's protection or welfare while the child was alive.

Within six months of the date the department becomes aware of a death, it must complete its review about its involvement with the child (an 'internal review') and provide a copy of the review report to the CDCRC, together with any documents obtained and used for the purpose of the review. If the review concerns the department's involvement with a child whose death is a reportable death under the Coroners Act, the department must also 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.

### The CDCRC's role

The CDCRC is an important independent mechanism for ensuring the external accountability of the department's child death reviews. The core responsibility of the CDCRC is to assess the quality of the department's internal reviews.

Once the department submits its report and source documentation, the CDCRC assesses and analyses the quality of the internal review with a view to:

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

The CDCRC also has a legislative responsibility for making recommendations about whether the department should assess the actions of individual officers

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<sup>62</sup> This includes a child who was born during this period and, before it was born, the department reasonably suspected that the child might be in need of protection after it was born.

<sup>63</sup> Appendix 1 details the members of the CDCRC during 2005–06.

within a disciplinary context. However, the CDCRC's functions do not include undertaking disciplinary investigations or processes; it must merely be satisfied that any information that may provide grounds for disciplinary action against departmental officers has been dealt with appropriately by the department. As Chapter 4 of this report makes clear, the department has the primary responsibility for individual accountability of departmental staff. In contrast, the key focus of the CDCRC's recommendations is systemic issues and the quality of the department's internal reviews.

### Review criteria

In carrying out its functions, the CDCRC must develop and use 'review criteria',<sup>64</sup> which provide an objective and transparent means for the CDCRC to assess the quality of the department's internal reviews. In developing the review criteria, the CDCRC must consult the Director-General of the department and other entities that the CDCRC considers have a sufficient interest. In the reporting period the CDCRC refined its established review criteria.<sup>65</sup>

### Time frames

Within three months of receiving the department's internal review report, the CDCRC must complete its external review and give a copy of its review report to the department and the Commissioner for Children and Young People and Child Guardian. The CDCRC's review report must not include any information that identifies, or is likely to lead to the identification of, any individual. However, the CDCRC may include with the copy of its report given to the department a separate document that allows the department to identify individuals.

Under the *Commission for Children and Young People and Child Guardian Act 2000*, the CDCRC must provide the Minister<sup>66</sup> with its annual report by 31 October each year. The Minister is required to table the report within 14 sitting days of receipt.

### Monitoring implementation of recommendations

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. 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 the CDCRC's report and, if no steps have been taken, the reasons for this. If the CDCRC, after considering the department's response, considers that no steps have been taken to give effect to the recommendations, or the steps taken are inadequate

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64 Appendix 2 details the review criteria used by the CDCRC in 2005–06.

65 See Appendix 2 and further discussion below.

66 The Premier is the Minister responsible for the CDCRC.

or inappropriate, the CDCRC may make a report to the Premier and the Minister for Child Safety.

For the CDCRC to adequately monitor the implementation of its recommendations to the department, it established a Monthly Implementation Report (MIR) process. The MIR was first trialled on 3 March 2006 and the exchange of the MIR between the department and the CDCRC occurs every two months.

### *Finalisation of matters on the MIR when the CDCRC is satisfied*

The CDCRC and the department have agreed that recommendations will be finalised and removed from the MIR in accordance with the following process:

- A recommendation will be finalised and removed from the MIR after a maximum of two exchanges between the CDCRC and the department.
- To finalise a recommendation where the CDCRC is ‘satisfied’ with the department’s response/s, it will advise the department to that effect. This process includes instances where the department advises the CDCRC that it does not propose to implement a recommendation or proposes to take a course of action different from the recommended action and the CDCRC is satisfied with the reason/s provided by the department. The recommendation will then be ‘removed’ from the MIR.

### **Escalation criteria**

In 2006–07, the CDCRC developed the following escalation criteria to inform its decision-making where it forms the view that no steps, inadequate steps or inappropriate steps have been taken to implement any of its recommendations.

The CDCRC will take the following steps to escalate such matters:

- The Assistant Commissioner (who is a permanent member of the CDCRC) will engage with the Deputy Director-General of the department in constructive dialogue about the implementation of the recommendation.
- The Chair of the CDCRC will engage with the Director General of the department in constructive dialogue about the implementation of the recommendation.
- The CDCRC will advise the department of its intention to report on the matter to the Premier and the Minister for Child Safety.<sup>67</sup> In all cases where reports are provided to the Premier and Minister for Child Safety, the matter will also be reported in the Committee’s annual report.

The CDCRC acknowledges that, in accordance with the MIR process, the time frames for addressing recommendations need to be reasonable and to be balanced against the time that will have already elapsed in seeking to resolve the matter and the circumstances of the case.

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<sup>67</sup> Pursuant to s. 89W of the CCYPCG Act.

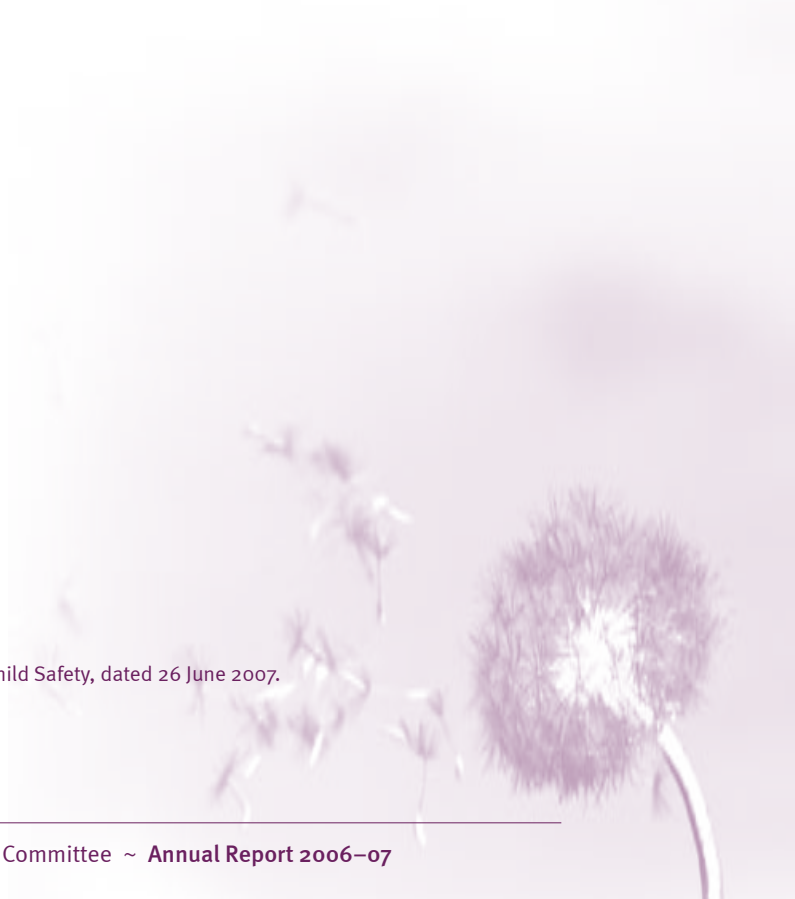
The department supports the transparent process for the escalation of matters where agreement cannot be reached, and is cooperating with the CDCRC in working towards considering and implementing the CDCRC's recommendations in a timely manner.<sup>68</sup>

### **Child death review processes in other jurisdictions**

The following table details and compares the child death review processes in other states and territories in Australia.

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68 Correspondence from the Department of Child Safety, dated 26 June 2007.



### Child death review processes in other jurisdictions

Review body	Year established	Jurisdiction	Scope of review work	Reporting relationship	Administrative support	Constitution of review panel	Number of reviews completed in past year
Victorian Child Death Review Committee (VCDRC)	2005	Reviews deaths of a child known to the Department of Human Services' child protection service at the time of death or within three months of their death.	<ul style="list-style-type: none"> <li>To promote continuous improvement and innovation in policies and practices relating to child protection and safety.</li> <li>To identify any themes, trends or patterns which emerge from the review process and advise the Minister for Children and Minister for Community Services of their implications for policy and practice in Child Protection and related services.</li> <li>To identify particular groups of child deaths that may benefit from further investigation and oversee a group analysis process to gain a more comprehensive understanding of the issues involved and best-practice responses.</li> </ul>	<p>The Minister for Children and Minister for Community Services are formally advised of the VCDRC's deliberations about each child death review.</p> <p>The VCDRC produces an annual report detailing its analysis of child death reviews during the previous year.</p>	The VCDRC appoints an individual committee member as lead analyst for each case to present to the VCDRC.	The VCDRC's membership is drawn from the health, welfare, police, legal and academic fields, mirroring the many professional groups involved in Victoria's Child Protection system. The VCDRC currently has 10 members.	20 (April 2005 – March 2006)

Review body	Year established	Jurisdiction	Scope of review work	Reporting relationship	Administrative support	Constitution of review panel	Number of reviews completed in past year
NSW Ombudsman  (Note: The Child Death Review Team at the NSW Commission for Children and Young People does not undertake reviews of reviewable deaths.)	2002	Reviews deaths involving: <ul style="list-style-type: none"> <li>a child in care</li> <li>a child in respect of whom a report was made to the department within a three-year period immediately preceding the child's death</li> <li>a child who is a sibling of a child in respect of whom a report was made to the department within a three-year period immediately preceding the child's death</li> <li>a child whose death is or may be due to abuse or neglect or whose death occurs in suspicious circumstances</li> <li>a child who was an inmate of a children's detention centre, a correctional centre or a lock-up at the time of death</li> <li>a child who, at the time of their death, was living in residential care provided by a service provider and authorised or funded under the <i>Disability Services Act 1993</i> or in a residential centre for handicapped persons.</li> </ul>	The identification of relevant systemic issues and any discernible trends or patterns in child deaths, and the making of recommendations in relation to policies and practices to be implemented by government and service providers for the prevention or reduction of deaths of children in care or at risk or harm.	The NSW Ombudsman provides an annual report to the Parliament detailing its findings for the preceding 12 months.	Staff employed by the NSW Ombudsman.	N/A	104 (July 2004 – June 2005)

Review body	Year established	Jurisdiction	Scope of review work	Reporting relationship	Administrative support	Constitution of review panel	Number of reviews completed in past year
Western Australian Child Death Review Committee (CDRC)	2002	<p>Reviews deaths where:</p> <ul style="list-style-type: none"> <li>the deceased child, young person or other children in the deceased child's family have been the subject of an allegation of child maltreatment or a child concern report recorded by the Department for Community Development in the 24 months preceding the child's death, or</li> <li>the deceased child's family has had a number of contacts with the Department for Community Development within the past 24 months and an emerging pattern is indicated, or</li> <li>the deceased child was in the care of the Department for Community Development or a request for departmental involvement in an out-of-home care placement for the child or young person had been made within the past 24 months.</li> </ul>	<ul style="list-style-type: none"> <li>To facilitate the accountability of the Department for Community Development by providing a quality assurance mechanism in cases involving the deaths of children.</li> <li>To review the policies and procedures of the department in circumstances where a child has died.</li> <li>To make recommendations for the improvement of the above; provide a report on these matters to the Minister.</li> <li>The CDRC also functions to identify particular classes of child death or related issues that may benefit from further investigation or research.</li> </ul>	<p>The CDRC reports to the Minister and Director-General of the Department for Community Development.</p> <p>The CDRC also provides an annual report to Parliament.</p>	<p>The CDRC is funded by the Department of the Premier and Cabinet in WA.</p>	<p>Four members external to the Department for Community Development.</p>	<p>10 (July 2004 – June 2005)</p>

Review body	Year established	Jurisdiction	Scope of review work	Reporting relationship	Administrative support	Constitution of review panel	Number of reviews completed in past year
South Australian Child Death and Serious Injury Review Committee (CDSIRC)	2005	Cases involving a child death should be reviewed by the CDSIRC where abuse or neglect may be involved, where there are grounds to believe that the death or injury might have been prevented by systemic change, where the child or a member of the child's family was known to the Department of Families and Communities within a three-year period before the child's death due to suspected abuse or neglect, or if the child was under the guardianship or custody of the Minister or a government agency. The State Coroner may also refer cases to the CDSIRC for review.	The purpose of the reviews is to identify general trends and patterns in child deaths, to facilitate the assessment of relevant policies, practices and procedures, and to make and monitor recommendations for avoiding preventable child deaths or serious injuries.	The CDSIRC provides an annual report to the Minister for Families and Communities.	The CDSIRC reports to the Minister for Families and Communities.	Information not available on the World Wide Web.	N/A
Proposed Child Death Committee in the Northern Territory (NT)	Not yet established.	Proposed to review all child deaths in the Northern Territory.	Proposed to address legislative inadequacies pertaining to the protection of children. Based on the initial draft of <i>Care and Protection of Children and Young People Act 2005</i> (NT); however, the function of the proposed Child Death Committee will be to collect and analyse data relating to all child deaths in the Northern Territory so as to make recommendations for the prevention of future deaths.	Proposed to table an annual report directly to Parliament.	Information not available on the World Wide Web.	Proposed multidisciplinary composition of the Child Death Committee.	N/A



Review body	Year established	Jurisdiction	Scope of review work	Reporting relationship	Administrative support	Constitution of review panel	Number of reviews completed in past year
Proposed Commission for Children and Young People in the Australian Capital Territory	Not yet established.	Proposed to involve children in the care of or known to Family Services.	Proposed to conduct reviews of departmental practice and action.	Not yet established.	Child Death Review Team within the proposed Commission.	Not yet established.	N/A
Proposed establishment of a child death review system in Tasmania	Not yet established.	Not yet established.	Proposed to identify and make recommendations about systemic issues and to investigate general patterns and trends in relation to child deaths so as to facilitate the development of strategies to reduce similar deaths in the future.	Not yet established.	Not yet established.	Not yet established.	N/A



