

## Chapter 4

# Outcomes of reviews conducted by the CDCRC in 2006–07

### Key messages

- In 2006-07 there has been a noticeable increase in the quality of the department's internal reviews, as evidenced by the assessment of the reviews against the CDCRC's 'review criteria'.
- The department submitted 97.0% of its internal review reports to the CDCRC within the six-month legislated timeframe, which represents a 34.0% increase on the previous reporting period.
- An Indigenous person was appointed or engaged in the review process in every review involving an Aboriginal and/or Torres Strait Islander child.
- Some slippage in the identification of individual accountability issues in review processes was evident during the year. However, where individual accountability issues were identified, an improvement was noted in their overall management.

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### Assessment against review criteria

This chapter discusses the CDCRC's findings and recommendations in relation to the department's 61 internal reviews (of 62 deaths) that the CDCRC considered in 2006–07.

Wherever possible, the CDCRC seeks to build the capacity of the department's internal child death review process. The main reason for this is the belief that the quality of reviews undertaken by the department will directly affect the extent of learnings that can be derived from the process. These learnings should, in turn, play a significant role in informing and improving child protection practice.

### Response to issues identified by the CDCRC in the 2005–06 reporting period

In 2005–06 the CDCRC identified the following key concerns about the department's internal reviews:

- not completing reviews within the six-month statutory time frame during the first half of the reporting period – that is, July–December 2005; however, time frames were increasingly met as the reporting period progressed

- limiting the extent of reviews to ‘desktop reviews’ during the first half of the reporting period – that is, July–December 2005
- not appointing or engaging an Indigenous person in review processes
- not obtaining all necessary information, or not obtaining all necessary information in a timely manner, from external agencies that are willing to cooperate (as opposed to those agencies less inclined to engage with reviews)
- not adequately identifying deficiencies or gaps in service delivery to the child and its family by all entities
- not commencing reviews as quickly as possible, often due to workload pressures associated with the number of reviews, which creates a risk of recollection-based evidence and information that may not be fully beneficial to the review, and
- not considering whether assessment of disciplinary action pursuant to s. 87(1)(a) of the *Public Service Act 1996* (PS Act) or referral to the Crime and Misconduct Commission (CMC) pursuant to s. 38 of the *Crime and Misconduct Act 2001* (CM Act) was warranted.

Overall, during 2006–07 the CDCRC has noted that the department has significantly improved its performance in these areas, resulting in reviews of a better quality, particularly in terms of adherence to administrative review and investigative best-practice principles.

## Quality of the department’s internal reviews in 2006–07

Table 4.1 sets out the rate at which the department met the review criteria (which are used to focus the CDCRC’s assessment and analysis of the quality of the department’s internal reviews).

In general, the positive aspects of the department’s internal reviews in 2006–07 were:

- compliance with statutory requirements significantly improved in comparison with the previous reporting period; in this period, 97.0% of time frames were met
- an Indigenous person was appointed or engaged in the review process in every Indigenous child death review
- the terms of reference used in 92.0% of the reviews were considered case specific and provided an appropriate scope and focus for the review
- in all reviews, the department’s dissemination of the internal review findings was in accordance with the department’s Child Death Case Review Policy and Procedures

- the department used a review/investigation plan which was considered to be of particular value to the reviews and the review process, and
- all information, in every review, was obtained by the department in a lawful, ethical and culturally sensitive manner.

### Improved compliance with the six-month statutory time frame

In 2006–07 the department completed all but two of its 61 reviews within the six-month statutory time frame (97.0%).<sup>17</sup> This is a significant improvement on the previous reporting period, when only 63.0% of the internal reviews were provided within the designated time frame.

### Reduction in the number of desktop reviews

In its 2004–05 annual report, the CDCRC observed that the department was determining at the commencement of a review process whether it would conduct a ‘full review’ or a ‘desktop review’.

During the 2005–06 reporting period, the department conducted desktop reviews in six cases and the CDCRC again concluded that this adversely impacted on the quality of the reviews.

However, in 2006–07, the CDCRC noted that the department did not conduct any desktop reviews. Overall, this has resulted in reviews of significantly better quality, as the flexibility of a full review and the ability to customise it give scope for all avenues of inquiry to be explored and analysed, with particular value being drawn from interviewing relevant persons involved in service delivery to the child or young person. Given the complexities of service delivery, historical deficiencies in record-keeping and the multitude of case-specific, contextual and individual factors which influence the actions or inactions of relevant parties, the CDCRC commends the department’s recognition that reviews are most useful when they involve an interview process.

This is an encouraging sign that the department is making progress in building its capacity to conduct holistic, thorough and meaningful child death case reviews.

### Cultural input into reviews

In 2006–07 the CDCRC was pleased to note that a cultural consultant was engaged in all of the cases considered involving Aboriginal or Torres Strait Islander children or young people. This is a marked improvement from the previous reporting period, during which a cultural consultant was engaged in only 54.0% of the cases. The CDCRC commends the department for the progress

<sup>17</sup> The CDCRC acknowledges that in both cases the department formally notified the CDCRC that it was not able to submit the review within the six-month statutory time frame and gave the reasons for this. Further, the department nominated a revised date when the reports would be provided and complied with the revised date in both cases.

it has made to enhance its capacity in this area, including the development of a cultural consultant paper to address previous CDCRC concerns/ recommendations about the lack of cultural input into reviews concerning Aboriginal or Torres Strait islander children.

The CDCRC wishes to acknowledge the considerable progress made by the department throughout the 2006–07 reporting period.

The areas where the CDCRC noted scope for strengthened performance by the department's internal reviews during the reporting period were:

- not adequately addressing substantive cultural issues in the conduct of reviews (despite the appointment of cultural consultants in all relevant cases)
- limiting the extent of reviews to a particular time frame, and not considering the entire period of the department's involvement/history
- not obtaining all necessary information, or not obtaining all necessary information in a timely manner, from external agencies that are willing to cooperate (as opposed to those agencies less inclined to engage with reviews)
- not supplying all relevant departmental information to the review, or not identifying all relevant departmental persons to be interviewed, in a timely manner
- not adequately identifying deficiencies or gaps in service delivery to the child and its family by all entities
- not commencing reviews in a timely manner (sometimes due to resource issues created by peaks in review activity), which raises the risk of recollection-based evidence and information not being fully beneficial to the review, and
- not adequately considering the application and adequacy of the relevant legislation, policies and procedures that applied or should have applied to the child and its family.

The department's performance against the individual review criteria is outlined in Table 4.1. Specific areas of improvement are also discussed below.

**Table 4.1 Issues identified about the quality of the 61 reviews considered by the CDCRC in 2006–07<sup>18</sup>**

CDCRC review criterion used to determine whether the internal review:	Finding	Sub-finding	Number (out of the 61 reviews) that met the CDCRC review criterion	Percentage (of the 61 reviews) that met the CDCRC review criterion	Percentage of the 2005–06 reviews that met the CDCRC review criterion
1. Was conducted in accordance with statutory and common law requirements	Complied with statutory and common law requirements	Complied with statutory time frame for provision of report to CDCRC (s. 246D, CP Act)	59	97% <sup>19</sup>	63%
		Provided copies of all documents obtained and used for the purpose of the review	61	100%	98%
		Provided procedural fairness	59	97%	98%
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)	Complied with policies and procedures	Appointed Indigenous person to review team where required	20	100% <sup>20</sup>	54%
		Indigenous person appointed to review team and adequately involved in review process where required	10	50% <sup>21</sup>	77%
3. Had appropriate terms of reference and the extent of the review was appropriate in the circumstances	Adequate terms of reference		55	90%	95%
		Extent of review adequate	61	100%	83%
4. Demonstrated that: (a) An adequate review and/or investigation plan was developed for the purpose of conducting the review	Review/investigation plan prepared and adequate	Time frame of review appropriate	40	66%	88%
		Review/investigation plan prepared and adequate	56	92%	65%
		Review/investigation plan prepared but inadequate	4	6%	35%
		Review plan prepared	60	98%	63%

<sup>18</sup> Review criterion 5, “Whether the review had findings and recommendations that were logical and reasonable”, has deliberately been omitted from this table, as the CDCRC is currently developing a detailed classification system that will form the basis for future reporting against this criterion. This data will be reported in the CDCRC’s 2007–08 Annual Report.

<sup>19</sup> Original review reports received as at 1 July 2006 are reported in this field.

<sup>20</sup> Based on the 20 Indigenous child death reviews conducted during the reporting period.

<sup>21</sup> Based on the 20 Indigenous child death reviews conducted during the reporting period.

CDCRC review criterion used to determine whether the internal review:	Finding	Sub-finding	Number (out of the 61 reviews) that met the CDCRC review criterion	Percentage (of the 61 reviews) that met the CDCRC review criterion	Percentage of the 2005–06 reviews that met the CDCRC review criterion
(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	Obtained all necessary information	All appropriate avenues of inquiry explored	42	69%	93%
		Conducted interviews with key staff/personnel	55	90%	85%
		Obtained relevant departmental information	43	70%	75%
		Obtained relevant documentation/information from other entities (external agencies)	36	59%	55%
(c) Any information obtained and considered as part of the review was obtained in a lawful, ethical and culturally sensitive manner, and	Considered all necessary information		31	51%	95%
	Reasonable efforts made to obtain information		36	59%	93%
	Information obtained in a lawful, ethical and culturally sensitive manner	Obtained in a lawful manner	61	100%	100%
(d) Cultural and Indigenous issues were addressed in the composition of the review team and the conduct of the review	Cultural and Indigenous issues addressed in the composition of the review team	Obtained in an ethical manner	61	100%	100%
		Obtained in a culturally sensitive manner	61	100%	100%
	Cultural and Indigenous issues adequately addressed in the conduct of the review		20	100% <sup>22</sup>	54%
			5	25% <sup>23</sup>	31%

<sup>22</sup> Based on the 20 Indigenous death reviews conducted during the reporting period.

<sup>23</sup> Based on the 20 Indigenous death reviews conducted during the reporting period.

CDCRC review criterion used to determine whether the internal review:	Finding	Sub-finding	Number (out of the 61 reviews) that met the CDCRC review criterion	Percentage (of the 61 reviews) that met the CDCRC review criterion	Percentage of the 2005–06 reviews that met the CDCRC review criterion
6. (a) Individual accountability	Where appropriate, identified failings, actions or inactions of individual officers that may warrant assessment for possible investigation and/or disciplinary action	<ul style="list-style-type: none"> <li>Considered whether a matter warrants referral to the CMC under s. 38 of the CM Act and/or</li> <li>Considered whether disciplinary action pursuant to s. 87(1)(a) of the PS Act is warranted</li> </ul>	46	75%	70%
(b) Departmental accountability	Identified whether or not a failure, action, inaction or other matter within the control of the department may have impacted directly or indirectly on the child's health and wellbeing	Identified all failings, actions or inactions of individual officers that may warrant referral to an appropriate entity for possible investigation and/or disciplinary action	38	62%	90%
7. Was timely	Complied with statutory time frame for provision of report to CDCRC (s. 246D, CP Act)		58	95%	63%
8 & 9. Adequacy of the department's action plan	Review was commenced and all relevant information was gathered in a timely manner		59	97%	63%
10. Dissemination of reviews findings	Developed an appropriate action plan		38	62%	n/a
	Dissemination of the internal review findings in accordance with the department's Child Death Case Review Policy and Procedures		33 <sup>24</sup>	54%	60%
			61	100%	65%

<sup>24</sup> As at 30 June 2007, the department had provided 33 action plans in respect of the 50 reports that the CDCRC had provided to the department.

Although there was evidence of overall improvement by the department against the review criteria during 2006–07, the CDCRC has identified some specific areas that would benefit from further capacity building work by the department in the year ahead. These areas are discussed below.

### **Timeliness of reviews and information gathering**

Once the department has been notified of a child’s death, it has six months to complete a review of its involvement with the child and submit the review report and relevant documents to the CDCRC. Although it is crucial that the department completes its reviews within the six-month statutory time frame, it is also important for the department to ensure that the quality of the reviews is not compromised by excluding relevant information for the purpose of meeting the review time frame. Therefore, in accordance with the CDCRC’s review criteria, the CDCRC is required to consider the timeliness of the department’s review process.

Although the department is to be commended for completing 97.0% of reviews in accordance with the six-month statutory time frame, the CDCRC is concerned about the overall timeliness of the department’s reviews, with the commencement of the review identified as having been delayed in 37.7% of the cases considered. The delays varied from one month to three and a half months. This delay, in turn, affected the ability of the department to obtain information from external agencies for the purpose of the review and further disrupted the review process – for example, through the need to reschedule and cancel face-to-face interviews, and limit the involvement of the cultural consultant. Inevitably, any initial delay in conducting interviews affected the ability of the department to follow up on issues raised during interviews, thus compromising the review’s ability to accurately address its stated terms of reference.

In addition, the CDCRC has identified that a significant lapse in time between a child’s death and the conduct of interviews with departmental staff and other relevant persons may adversely affect the interviewees’ powers of recollection. This can cast doubt on the accuracy and completeness of detailed information provided to the review.

In 2005–06 the CDCRC recommended that the department give consideration to a standardised procedure for facilitating timely information requests to external agencies, so as to ensure that all relevant information is obtained and can be considered as part of the review process.<sup>25</sup> However, the CDCRC continues to have concerns about the timeliness of the department’s internal processes (if any) for obtaining such information, and continues to highlight this as an ongoing deficiency in review processes.

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<sup>25</sup> Case Review 16/2005.

## Case study<sup>26</sup>

The review was not commenced until three and a half months after the department learnt of the child's death. As a result of this significant delay, requests for information from external agencies, in particular the Queensland Police Service (QPS), were not progressed in a timely manner. Consequently, the department's review noted that "*information was sought from QPS; however, due to the short timeframe a response was not expected prior to the due date of the review*". The CDCRC noted that the department did not request the information from the QPS in a timely manner.

As the case study highlights, the failure to request information from external agencies in a timely manner increases the likelihood that the review will not benefit from the information, thus impacting on the overall quality of the review. The CDCRC considers that there is scope for the department to streamline its internal processes in order to improve the overall timeliness of its requests for information from external agencies. One possible option is for the department to develop a template for such information requests which could be sent as a matter of course upon learning of the child's death. The CDCRC will encourage further consideration of the issue by the department in 2007–08, to improve the overall timeliness of its reviews.

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A further aspect of this process issue is the failure to identify and supply all relevant departmental documents and materials to the review process, including complete contents of case files, copies of screening and assessment tools and the names, contact details and employment status of relevant departmental and former departmental staff who had involvement with the child or young person.

The CDCRC was particularly concerned to note the failure by senior officers of the department to provide case file materials within seven days, as required by the department's internal Child Death Case Review (CDCR) Policy and Procedures. This was a recurring issue in the child death case reviews considered during the reporting period. In some cases, this information was not provided for over two months, thus significantly delaying the review process. In addition, the need for the independent reviewer to check that all required materials had been provided to the review further detracted from its timely completion and, on occasion, led to the need to significantly redirect the focus of the review when key files and additional materials, when eventually supplied, changed the complexion of the review findings.

The CDCRC made the following recommendation in relation to this issue.

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<sup>26</sup> Case Review 44/2006

## CDCRC recommendation<sup>27</sup>

The CDCRC recommends that the department:

- provides further advice to the CDCRC as to whether there is a process by which the relevant senior officer is made accountable for ensuring that all relevant documents in the department's possession and control have been provided to the Case Review Unit
- considers (if no such process currently exists) amending its CDCR Policy and Procedures to include a requirement that senior officers must detail the extent to which departmental files have been searched and must sign off to confirm that all relevant documents have been provided
- highlights at the next senior officers' meeting that their recurring failure to provide all relevant documents to the Case Review Unit within seven days of their request is a breach of paragraph 4.3 of the CDCR Policy and Procedures.

## Cultural input to internal reviews

Despite the appointment of a cultural consultant to the review team in 100.0% of cases involving an Indigenous child or young person, the CDCRC found that only 25.0% of reviews adequately addressed cultural and Indigenous issues.

In the majority of cases, the CDCRC noted that the role of the cultural consultant in the review either was unclear or appeared to be limited to consultation on discrete issues, as opposed to direct and ongoing involvement in the conduct of the whole review.

The following is an example of a case where the CDCRC considered that the review failed to adequately address cultural and Indigenous issues.

## Case study<sup>28</sup>

SC's family was known to the department because of concerns about the children's safety and wellbeing arising from the parents' domestic violence and drug and alcohol abuse.

A cultural consultant was appointed to the review team. However, the CDCRC identified that the cultural consultant was only consulted on certain occasions, such as during the department's liaison with the Recognised Entity and Community Agency.

In relation to the exploration of cultural and Indigenous issues for the purpose of the review, the CDCRC identified that:

<sup>27</sup> Case Review 35/2006.

<sup>28</sup> Case Review 41/2006.

- The genogram provided in the review was not comprehensive and did not adequately reflect SC's family mapping and extended relationships. The CDCRC particularly noted that in an Aboriginal family it is possible to have three generations living together as part of a family, and, generally, grandparents can represent the strength of the family. However, the review did not extend the genogram to include any surrounding family support network or kinships that may have been available to the family, such as cousins, grandparents, uncles and aunties.
- The genogram raised potential issues about the relationship mapping, which may have been a catalyst for or contributor to the level of violence and alcohol abuse within the family.
- The review was limited in its discussion of any follow-up on the substance abuse problem (drugs and alcohol) and did not identify the risk factors and strengths within the extended family in relation to this problem.

Overall, the CDCRC concluded that the review team did not appear to fully utilise the cultural consultant to identify issues and strengths of this Indigenous family, and did not appear to display an understanding of the purpose and potential contribution of such involvement in the review process and outcomes.

In comparison, the following case study illustrates a review where the CDCRC commended the department's consideration of cultural issues.

### Case study<sup>29</sup>

A child death case review involved a child and the child's family who identified as Aboriginal. The department engaged a cultural consultant, who had significant involvement in the conduct of the review and ensured that all relevant cultural issues were identified and addressed. The review's terms of reference were also expanded in this case to include 'cultural considerations'.

The CDCRC formed the opinion that the cultural consultant had a significant role in the conduct of the review by ensuring that relevant cultural protocols were observed, by participating in the interviews and by ensuring that the department's interventions with the child and the child's family were culturally appropriate.

The CDCRC acknowledges that the recruitment of appropriately qualified cultural consultants has been a significant challenge for the department and commends the progress it has made to improve this aspect of its reviews.

<sup>29</sup> Case Review 31/2006.

The inclusion of a cultural consultant in relevant cases is not merely a process requirement but a potential source of insight and added value to the outcomes of the review.

To ensure that the department continues to build capacity in this area, the CDCRC made the following recommendation in 2006–07:

### **CDCRC recommendation<sup>30</sup>**

The CDCRC recommends that the department develops a template to be used by all cultural consultants which identifies specific cultural issues to be addressed during a review process – for example, generic cultural issues, kinship mapping, extended family issues and community and homeland issues.

Over time the CDCRC expects that the learnings emerging from child death case reviews will be maximised through ongoing cultural input and this will, ultimately, improve the cultural competency of the department’s professional practice and service delivery framework.

### **Accountability**

Review criterion 6(a) addresses the CDCRC’s individual accountability obligation under section 89ZC(iii) of the *Commission for Children and Young People and Child Guardian Act 2000*. It requires the CDCRC to consider whether, on the information available, the department’s review identified any failings, actions or inactions of individual officers or employees of the Department of Child Safety that might warrant referral to an appropriate entity for possible investigation and/or disciplinary action<sup>31</sup> – that is, by this criterion, the CDCRC seeks to be satisfied that the department’s review appropriately identified and/or assessed individual accountability issues. In 2006–07 the CDCRC was satisfied that the department adequately addressed individual accountability in 75.0% of the cases considered.

As outlined in its previous Annual Reports, the CDCRC has taken the position that, if possible misconduct, suspected ‘official misconduct’ or code of conduct breaches are identified during the department’s review, such matters should be assessed within the appropriate context and/or referred to the CMC<sup>32</sup> without undue delay. As a minimum requirement, the department’s review report and/or the department’s steps to implement a CDCRC recommendation relating to such an issue should:

<sup>30</sup> Case Review 9/2006.

<sup>31</sup> In accordance with the Public Service Act 1996, s. 87(1).

<sup>32</sup> In accordance with the department’s obligations under s. 38 of the Crime and Misconduct Act 2001.

- state whether conduct identified in the course of its review has been actioned, and
- state the reasons.

Where the CDCRC considers that the department's review contains evidence of deficiencies in professional decision-making or conduct, but the review fails to adequately identify these deficiencies or make a recommendation that the matter be referred for assessment (for example, to the department's Ethical Standards Unit), the CDCRC makes the following recommendation:

The CDCRC recommends that the department give further consideration to whether the officer performed their duties carelessly, incompetently or inefficiently or whether disciplinary action should be imposed under section 87(1)(a) of the *Public Service Act 1996*.

Accordingly, in cases where the department's review is silent as to whether it has considered an issue or referred it to either its internal Ethical Standards Unit or the CMC, the CDCRC will make the above recommendation. Therefore, the department's reviews should, as a matter of course, clearly state whether it referred any issues identified in the course of its review, thereby reducing the need for the CDCRC to make a recommendation (possibly in instances where the department has already taken that course of action).