



commission for  
children and young people  
and child guardian

# **Children of Parents with Mental Health Issues Report**

**A report on a review into government service provision preceding the alleged murder of a ten-year-old child by her father; where the father had received involuntary treatment for mental health issues shortly prior to the child's death**

**April 2008**

# **WARNING!**

## **Confidentiality statement**

This report may contain information of a confidential nature under the  
*Child Protection Act 1999*  
and  
*Commission for Children and Young People and Child Guardian Act 2000.*

The above legislation contains provisions that establish criminal offences in relation to the unauthorised disclosure of confidential information.

Should you have any inquiries as to the appropriateness or otherwise of disclosing the contents of this report, please contact the Director, Complaints and Investigations Program, Commission for Children and Young People and Child Guardian, on (07) 3033 0242.

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## Abbreviations and Dictionary

### **CCYPCG**

Means the Commission for Children and Young People and Child Guardian

### **CCYPCG Act**

Means the *Commission for Children and Young People and Child Guardian Act 2000* (Qld).

### **Children**

Means children and young people under 18 years of age.

### **Confidential information**

Means information that could identify a person who is receiving or has received a public sector health service and is therefore subject to the confidentiality requirement under s62A of the HS Act.

### **CP Act**

Means the *Child Protection Act 1999* (Qld).

### **DChS**

Means the Department of Child Safety

### **Emergency Examination Order or EEO**

Means an order made by a police or ambulance officer pursuant to s35 of the MH Act, to provide for the examination of a person who has a mental illness at an authorised mental health service.

### **HQCC**

Means the Health Quality and Complaints Commission

### **HQCC Act**

Means the *Health Quality and Complaints Commission Act 2006* (Qld)

### **HS Act**

Means the *Health Services Act 1991* (Qld)

### **Involuntary Treatment Order or ITO**

Means an order made pursuant to s108 of the MH Act, to provide for the involuntary treatment of a person who has a mental illness.

### **MH Act**

Means the *Mental Health Act 2000* (Qld)

### **PH Act**

Means the *Public Health Act 2005* (Qld)

### **QH**

Means Queensland Health

### **QPS**

Means the Queensland Police Service

### **RBWH**

Means the Royal Brisbane and Womens' Hospital, Queensland Health

## Executive Summary

This is the report on a review by the Commission for Children and Young People and Child Guardian (the CCYPCG) into government service provision preceding the alleged murder of a ten-year-old child by her father, who had received involuntary treatment for mental health issues shortly prior to the child's death.

My review determined that there is currently no framework within Queensland for establishing multi-agency responses to specifically address the safety and wellbeing of children of parents with mental health issues, particularly where the parent is the primary recipient or focus of a service.

Currently within Queensland, there are only broad statutory and policy requirements for cross-agency reporting in relation to a child that '*has been, is being or is likely to be harmed*' or a '*child in need of protection*'. These requirements do not provide for proactive, child-focussed assessments in relation to children of parents with mental health issues.

### Recommendations

I make the following recommendations under s31H of the CCYPCG Act:

1. That QH, QPS and DChS immediately coordinate the following interim cross-agency measures to address the safety and wellbeing of children of parents with mental health issues:
  - Distribution of educational material to front line officers who have responsibility for assessing, acting on and/or reporting information that may concern persons with mental health issues who have children, to promote a better understanding of how parental mental illness may impact on children of parents with a mental illness.
  - Interim guidelines for front line officers for exchange of information between agencies specifically in relation to children of parents with mental health issues, including '*confidential information*' under the *Health Services Act 1991*.<sup>1</sup>
2. That QH initiates a legislative review of the confidentiality provisions of the *Health Services Act 1991* to establish whether there is a need for a specific statutory exception that recognises '*the care and protection needs*' or the '*best interests*' of a child. The review should be informed by this report, as well as any recent child deaths known to QH (including coronial inquiries) where issues were identified concerning disclosure of '*confidential information*'.
3. That QH undertakes a state-wide project in relation to children of parents with a mental illness, with the purpose of ensuring that QH meets its responsibilities towards children of parents with a mental illness pursuant to the '*National Practice Standards for the Mental Health Workforce*'.

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<sup>1</sup> The educational material and guidelines should be specific, concise and easily accessible by all front line officers eg through access to an intranet or internet resource or in poster or leaflet format.

4. (a) That the Child Safety Directors and/or appropriate representatives of QH, QPS, DChS and CCYPCG establish a multi-agency Working Party, to develop a multi-agency framework for promoting the safety and wellbeing of children of parents with mental health issues in the future, informed by this report.
- (b) That the Working Party consult with and/or otherwise involve the HQCC in the development of the framework.

### ***Timeframes and Reporting***

The above recommendations require urgent and timely action in order to reduce potential risks for children of parents with mental health issues who may otherwise not benefit from the above initiatives.

As such, I request that the agencies immediately action the recommendations and provide a report to the responsible Minister, with information to satisfy the Minister that the recommendations have been implemented. I request that these reports are made within the following timeframes:

<b>Recommendation</b>	<b>Timeframe (from the date of this report)</b>
One	Within three months
Two	Within three months
Three	Within six months
Four	Within three months

I also request that a copy of the agencies' reports on the recommendations are provided to me, so that I may provide final advice to the Premier.

### ***Report structure***

My review report is structured as follows:

<b>Part</b>	<b>Title</b>	<b>Content</b>
	Introduction	Outlines the basis for my review including the terms of reference, jurisdiction, scope and other procedural matters.
One	Current Cross-Agency Responsibilities	Identifies the current cross-agency responsibilities with respect to assessing, acting on and reporting foreseeable risk of harm to children of parents with mental health issues.
Two	Case Analysis	Analyses the facts of the case the subject of my review against the existing cross-agency framework outlined in Part Two, so as to inform Part Three of my report.
Three	Adequacy of Existing Framework	Identifies whether there is an existing framework for establishing multi-agency responses to address foreseeable risk of harm to children of parents with mental health issues in the future.
Four	Recommendations	Contains the recommendations of my review.

## Introduction

### Background

On 3 January 2008, the then Acting Premier, the Honourable Mr Paul Lucas MP, wrote to me to request that I conduct an independent review into the quality of government service provision prior to the death of a ten-year-old child at Bribie Island, with recommendations to address any issues identified by the review in relation to cross-agency responsibilities for dealing with information concerning children of parents with mental health issues.

Information available at that time suggested the following:

- A father allegedly raped and murdered his ten-year-old daughter on 31 December 2007.
- The father had recently been in involuntary care in a Queensland Health (QH) mental health unit at the Royal Brisbane and Women's Hospital (RBWH) for a two week period, following being taken into custody by the Queensland Police Service (QPS) on 8 December 2007 after a 'manic' episode at a shopping centre.
- The father was assessed by a psychiatrist employed by QH as fit for discharge and released from the mental health unit on 22 December 2007<sup>2</sup>, nine days before his daughter's death.
- The father had sole custody of the deceased child, as well as her three siblings.
- The ten-year-old's body was discovered by two of her siblings in a bedroom of a holiday home that the father had rented at Bribie Island, on 1 January 2008. The father was not at the holiday home when the death was reported to QPS.
- The father was subsequently located by QPS at another location and taken into custody, charged with the ten-year-old's rape and murder.
- The deceased child and her siblings were known to the Department of Child Safety (DChS) as a result of 'a small number of low-level child concern reports' in the previous three years. The children were not the subject of any current child protection concerns at the time of the ten-year-old's death.

### Terms of Reference

The Terms of Reference for my review, pursuant to the Acting Premier's request, were as follows:

*Determine the relevant agencies' cross-agency responsibilities with respect to assessing, acting on and reporting foreseeable risk of harm to children of parents with mental health issues*

*Determine whether, in this instance, each of the relevant agencies implemented their cross-agency responsibilities in relation to the deceased child and her siblings*

<sup>2</sup> My review later established that the date of release was 21 December 2007.

*Determine whether there is an existing framework for establishing multi-agency responses to address foreseeable risk of harm to children of parents with mental health issues in the future*

*Make any necessary findings and recommendations*

### **Jurisdiction**

The Acting Premier's letter of 3 January 2008 stated (in part):

I note that under section 15AA of the CCYPCG Act, the Commissioner has the function to monitor, audit and review the systems, policies and practices of the child safety department and other service providers that affect children in the child safety system.

My view is that the cross-agency dimensions of this case warrant a review by you of the conduct of all agencies involved. I therefore request that you exercise your powers under the Act.

In considering my jurisdiction under the CCYPCG Act to conduct a review pursuant to the Acting Premier's request, I was cognisant of the following:

- Part 3 of the CCYPCG Act authorises me to undertake an investigation relating to a service provided, or required to be provided, to a '*child in the child safety system*'. However, the children involved in the case the subject of the Acting Premier's request were not 'in the child safety system' at the relevant time.<sup>3</sup> As such, it was not possible for me to undertake my review under this Part.
- My monitoring functions under s15AA of the CCYPCG Act include '*to monitor, audit and review the systems, policies and practices of the child safety department and other service providers that affect children in the child safety system*'.
- The issues raised by the Acting Premier necessarily affect children in the child safety system, for whom DChS, QH and QPS have specific cross-agency responsibilities in relation to assessing, acting on and reporting foreseeable risk of harm, including harm to children of parents with mental health issues. Accordingly, my review was conducted pursuant to s15AA.
- In performing my functions under s15AA of the CCYPCG Act, I am not able to review a decision taken in an individual case.<sup>4</sup> As such, whilst the facts of the case the subject of my review inform my analysis of the adequacy of the existing systems, policies and practices of the relevant agencies in relation to children of parents with mental health issues, I have not made any findings in relation to the decisions taken by each of the agencies in this particular case.<sup>5</sup>

<sup>3</sup> See s11A and s7A of the CCYPCG Act. Also see further in this Part, under 'Scope', p9, for information about the extent of DChS' involvement with the children.

<sup>4</sup> Section 15AA(4), CCYPCG Act.

<sup>5</sup> See Part Two of this report, p19, for further discussion in relation to this jurisdictional limitation and how it impacted on my review and Terms of Reference.

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### ***Involvement of other entities***

My review was conducted in cooperation with the Health Quality and Complaints Commission (HQCC), who undertook a concurrent investigation under the *Health Quality and Complaints Commission Act 2006* (the HQCC Act).<sup>6</sup>

As part of this cooperative effort, interviews were conducted conjointly by officers from the CCYPCG and the HQCC and information relevant to each review/investigation was exchanged between our agencies. This cooperative effort was guided by and conducted pursuant to a formal '*Memorandum of Understanding: Co-ordination of Responses to Serious Adverse Health Incidents*', of which the CCYPCG and the HQCC are parties.

### ***Scope***

#### ***HQCC Jurisdiction***

Pursuant to the HQCC Act, the HQCC is authorised to investigate, among other things, the quality of a health service or systemic issues relating to the quality of health services.

In recognition of the HQCC's concurrent investigation and jurisdiction under the HQCC Act, as well as the specialised expertise and knowledge of HQCC officers, my review report does not make any findings about the quality of health services provided, or that should have been provided, to the father by QH and QPS including:

- whether those services were provided in accordance with the relevant statutory requirements of the MH Act and other legislation;
- the appropriateness of mental health assessments and diagnoses;
- whether the decision to discharge the father from hospital was based on sound clinical assessments; and
- the appropriateness of medications and treatment plans.

However, pursuant to the terms of reference for my review, my review report does make recommendations about systemic issues, including systemic health service issues, where those issues directly concern children of parents with mental health issues.

#### ***DChS Involvement***

Initial information indicated that the family was known to DChS. As such, I issued a formal notice to the Director-General of DChS requesting all records held by DChS relevant to the matter under review.

Upon receiving and reviewing this information, it became apparent that DChS' involvement with the family was limited to the following:



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<sup>6</sup> The HQCC will prepare its own report on its investigation, separately to my review report.

I assessed that this limited involvement was not directly relevant to the matter under review, for the following reasons:

- The report received in November 2006 did concern parental mental illness, but of the mother rather than the father. (This information is discussed later in my review report, as it contributes to an understanding of QH's current cross-agency responsibilities with respect to assessing, acting on and reporting foreseeable risk of harm to children in the context of the *father's* mental illness in this case.<sup>7</sup>)
- Only one report concerned the behaviour of the father. This report, in March 2006, alleged use of 'slapping' as a form of discipline, but did not indicate mental illness.
- In all of the reports, there was no information that the father suffered from a mental illness. Further, DChS had not received any recent reports in relation to the children and the children were not subject to any child protection orders. As such, there was no indication that DChS had received any information that required it to assess, act on or report foreseeable risk of harm to the children due to their father's mental illness.
- Given the above, an examination of DChS' involvement with the family would not assist me to determine the adequacy of DChS' systems, policies and practices for assessing, acting on and reporting foreseeable risk of harm to children of parents with mental health issues in the context of this case.

Part One of my review report includes an examination of DChS' responsibilities in relation to children of parents with mental health issues, so as to provide a holistic overview of the current framework for cross-agency responsibilities concerning foreseeable risk of harm to this group of children. However, for the reasons given above, an analysis of DChS' involvement with the family does not form part of my review report.

### ***Obtaining information***

Under s31C of the CCYPCG Act I may issue a statutory notice to a service provider requiring it to give me certain information or documents.

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<sup>7</sup> See '*Part Two: Case Analysis*', p22 of this report.

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On 4 January 2008 I issued statutory notices to the chief executive officers of QH, QPS and DChS. The notices required each agency to provide me with copies of all records and documents concerning the family involved in the case the subject of my review, as well as any policies, procedures, guidelines or protocols relevant to children of parents with mental health issues. I received the full cooperation of each agency and all relevant documents were provided to me within a very short timeframe.

From this information, I identified the individual officers from QH and QPS who may have had direct involvement in matters relevant to my review. I then issued further statutory notices to the chief executive officers of QH and QPS, requesting the provision of information from these officers by way of formal recorded interview.

Interviews were subsequently conducted with all relevant QH officers.<sup>8</sup> However, relevant QPS officers participated in my review by way of providing written answers to written questions, rather than attendance at interview.<sup>9</sup>

I also obtained information from a number of private individuals who had direct involvement in matters relevant to my review and consented to participate in recorded interviews.

### ***Standard of proof and sufficiency of evidence***

The CCYPCG Act is silent as to what standard of proof is required for me to make a finding in relation to the issues under review. There are two standards of proof, the criminal standard and the civil standard. The criminal standard requires proof beyond a reasonable doubt. The civil standard requires proof on the balance of probabilities.

I am of the view that the common law supports the application of the civil standard of proof to reviews conducted under the CCYPCG Act. I have taken it to mean that before making a finding, the evidence must establish that it is more probable than not that a particular event occurred or circumstances existed.<sup>10</sup>

The evidence I obtained for my review was the best possible evidence that was reasonably available to me. The findings of fact that I have made are the objective facts as determined by an analysis of the evidence gathered during my review.

Although I am not bound by the rules of evidence, I observed those rules to the greatest extent practicable when analysing the evidence and making findings of

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<sup>8</sup> One QH officer sought my agreement to participate by way of a written statement rather than attendance at an interview, based on specialist medical advice concerning the officer's health. I agreed to this request.

<sup>9</sup> QPS requested that I consider this alternative method for obtaining information from QPS officers, in recognition of certain competing interests. I agreed to this request with certain conditions, all of which were met by QPS.

<sup>10</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336.

fact. I assessed the cogency<sup>11</sup> of the evidence I obtained and considered the applicable standard of proof for forming opinions about that evidence.

### ***Reporting procedures, recommendations and natural justice***

Section 31H of the CCYPCG Act authorises me to make recommendations about matters arising from my review. However, before making the recommendations, I must give the agencies about whom the recommendations relate a written copy of my proposed recommendations and a reasonable opportunity to comment on them.

Section 63(1) of the CCYPCG Act states that I must not include in a report any comments adverse to an entity identifiable from the report, unless the entity has been given a copy of the comments and a reasonable opportunity to respond to them.

My report contains recommendations that relate to QH, QPS and DChS. My report also contains comments that could be considered adverse to QH and QPS. Accordingly, my report was provided to QH, QPS and DChS in provisional form for each agencies' comment and response, pursuant to my statutory obligations.

I carefully considered all relevant information, arguments and submissions put forward by each of the agencies and, where required, made amendments or additions to my report. However, I also ensured that I conducted this reporting process in accordance with my paramount statutory obligation to act independently and in a way that promotes and protects the rights, interests and wellbeing of children.<sup>12</sup>

### ***De-identification***

In deciding to de-identify my report, I took into consideration the following:

- The sensitive nature of the matter under review.
- The need to protect the identity and privacy of the deceased child's siblings and other family members.
- That the intention of my report is to review issues at a systemic rather than individual level.

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<sup>11</sup> Cogency includes the credibility of witnesses, the reliability of documents, the inferences to be drawn from things, and the effect of the evidence as to the facts in issue generally. Cogency depends largely upon general considerations of probability.

<sup>12</sup> Section 17, CCYPCG Act.

## Part One: Current Cross-Agency Responsibilities

This Part seeks to address the following Term of Reference:

*Determine the relevant agencies' cross-agency responsibilities with respect to assessing, acting on and reporting foreseeable risk of harm to children of parents with mental health issues*

### Queensland Health

#### **Public Health Act 2005 (PH Act)**

The PH Act contains provisions in relation to protecting and promoting the health of the Queensland public.

Section 191 of the PH Act imposes a mandatory obligation upon health professionals (ie doctors and registered nurses) to notify DChS about harm or likely harm to a child. A notification must be made if:

- The health professional becomes aware, or reasonably suspects, during the practice of his or her profession, that a child '*has been, is being, or is likely to be, harmed*'; and
- as far as the health professional is aware, no other professional has notified DChS about the harm or likely harm.

The notification must be made immediately that the health professional becomes aware or forms a reasonable suspicion. However, s191(4) declares that a health professional may need to seek further information about harm or likely harm to a child before forming a reasonable suspicion about the matter. The example given in the PH Act to illustrate this is of a health professional receiving information about *possible* harm, then seeking further information, after which the health professional forms a *reasonable suspicion* that the child has been harmed.

Failure to notify DChS in accordance with this mandatory obligation is an offence under the PH Act.

The PH Act does not contain any provisions that specifically relate to foreseeable risk of harm to children of parents with mental health issues.

#### **Mental Health Act 2000 (MH Act)**

The MH Act provides for the involuntary assessment and treatment of persons with mental illnesses. It includes provisions relating to Emergency Examination Orders (EEOs), Involuntary Treatment Orders (ITOs) and treatment plans for persons on an ITO.

The MH Act does not contain specific provisions in relation to assessing, acting on and reporting foreseeable risk of harm to children of parents with mental health issues.

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### **Policies, Procedures and Guidelines**

QH's 'Integrated Resource Manual 3.19: Child Safety – Health Professionals Capability Requirements and Reporting Responsibilities', August 2005, explicitly outlines the mandatory obligations of all QH staff to report any 'reasonable suspicion that a child has been, or is being or is likely to be harmed', both as a QH policy obligation and, for health professionals, in accordance with the PH Act. This policy also refers to the 'Report of a Reasonable Suspicion of Child Abuse and Neglect' form, which QH staff must complete when making a mandatory notification to DChS.

QH Child Safety Unit's 'Protecting Queensland Children: Policy Statement and Guidelines on the management of abuse and neglect of children and young people (0-18 years)', September 2005, recognises parental mental health disorder as a risk factor for all types of child abuse and neglect.<sup>13</sup> It further identifies children of parents with mental health problems as a 'Special Needs Group' that may be more vulnerable to child abuse and neglect. It goes on to state: 'If a parent has a mental health problem...their ability to care for, nurture and protect their children may be limited. The children may also have to fend more for themselves than other children of the same age. They may be taking responsibility for household management. Without an adult carer's guidance, children may find themselves in high risk situations.'<sup>14</sup>

After commencement of my review, and in consultation with me, QH took steps to provide for interim measures to address the safety of children of parents with a mental illness. Specifically, the Director, Mental Health Services, QH, issued a directive to all authorised mental health services within QH, requiring them to conduct certain assessments in relation to children of parents with a mental illness and develop child care plans to ensure the safety and wellbeing of those children.<sup>15</sup>

However, at the time of the father's admission to RBWH, there were no specific policies, procedures or guidelines for QH staff to assess, act upon or report foreseeable risk of harm to children of parents with mental health issues.

### **Queensland Police Service**

#### **The Police Powers and Responsibilities Act 2000 (PPR Act)**

The PPR Act outlines the powers and responsibilities that QPS officers have for investigating offences and enforcing the law.

The PPR Act does not create any mandatory notification obligations for QPS officers in relation to children, and does not contain any provisions that specifically relate to foreseeable risk of harm to children of parents with mental health issues.

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<sup>13</sup> QH 'Protecting Queensland Children', pp42-50.

<sup>14</sup> QH 'Protecting Queensland Children', p56.

<sup>15</sup> QH Memorandum 'Policy relating to mental health patients and child safety issues', 4 January 2008.

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**Child Protection Act 1999 (CP Act)**

The CP Act bestows certain powers upon QPS officers where they are investigating an offence that involves allegation of harm or risk of harm to a child, and they reasonably suspect that a child is at *immediate risk* of harm.<sup>16</sup>

However, the CP Act does not create any mandatory notification obligations for QPS officers in relation to children, and does not contain any provisions that specifically relate to foreseeable risk of harm to children of parents with mental health issues.

**Mental Health Act 2000 (MH Act)**

The MH Act contains specific provisions regarding the involvement of QPS officers with mentally ill persons.

In relation to risk of harm, if a QPS officer reasonably believes that a person has a mental illness and, because of the person's mental illness, there is an '*imminent risk of significant physical harm being sustained by the person or someone else*', the officer is required to take a person to an authorised mental health service for examination and make an EEO.<sup>17</sup>

However, apart from this provision, the MH Act does not create any mandatory notification obligations for QPS officers in relation to children, and does not contain any provisions that specifically relate to foreseeable risk of harm to children of parents with mental health issues.

**Policies, Procedures and Guidelines**

QPS' Operational Procedures Manual (OPM), '*Chapter 7: Child Protection*', provides specific directions and guidelines for QPS officers in relation to child protection matters. However, Chapter 7 of the OPM is directed more to formal investigations of offences that involve alleged harm to a child. Generally, these investigations are conducted by specialised units within QPS, including the Child Protection Investigation Unit (CPIU), the Criminal Investigation Branch or the Child Safety and Sexual Crime Group.

Where a QPS officer believes that a child is a '*child in need of protection*' as defined by the CP Act<sup>18</sup>, QPS must consider whether the matter warrants referral to a Suspected Child Abuse and Neglect (SCAN) team. These are established under the CP Act to provide for a multi-agency approach to formulating recommendations regarding the welfare and protection needs of children, and monitoring the implementation of those recommendations.<sup>19</sup> The mechanism for QPS to make a referral to a local SCAN team or to otherwise notify DChS of a child protection matter is generally by QPS officers referring a matter to the relevant CPIU, who will then assess the information and make the referral or notification if warranted.

QPS' OPM, '*Chapter 6: Special Needs Groups*', provides detailed policies and procedures for dealing with mentally ill persons under the MH Act. Whilst the

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<sup>16</sup> Sections 16-18, CP Act.

<sup>17</sup> Sections 33-35, MH Act.

<sup>18</sup> Section 10, CP Act.

<sup>19</sup> See further in this Part, under '*Shared Responsibilities*', p17, for discussion of the SCAN system.

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OPM provides comprehensive guidelines for QPS officers in relation to their powers and responsibilities under the MH Act, there are no specific guidelines or directions in relation to the safety and wellbeing of any children in the care or custody of mentally ill persons.

### ***Department of Child Safety***

#### ***Child Protection Act 1999 (CP Act)***

The purpose of the CP Act is to provide for the protection of children in Queensland. The Director-General of DChS is responsible for the administration of the CP Act.

Section 14 of the CP Act provides that if DChS becomes aware of alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, it must investigate the allegation and assess the child's need of protection or take other action the Director-General of DChS considers appropriate.

'Harm' to a child is any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.<sup>20</sup>

A '*child in need of protection*' is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; and does not have a parent able and willing to protect the child from the harm.<sup>21</sup>

The CP Act does not contain any provisions that specifically relate to foreseeable risk of harm to children of parents with mental health issues.

#### ***Policies, Procedures and Guidelines***

DChS currently has no specific policies or procedures for receiving, assessing or otherwise dealing with information concerning children of parents with mental health issues.

Limited reference is made in the DChS '*Child Safety Practice Manual*' and '*Structured Decision Making*' tools to the mental illness of parents. In these documents, parental mental illness is listed as one of a number of possible causes of parental incapacity or dysfunction, such as may result in neglect, emotional or physical harm or reduced capacity to protect a child from harm.

DChS' '*Practice Papers*' intranet page includes the paper '*Principles and Actions for Services and People Working with Children of Parents with a Mental Illness*', Commonwealth Department of Health and Ageing, April 2004.<sup>22</sup>

However, there is no information from DChS to suggest that departmental officers are otherwise specifically directed, educated or trained in relation to using this paper to inform their professional practice or decision making.

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<sup>20</sup> Section 9, CP Act.

<sup>21</sup> Section 10, CP Act.

<sup>22</sup> See Part Three of this report, p31, for further discussion concerning this paper.

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There is no specific reference to children of parents with mental health issues in any protocols or memorandums of understanding between DChS and other relevant service providers.

### ***Shared Responsibilities***

#### ***Mental Health Intervention Project (MHIP)***

The MHIP is a tri-agency partnership between QH, QPS and the Queensland Ambulance Service, in which the three agencies share expertise and resources to respond effectively to mental health crisis situations. The MHIP commenced in 2005 and is being established across a number of health service, police and ambulance districts throughout Queensland. The MHIP includes the establishment of dedicated positions within each of the agencies for coordination of mental health crisis intervention services and information sharing across the agencies. The MHIP also delivers training (both agency-specific and across all three agencies) to enhance officers' knowledge and skills for responding to mental health emergencies.

However, the MHIP does not specifically provide for cross-agency collaboration or training in relation to the safety and wellbeing of children of parents with mental health issues.

#### ***Mental Health Collaboration***

There is currently a memorandum of understanding (MOU) between QH and QPS for '*Mental Health Collaboration*', 2006.<sup>23</sup> This MOU provides for the exchange of confidential information<sup>24</sup> between the two agencies so as to adequately respond to mental health crisis situations.

Further to the MOU, QH and QPS have also developed joint '*Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines*'.<sup>25</sup> These guidelines were developed to provide a process for QH mental health practitioners and QPS officers to effectively manage crisis situations involving mentally ill persons. The guidelines provide for both prevention and intervention measures. Prevention includes the development of individualised "*Crisis Intervention Plans*", which are a mechanism for consumers of mental health services to actively contribute to their treatment in times of crisis and to maximise their health and safety in such circumstances. Intervention measures are specific responses to mental health crisis situations.

A mental health crisis situation is defined as '*a series of events and a combination of circumstances in which a person appears to be mentally disturbed, impaired in judgement and/or exhibiting highly disordered behaviour. It is a situation that may involve serious and imminent risk to the health and safety of the person or another person*'. Further in the document, the mental health crisis situation is referred to as the '*incident*' and the '*scene*' and persons are referred to as being '*on-site*' and '*off-site*', which indicates that the guidelines are intended to apply to an incident that occurs at a specific location.

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<sup>23</sup> An agreement made under s62N of the *Health Services Act 1991* and prescribed in the *Health Services Regulation 2002*.

<sup>24</sup> As defined by s62A of the *Health Services Act 1991*.

<sup>25</sup> Dated 22 June 2006.

The guidelines require that in the management of a mental health crisis situation, primacy should be given to the safety of all persons concerned. However, apart from this requirement, there is no particular reference to the safety and wellbeing of children. There is no specific requirement for determining whether the mentally ill person is a parent and assessing possible risk of harm to their children.

***The SCAN system***

A '*Suspected Child Abuse and Neglect*' (SCAN) system is established under the CP Act to provide for a coordinated response to the protection needs of children.<sup>26</sup>

The Directors-General of QH and DChS and the Commissioner of the QPS are all members of the SCAN system. Representatives of each agency coordinate and attend local SCAN meetings for the purpose of assessing and responding to the protection needs of particular children. Each representative is responsible for sharing information about the child, their family and other relevant persons held by their respective agency, formulating recommendations to DChS for assessing and responding to the child's protection needs, and monitoring the implementation of those recommendations.

There are no specific requirements or obligations in relation to the referral of matters concerning children of parents with mental health issues to the SCAN system.

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<sup>26</sup> Chapter 3, Part 5A, CP Act.

## Part Two: Case Analysis

This Part seeks to address the following Term of Reference:

*Determine whether, in this instance, each of the relevant agencies implemented their cross-agency responsibilities in relation to the deceased child and her siblings*

In my provisional report I made a number of provisional findings about the conduct of the agencies involved in this particular case, pursuant to this Term of Reference.

In response to my provisional report, one of the agencies put forward an argument against these findings, based on its own interpretation of s15AA(4) of the CCYPCG Act.<sup>27</sup> Whilst it was open to me to either accept or reject that argument, I was cognisant that, regardless of any findings I may make about the conduct of the individual agencies in this case, those findings do not directly impact on my ability to review, at a broader level, the systems, policies and procedures of the agencies involved and make recommendations about matters arising from such a review.<sup>28</sup>

I was also cognisant of the HQCC's concurrent investigation and jurisdiction under the HQCC Act to make findings about the quality of health services provided, or that should have been provided, to the father by QH and QPS<sup>29</sup>. In this context there is significant scope for the HQCC to independently examine and make findings about the conduct of the agencies involved in this particular case, which provides an additional accountability mechanism external to my review.<sup>30</sup>

Given all of the above, and in recognition of my paramount statutory obligation to act in a way that promotes and protects the rights, interests and wellbeing of children<sup>31</sup>, I determined that my review report would be at least, if not more, effective in achieving positive systemic change in a timely way if I elected not to retain my provisional findings in relation to the conduct of the agencies in this particular case.<sup>32</sup>

In this Part, I have sought to provide a clear outline of the facts of the case the subject of my review<sup>33</sup> followed by an analysis of those facts against the existing cross-agency framework for assessing, acting on and reporting foreseeable risk

<sup>27</sup> See 'Jurisdiction', p8 of this report, for an explanation of this legislative provision.

<sup>28</sup> Sections 15AA & 31H, CCYPCG Act.

<sup>29</sup> See 'Scope', p9 of this report, for further discussion in relation to HQCC's involvement in this matter.

<sup>30</sup> In this regard, I note that I have referred certain issues that have arisen during the course of my review to the HQCC for its consideration and further action.

<sup>31</sup> Section 17, CCYPCG Act.

<sup>32</sup> Thereby reducing the likelihood that my final review report may be subject to an administrative or legal challenge (which may, in turn, negatively impact on the timely implementation of my recommendations).

<sup>33</sup> As determined by an analysis of the information gathered during my review. See 'Standard of proof and sufficiency of evidence', p11 of this report, for further explanation as to how these facts were determined.

of harm to children of parents with mental health issues. This analysis then informs my subsequent consideration of the adequacy of the existing framework (in Part Three of my report). However, for the reasons outlined above, I have not sought to make any definitive findings arising from this analysis.

The facts are described in chronological order, and separated into three distinct periods of time:

**Table Two: Distinct periods of time the subject of case analysis**

<b>Period of Time</b>	<b>Description</b>	<b>Dates</b>
Admission to hospital	The events leading to the father's admission to the RBWH, and the actions taken upon his admission	8 December 2007
Period of hospital admission	The period of time that the father was admitted to the RBWH for treatment, and the decision to discharge the father	8 to 21 December 2007
Post discharge from hospital	Information that was received by QH and QPS about the father after he was discharged from hospital, but prior to the alleged murder	21 to 31 December 2007

Apart from these periods of time, I also note the following contextual information about the family:

#### ***Contextual information about the family***

- The family was not the subject of current child protection concerns, but was known to DChS.<sup>34</sup>
- The father had six children, two from his first marriage (aged 15 and 18) and four from his second marriage (aged 10, nine, seven and six).<sup>35</sup> His two children from his first marriage did not reside with him at the relevant time.

<sup>34</sup> See 'Scope', p9 of this report, for details of DChS involvement with the family.

<sup>35</sup> See 'Annexure One: Genogram', p39 of this report.

**Admission to hospital: 8 December 2007**

- On 8 December 2007, the father was detained by QPS at a shopping centre after displaying 'manic' symptoms and showing aggression and physical violence towards QPS officers. His four young children were present during the incident.
- The QPS officers attending the incident contacted the CPIU for advice in relation to the children. Based on the CPIU's advice, the QPS officers delivered the children into the care of their paternal grandparents. The CPIU did not subsequently make any referral to the local SCAN team or contact DChS in relation to the children.
- QPS took the father to the RBWH Emergency Department, where it completed an Emergency Examination Order (EEO) under the Mental Health Act.
- The father was reviewed in the Psychiatric Emergency Centre, and a decision was made to admit him to the Mental Health Unit, RBWH, under an Involuntary Treatment Order (ITO). He was assessed at this time as being a risk to himself and others.

**Analysis**

Due to its involvement in the incident at the shopping centre QPS was required to consider whether there was a '*child in need of protection*'<sup>36</sup> and whether this warranted referral to the local SCAN team.<sup>37</sup> From the time of receiving the father in the Emergency Department, QH was obligated to notify DChS if it became aware, or formed a reasonable suspicion, that a child '*had been, is being, or is likely to be harmed*'.<sup>38</sup>

No *formal* assessment or discussion of harm or risk of harm to the children was undertaken by QPS or QH, either independently or jointly. However, each agency undertook some assessment of the information received in relation to the father and, by necessary implication, decided that the information did not require a notification to DChS.

In making this decision, QPS and QH had regard for the following:

- The father had not physically harmed or shown aggression towards the children during the incident;
- Whilst the children were witness to their father's manic symptoms and his aggression and violence towards QPS, there was no information to suggest that the children had suffered any '*detrimental effect of a significant nature on (their) physical, psychological or emotional wellbeing*'<sup>39</sup> as a result of witnessing these;
- The children had been removed from the father's custody and would remain so at least for the period of the father's involuntary admission; and

<sup>36</sup> That is, '*a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; and does not have a parent able and willing to protect the child from the harm*', s10, CP Act.

<sup>37</sup> QPS' OPM, Chapter 6.

<sup>38</sup> Section 191, PH Act.

<sup>39</sup> Definition of '*harm*', s9, CP Act.

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- The father's parents did not report any historical concerns about the father's care and protection of the children.

The father had been assessed by both QPS and QH as posing a risk of harm to himself and others at the time of his admission to hospital. However, there was no information to indicate that the children had suffered harm prior to or during the shopping centre incident and were suffering harm from the father whilst he was admitted to hospital. As such, the issue of whether QPS or QH should have made a referral to the local SCAN team or a notification to DChS at the time of the father's admission turns on the question of whether the children were '*likely to be harmed*'<sup>40</sup> or were at '*unacceptable risk of suffering harm*'<sup>41</sup> in the future ie after the father's discharge.

Obviously, an assessment as to whether the children were at unacceptable risk of suffering harm in the future depended on a clinical assessment of the father's mental state, which was the responsibility of QH. As such, once the father was admitted to hospital, the responsibility for assessing the risk of future harm to the children (and for notifying DChS) also rested with QH. QPS had no further obligations in relation to foreseeable risk of harm to the children.

As to the question of whether there was information that the children were likely to be harmed such as would require QH to make a notification to DChS at the time of the father's admission, I believe there are two valid and competing arguments in relation to this issue.

On the one hand, it could be argued that the information *did* indicate that the children were likely to be harmed in the future, for the following reasons:

- There was no information that the children would *not* be returned to the custody of the father once he was discharged.
- Further, there was no information that the father would *not* experience another manic episode of his mental illness after he was discharged.
- If a manic episode recurred, the father would, by logical reasoning, pose a risk of harm to himself and others at that time.
- If a recurrence of a manic episode was 'likely' (ie because of the nature of the father's mental illness) then, by logical reasoning, the risk of harm to the children in the future must also be assessed as 'likely'.



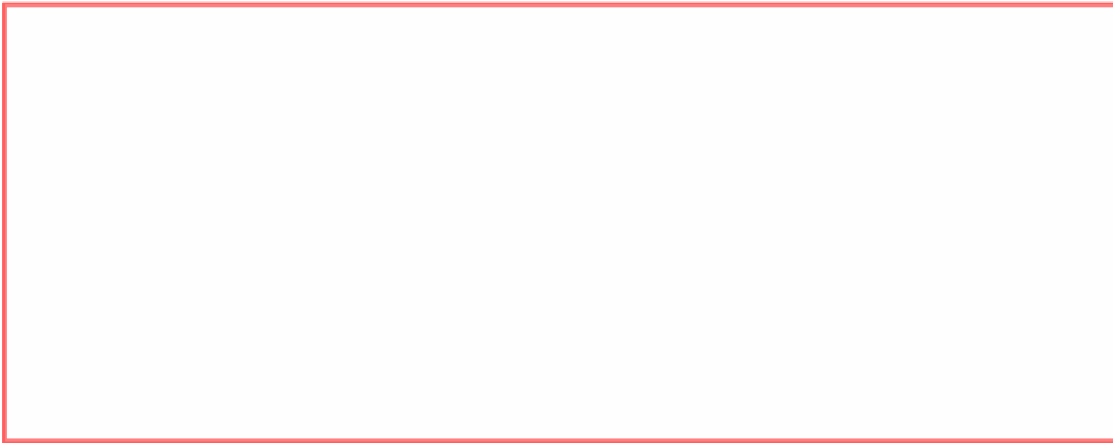
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<sup>40</sup> Section 191, PH Act.

<sup>41</sup> Section 10, CP Act and QPS' OPM, Chapter 7.

<sup>42</sup> See 'Scope', p9 of this report.

<sup>43</sup> As evidenced by QH's '*Report of a Reasonable Suspicion of Child Abuse and Neglect*' faxed to DChS on 1 November 2006.



I further acknowledge the following:

- The argument that a notification was required in this case hinges on whether a recurrence of a manic episode of the father's mental illness was 'likely'.
- It may not have been appropriate or possible to make an assessment as to whether a recurrence was 'likely' until after appropriate treatment and assessment, over the period of the father's hospital admission.
- If it could be said that a recurrence of the father's manic episode was 'likely', due purely to the nature of his mental illness, this may be counter to QH's clinical assessment at the time of the father's discharge that he did not pose a risk to himself or others and that he was likely to comply with his treatment plan.

This argument can not be fully considered without making determinations about clinical matters. For the reasons noted earlier in my report in relation to the HQCC's terms of reference for its concurrent investigation<sup>44</sup>, I do not propose to make determinations about clinical matters.

On the other hand, it could be argued that the information *did not* indicate that the children were likely to be harmed in the future, for the following reasons:

- Parental mental illness is a risk factor for child abuse and neglect. However, with appropriate treatment and support, a parent with a mental illness may be capable of meeting their child's care and protective needs.
- In such circumstances, it is not appropriate to say that a child is 'likely' to be harmed because of their parent's mental illness. Rather, it is more appropriate to say that, whilst the child is not *likely* to be harmed (provided the parent is capable of meeting the child's care and protective needs), they are at *greater risk* of harm than a child whose parent does not have a mental illness.

In consideration of these two valid, competing arguments and the lack of clarity in relation to this issue, and consistent with my decision that my report will not make findings about the conduct of each of the agencies in this case, I do not propose to make a definitive determination in relation to whether the information received by QH at the time of the father's admission indicated that the children were at risk of harm, such as would require a notification to DChS.

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<sup>44</sup> See 'Scope', p9 of this report.

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Rather, I believe an examination of this issue in the context of the broader multi-agency framework, in Part Three of my report, will better inform my consideration of appropriate recommendations to promote better outcomes for children of parents with mental health issues in the future.

***Period of hospital admission: 8 to 21 December 2007***

- During the father's admission, QPS had contact with the hospital on two further occasions – to clarify QPS' interest in the father, and to serve a 'Notice to Appear' on the father (for charges arising from the shopping centre incident). No discussions occurred between QPS and hospital staff in relation to the father's children.

- Nursing staff observed one occasion where the father was visited by his young children. No concerns were raised by nursing staff in relation to the father's behaviour towards the children during this visit.

- The psychiatric treating team understood (correctly) that the father would not have access to his children during his periods of temporary leave, as they were away on holiday with the father's parents.

- After a period of weekend leave, the psychiatric treating team reviewed the father and decided to discharge him from hospital. The psychiatric treating team based this decision on their clinical assessment that the father's mental state was 'stable', that he was 'likely' to comply with his treatment plan, and that he did not pose a risk of harm to himself or others at that time.

- The availability of resources was not a factor in the decision to discharge the father. The psychiatric treating team understood that there was a surplus of available beds and an adequate supply of staff at that time.
- The psychiatric treating team did not revoke the ITO upon the father's discharge. Rather, the team decided to continue the ITO as a 'community based' order. The rationale for this decision was that this would allow the father to be monitored and brought back to hospital involuntarily if he suffered another manic episode.
- The treatment plan under the ITO required the father to comply with his medications, abstain from using illegal drugs and return for an assessment by a member of the psychiatric treating team.
- The assessment date was initially proposed for ten days after discharge. However, the psychiatric treating team agreed to postpone the assessment date for a further seven days upon the father's request as he had booked a holiday at Bribie Island with his children and would find it difficult to travel back to Brisbane for an appointment during that time.
- The father was discharged from hospital on 21 December 2007 and his parents returned the young children to his care the day following his discharge, 22 December 2007.
- The father's parents were not informed of the father's diagnosis, the decision to discharge the father or the conditions of his treatment plan.

### **Analysis**

During the period of the father's admission and upon his discharge, QH was obligated to notify DChS if it became aware, or formed a reasonable suspicion, that a child '*had been, is being, or is likely to be harmed*'.

No *formal* assessment or discussion of risk of harm to the children was undertaken by QH. However, QH clearly conducted ongoing clinical assessments of the father during his admission and, by necessary implication, decided that the information gathered during these assessments did not require a notification to DChS.

In making this decision, QH had regard to the following:

- Collateral information received from a number of sources including QPS, family members and other significant persons in the father's life, as well as observations by nursing staff of interactions between the father and his young children on the ward, did not raise any concerns about the father's parenting ability or behaviour towards the children.
- Further collateral information received by QH indicated that, during discussions with his psychiatric treating team, the father spoke very lovingly and positively about his children.
- At the time of discharge, QH made a clinical assessment that the father's mental state was 'stable', that he was 'likely' to comply with his treatment plan, and that he did not pose a risk of harm to himself or others at that time.

Certainly, the collateral information received by QH in relation to the father did not indicate any concerns in relation to the father's parenting ability or behaviour towards his children. It was reasonable to assess that this information, in and of itself, did not indicate harm or likely harm to the children.

Again, the issue of whether QH should have made a notification to DChS during the period of the father's admission or upon his discharge turns on the question of whether the children were '*likely to be harmed*' in the *future* ie after the father's discharge. I again note the two valid and competing arguments in relation to this question.<sup>45</sup> For the same reasons as previously given, I do not propose to make a definitive determination in relation to this issue.

Rather, I believe an examination of this issue in the context of the broader multi-agency framework will better inform my consideration of appropriate recommendations to promote better outcomes for children of parents with mental health issues in the future.

#### ***Post discharge from hospital: 21 to 31 December 2007***

- The father and his young children left for their holiday at Bribie Island on 29 December 2007, but returned to Brisbane the following day, 30 December 2007.

<sup>45</sup> As discussed previously in this Part, under '*Admission to hospital: 8 December 2007*', pp21-24 of this report.

- Also on 31 December 2007, QPS received information about a man and four young children trespassing in a private swimming pool at a Bribie Island residence, with the man stating that he had been conducting a 'baptism' and making other religious references. QPS conducted searches for the man and the children but were unable to locate them. QPS did not contact DChS in relation to the incident. (The Commission's review has evidence indicating that the father and his children had returned to Bribie Island sometime in the evening of 30 December or on the morning of 31 December, and that the man and children involved in this incident were the family the subject of this review).
- There was no further information received by QPS, QH or any other agencies in relation to the family prior to the alleged murder.

**Analysis**

On each occasion that information was provided to QPS about the father after his discharge from hospital, QPS was required to consider whether there was a

'child in need of protection'<sup>46</sup> and whether this warranted referral to the local SCAN team.<sup>47</sup>

Lack of supervision is an indicator of neglect, which may result in harm to a child as defined by the CP Act. Parental mental illness is an indicator of parental incapacity or dysfunction, which may support an assessment that a child does not have a parent able and willing to protect a child from harm. As such, this information, on its face, did indicate that there may be children in need of protection.<sup>48</sup>

The QPS officers involved in assessing, acting on and reporting the information from the father's parents all understood that the matter should be referred to the CPIU for further assessment and appropriate action, in accordance with normal QPS practice. However, this referral was not made, for the following reasons:

- After initially making one unsuccessful attempt to speak directly with officers from the CPIU (who were unavailable), the QPS officer who was directly involved in receiving the information from the father's parents and responsible for referring the information to the CPIU then assumed that the officers who were tasked with conducting the search would subsequently make a referral to the CPIU if required (presumably after conducting the search).
- The QPS officers who conducted the search assumed that the CPIU would have already received information about the incident and would take appropriate action, including further action to locate the family and/or refer the matter to the SCAN team or otherwise notify DChS.

<sup>46</sup> That is, 'a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; and does not have a parent able and willing to protect the child from the harm', s10, CP Act.

<sup>47</sup> QPS' OPM, Chapter 7.

<sup>48</sup> In its response to my provisional report, QPS advised that it was unable to support my opinion that this information did, on its face, indicate that there may be children in need of protection. QPS advised as follows: 'What amounts to a lack of supervision is dependant upon known existing circumstances. There is no evidence to conclude the children lacked supervision or an appropriate level of care on or about 31 December 2007.' Whilst I acknowledge that the information provided to QPS on 31 December 2007 did not indicate harm or likely harm commensurate with the level of harm that was subsequently suffered by the child who was allegedly murdered by her father, the information did indicate that the children were being left unsupervised. In my opinion, this is evidence of lack of supervision which is an indicator of neglect. This information, coupled with the information that the father was incapacitated due to a deterioration in his mental state and was therefore not 'able and willing to protect' the children from harm (a point which QPS did not challenge in its response to my provisional report), did, in my opinion, indicate that there may be children in need of protection.

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As previously discussed, I do not propose to make any findings in relation to the conduct of QPS in this instance. However, I note that whilst a referral to the CPIU may have triggered additional investigative processes that may have resulted in one of the agencies locating the father and children prior to the alleged murder, this was not a likely outcome.

In relation to the information received by QPS concerning the swimming pool incident at Bribie Island on 31 December 2007, the persons who informed QPS of the incident also advised that the man was not aggressive but had '*obviously lost the plot*', and that the children in his care did not seem scared or upset but were '*cold and wet*'.

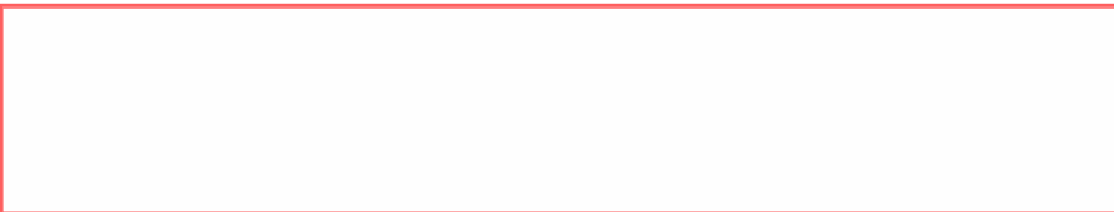
Because it had no identifying information in relation to the man or the children, QPS determined that a referral to DChS was not required, as it would not be '*relevant or useful*'.

On my examination of the evidence obtained by my review in relation to this incident, it appears that:

- QPS made reasonable attempts to locate the man and four young children.
- At no time was any information obtained by QPS that could have reasonably lead to QPS being able to identify the father and the children.
- Whilst the information was sufficient to raise a reasonable suspicion that the children may be in need of protection (due to indications that the man may be incapacitated because of mental health issues), QPS did not have sufficient identifying information to enable a referral of the matter to DChS.

However, as previously discussed, I do not propose to make any findings in relation to the conduct of QPS in this instance.

On each occasion that information was provided to QH about the father after his discharge from hospital, QH was obligated to notify DChS if it became aware, or formed a reasonable suspicion, that a child '*had been, is being, or is likely to be harmed*'.



In considering whether there was information that the children had been, were being or were likely to be harmed such as would require QH to make a notification to DChS, I note the following:

- At the time of the father's previous manic episode and admission to hospital on 8 December 2007, QH assessed that the father posed a risk to himself and others.
- At the time of receiving information on 31 December 2007 that the father had experienced a significant decline in his mental state, QH had information about his previous manic episode and assessment, and also had information that the father was a sole parent of four young children.

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- By logical reasoning, the only assessment that could be made in relation to this information is that it was likely that the father again posed a risk to himself and others and that, therefore, the children who were in his care were *'likely to be harmed'*.
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Given the above, it appears that there is evidence that the information provided to QH on 31 December 2007 did indicate that the children had been, were being and were likely to be harmed, and therefore did require a notification to DChS.

As previously discussed, I do not propose to make any findings in relation to the conduct of QH in this instance. However, I note that whilst different assessments and actions may have triggered additional investigative processes that may have resulted in one of the agencies locating the father and children prior to the alleged murder, this was not a likely outcome.

### Part Three: Adequacy of existing framework

This Part seeks to address the following Term of Reference:

*Determine whether there is an existing framework for establishing multi-agency responses to address foreseeable risk of harm to children of parents with mental health issues in the future*

Based on my review of the current framework and my analysis of the case the subject of my review, I make the following observations:

#### **Child-focussed assessments and responses**

- There is currently no framework within Queensland for establishing multi-agency responses to specifically address the safety and wellbeing of children of parents with mental health issues, particularly where the parent is the primary recipient or focus of a service (eg the adult mental health service provided by QH or the law enforcement service provided by QPS). There is only a general statutory requirement for health professionals to notify DChS where there is a suspicion that a child *'has been, is being or is likely to be harmed'* and a policy within QPS for referring matters concerning *'children in need of protection'* to a SCAN team.
- Whilst there was some assessment of the safety of the children in the case the subject of my review, this assessment was based only on information received in a passive, incidental way and was not child-focussed. The framework in which the relevant officers of QH and QPS were operating did not require them to actively seek further information in relation to the children or take any preventative action to promote their safety and wellbeing into the future, despite the fact that they were in a recognised category of children who are at greater risk of child abuse and neglect.
- At the time of the father's discharge from hospital, the clinical assessment was that he did not pose a risk of harm to himself or others and was likely to comply with his treatment plan. Because of this clinical assessment, the information held by QH at the time of the father's discharge may not have indicated that the children were at risk of harm such as would require a referral to DChS. Further, the MH Act does not provide for the commencement or continuation of involuntary treatment based solely on risk. That is, involuntary detention under the MH Act can not be used as a mechanism for reducing or preventing harm to children of parents with a mental illness.
- The risk to the children in this case was further increased by the fact that the father was a sole parent, that is, there was no other adult responsible for the care and protection of those children. The father did receive significant support from his parents to care for the children, but the father's parents did not reside with the father and were not able to independently observe whether the children's care and protective needs were being met or take action in relation to the children independent of the father's wishes.

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- It appears that this was a case where the outcome may have been different only if there was a framework in place for prevention and early intervention in relation to children of parents with a mental illness, and where the framework specifically recognised and addressed the special risks posed to children where the parent with a mental illness is a sole parent.<sup>49</sup> Whilst significant research would need to inform the development of such a framework, I envisage that it would likely require specific legislative obligations and powers, supported by multi-agency policies, procedures, education and training.

### ***Current initiatives in other jurisdictions***

- Significant work has been undertaken in other jurisdictions in relation to children of parents with a mental illness, including:
  - The ‘*National Practice Standards for the Mental Health Workforce*’, Commonwealth Department of Health and Ageing, 2002, which specifically recognise the rights and needs of children of parents with a mental illness and require practitioners and service providers to work in ways that protect and promote these rights and needs.
  - The paper ‘*Principles and Actions for Services and People Working with Children of Parents with a Mental Illness*’, Commonwealth Department of Health and Ageing, April 2004, which provides guidelines for how to meet the national practice standards in relation to children of parents with a mental illness.
  - The ‘*Children of Parents with a Mental Illness (COPMI) Resource Centre*’ (<http://www.copmi.net.au/>), an initiative developed as a result of the aforementioned Commonwealth paper, which provides tools and information for working with families and children of parents with a mental illness.
  - ‘*The COPMI Project*’ undertaken by the Office of Mental Health, Western Australia, which was completed in July 2006 and led to the development of cross-agency protocols for working with children of parents with a mental illness.

### ***Informing and engaging children***

- The facts of this case lend weight to the proposition that children of parents with a mental illness, regardless of age, should be given information about their parent’s mental illness and involved in the development of a safety plan for times when their parent becomes ill, *particularly where the parent is a sole parent*. This argument is further supported by current legislative provisions in relation to administration of child protection matters, which recognise that a child should be kept informed of matters affecting him or her in a way and to

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<sup>49</sup> In response to my provisional report, DChS expressed the view that ‘*The case arose from an isolated, unforeseeable event, and although considered tragic, the Department is of the view that no amount of quality practice or frameworks for promoting the safety and wellbeing of children of parents with a mental illness would have made a difference in this particular case*’. With respect, I disagree with this view. I intend to discuss my final report directly with the Director-General of DChS, with a view to promoting DChS’ understanding of my review and recommendations and its commitment to the implementation of those recommendations that require DChS’ involvement.

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an extent that is appropriate, having regard to the child's age and ability to understand.<sup>50</sup>

### **Confidential information**

- Health professionals in this case provided evidence that statutory confidentiality requirements were a barrier to providing information to the father's parents in relation to his mental illness and treatment plan. This is despite the fact that the health professionals were aware that the father's parents had significant involvement in the lives of the father and the children, including providing care for the children.
- Part 7 of the *Health Services Act 1991* (HS Act) imposes a duty of confidentiality on QH officers in relation to disclosure of information that could identify a person who is receiving or has received a public sector health service. Such information is called '*confidential information*'.
- The provision of confidential information to a person's support network and children would form a necessary requirement of a framework for prevention and early intervention in relation to the safety and wellbeing of children of parents with a mental illness.
- There are currently a number of exceptions to the confidentiality requirement contained in the HS Act, including:
  - Where the person gives consent.<sup>51</sup>
  - Where the person is a child and the disclosure of the confidential information is by a health professional who reasonably believes the disclosure is in the child's best interests.<sup>52</sup>
  - If the confidential information is communicated by a health professional to a person who, in the health professional's reasonable opinion, has a sufficient personal interest in the health and welfare of the person to whom the information relates (eg a spouse, child or parent)<sup>53</sup>; provided that person has not asked that the confidential information not be disclosed generally or to the person who has a personal interest.<sup>54</sup>
  - If the Director-General of QH believes, on reasonable grounds, that the disclosure is necessary to assist in averting a serious risk to the life, health or safety of a person or to public safety, and provided the Director-General has authorised the disclosure in writing.<sup>55</sup>
- Each of the above exceptions have significant limitations. For example:
  - Whilst one of the exceptions recognises the paramount importance of the best interests of a child, that exception only applies to confidential information about that child, not about the parent of that child.

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<sup>50</sup> Section 5(2)(g), CP Act and s185(2)(e), PH Act.

<sup>51</sup> Section 62C(a), HS Act.

<sup>52</sup> Section 62C(d), HS Act.

<sup>53</sup> Section 62D(1)(b), HS Act.

<sup>54</sup> Section 62D(3), HS Act.

<sup>55</sup> Section 62I, HS Act.

- Whilst the 'sufficient personal interest' exception is potentially fairly broad, it may only be used in cases where the person to whom the confidential information relates has not asked that the information not be disclosed.<sup>56</sup> In other words, this exception does not give paramount importance to the safety or wellbeing of a child (similarly with the 'consent' exception).
- Whilst there is an exception relating to the life, health and safety of a person, the threshold above which this exception operates is quite high (ie a 'serious risk') and requires written authorisation by the Director-General.
- Recent coronial findings about child deaths<sup>57</sup> have identified instances where the disclosure of confidential information to family members, carers or other relevant persons may be required for the care and protection of a child.
- Further, I note that the principles for administering the SCAN system under the CP Act include the principle that, because a child's welfare and best interests are paramount<sup>58</sup>, *'their protection and care needs take precedence over the protection of an individual's privacy'*.<sup>59</sup>
- Given all of the above, it would appear that there is an argument for *'the care and protection needs'* or the *'best interests'* of a child to be a specific statutory exception to the confidentiality requirement contained in the HS Act, so as to allow for the provision of confidential information to a person's children, other family members, support network and other relevant persons in such circumstances.<sup>60</sup> Significant support would need to be provided to health professionals and other relevant service provider officers (including guidelines, education and training), so as to promote understanding and ensure best practice in relation to the use of the exception.

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<sup>58</sup> The overriding principle for administration of the CP Act.

<sup>59</sup> Section 159B(f), CP Act.

<sup>60</sup> I note that in its response to my provisional report, QH asked that this part of my report dealing with the release of confidential information should also mention s159O of the CP Act, which provides an exception for designated persons to be able to provide confidential information about the *'protection or welfare'* of a child to a police officer, an authorised officer, the chief executive of DChS or the Children's Court. QH further suggested that *'the current exceptions (contained in the HS Act), together with the provision in the CP Act, provide a detailed framework for providing information to family (including children), friends and authorities'*, and that it is *'more accurate to say that the legislative framework may not be fully understood by health professionals who make time-critical decisions, rather than that the framework is inadequate'*. In this regard, I note that s159O of the CP Act does not provide for release of confidential information to a person's children, family, support network or other relevant persons. As such, it does not assist in my consideration of the adequacy of the current framework for providing confidential information to a person's family and support network which, as this case demonstrates, is a crucial requirement for prevention and early intervention in relation to children of parents with mental health issues. In my opinion, for the reasons noted above in relation to the current exceptions to the duty of confidentiality, the current framework is not adequate. However, for balance, I note that QH did agree that *'there is merit in the inclusion of a specific exception to allow disclosure of confidential information for ensuring the protection and welfare of a child'* and that QH proposes to conduct a review of the duty of confidentiality with a view to including such an exception.

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- In this regard, I note the current '*Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines*' between QH and QPS, which provide clear and specific guidelines for agency officers in relation to how confidential information can be shared between agencies so as to adequately respond to mental health crisis situations. It is possible that this document could inform the development of a similar inter-agency agreement for assessing, acting on, reporting and sharing information about children of parents with a mental illness, particularly where the parent is the primary recipient or focus of a service. Such guidelines should focus on the provision of information to and involvement of the person's children, other family members, support network and other relevant persons.

### **Current QH initiatives**

- One of the QH Health Service Districts has initiated a district-wide program to support children of parents with a mental illness, informed by the national 'COPMI' initiatives. A state-wide COPMI conference was also conducted in 2007.
- After commencement of my review, and in consultation with me, QH took steps to provide for interim measures to address the safety of children of parents with a mental illness. Specifically, the Director, Mental Health Services, QH, issued a directive to all authorised mental health services within QH, requiring them to conduct certain assessments in relation to children of parents with a mental illness and develop child care plans to ensure the safety and wellbeing of those children.<sup>61</sup>
- During the course of my review QH advised that '*additional resources to support mental health service providers to meet the needs of children of parents with a mental illness (COPMI) will be developed as part of a two-year project to develop and implement a Queensland framework for responding to the program development needs for COPMI*'. QH advised that it anticipates that this project will commence in early 2008.<sup>62</sup>
- In response to my provisional report, QH advised of the following further initiatives undertaken to date:
  - A number of other QH Health Service Districts have also commenced various district-wide COPMI programs for supporting children of parents with a mental illness.
  - QH is currently developing a policy, '*Promoting the protection needs of children with whom a person with a mental illness has care, custody or access to in their place of residence*', which will provide assessment and

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<sup>61</sup> QH Memorandum '*Policy relating to mental health patients and child safety issues*', 4 January 2008.

<sup>62</sup> Further details in relation to this project and the development of a statewide COPMI coordinator position were provided by QH in response to my provisional report. I particularly note QH's advice that the job description for the coordinator position has been revised to '*ensure a strong focus on improving adult mental health service responses to COPMI issues*'. This is consistent with my review, which has identified that improvements to service delivery to children of parents with mental health issues is most needed in circumstances where the parent is the recipient or focus of the service (eg within adult mental health services).

planning tools for promoting the protection needs of this group of children.

- The QH Mental Health Branch and Maternity, Child Health and Safety Branch are developing fact sheets and supporting the implementation of mandatory training on forming a reasonable suspicion of child abuse and neglect and supporting children of parents with a mental illness.
- The RBWH Mental Health Service has developed a draft '*Guideline for Identifying Potential Child Safety Issues*', which prompts mental health clinicians to consider whether a patient has children in their care, identify any child protection concerns, obtain collateral information regarding care arrangements and consider this information in the development of the patient's treatment and discharge plan.
- A series of reforms are currently underway in relation to the QH forensic mental health system, as a result of a recent review of the MH Act in 2006 and informed by previous inquiries and coronial matters. These reforms are aimed at enhancing risk management of forensic patients.
- Whilst these initiatives may go some way to promoting the safety and wellbeing of children of parents with a mental illness, particularly within QH, they do not establish a holistic framework within Queensland for establishing multi-agency responses to specifically address the safety and wellbeing of these children.

## Part Four: Recommendations

This Part seeks to address the following Term of Reference:

*Make any necessary findings and recommendations*

Whilst this Term of Reference encompasses both findings and recommendations, for reasons explained earlier in my report<sup>63</sup>, I do not propose to make any specific findings in relation to the conduct of the agencies in this particular case.

Instead, I have reviewed the adequacy of the existing framework for establishing multi-agency responses to address foreseeable risk of harm to children of parents with mental health issues in the future.

In this Part of my report I make recommendations about matters arising from my review<sup>64</sup>.

### Recommendations

#### **Recommendation One:**

That QH, QPS and DChS immediately coordinate the following interim cross-agency measures to address the safety and wellbeing of children of parents with mental health issues:

- Distribution of educational material to front line officers who have responsibility for assessing, acting on and/or reporting information that may concern persons with mental health issues who have children, to promote a better understanding of how parental mental illness may impact on children of parents with a mental illness.
- Interim guidelines for front line officers for exchange of information between agencies specifically in relation to children of parents with mental health issues, including '*confidential information*' under the *Health Services Act 1991*.<sup>65</sup>

#### **Recommendation Two:**

That QH initiates a legislative review of the confidentiality provisions of the *Health Services Act 1991* to establish whether there is a need for a specific statutory exception that recognises '*the care and protection needs*' or the '*best interests*' of a child. The review should be informed by this report, as well as any recent child deaths known to QH (including coronial inquiries) where issues were identified concerning disclosure of '*confidential information*'.

<sup>63</sup> See '*Jurisdiction*', p8, and '*Part Two: Case Analysis*', p19 of this report.

<sup>64</sup> Pursuant to s31H of the CCYPCG Act.

<sup>65</sup> The educational material and guidelines should be specific, concise and easily accessible by all front line officers eg through access to an intranet or internet resource or in poster or leaflet format.

**Recommendation Three:**

That QH undertakes a state-wide project in relation to children of parents with a mental illness, with the purpose of ensuring that QH meets its responsibilities towards children of parents with a mental illness pursuant to the 'National Practice Standards for the Mental Health Workforce'.

**Recommendation Four:**

- (a) That the Child Safety Directors and/or appropriate representatives of QH, QPS, DChS and CCYPCG establish a multi-agency Working Party<sup>66</sup>, to develop a multi-agency framework for promoting the safety and wellbeing of children of parents with mental health issues in the future, informed by this report.
- (b) That the Working Party consult with and/or otherwise involve the HQCC in the development of the framework.

**Timeframes and Reporting**

The above recommendations require urgent and timely action in order to reduce potential risks for children of parents with mental health issues who may otherwise not benefit from the above initiatives.

As such, I request that the agencies immediately action the recommendations and provide a report to the responsible Minister, with information to satisfy the Minister that the recommendations have been implemented. I request that these reports are made within the following timeframes:

<b>Recommendation</b>	<b>Timeframe (from the date of this report)</b>
One	Within three months
Two	Within three months
Three	Within six months
Four	Within three months

I also request that a copy of the agencies' reports on the recommendations are provided to me, so that I may provide final advice to the Premier.

<sup>66</sup> In its response to my provisional report, QH suggested that 'the implementation of the proposed action may be expedited by referring it to the existing Child Safety Directors Network, with an extended membership, rather than establishing a new working group'. Whilst I agree with this approach, I am mindful that I can only make recommendations to a 'relevant service provider' as defined by s31B of the CCYPCG Act. In my view, the Child Safety Directors Network is not a 'relevant service provider', hence why my recommendation is framed in this way.

**Annexure One: Genogram**



