



Child Death Case Review Committee

**Submission to the Queensland Child Protection
Commission of Inquiry**

SUITABLE FOR PUBLIC RELEASE

September 2012



commission for
children and young people
and child guardian

Level 17, 53 Albert Street, Brisbane Qld 4000
PO Box 15217, Brisbane City East Qld 4002
Ph: 07 3211 6700 Fax: 07 3035 5900
www.ccydpcg.qld.gov.au

28 September 2012

The Honourable Tim Carmody SC
Commissioner
Queensland Child Protection Commission of Inquiry
PO Box 12196 George Street
BRISBANE QLD 4003

Dear Commissioner

Please find attached the formal submission from the Child Death Case Review Committee (the CDCRC) to the Commission of Inquiry into Queensland's Child Protection System (CIQPS).

A number of confidential case studies have been included as appendices to this submission (confidential appendices 3–8) to provide detailed evidence of issues identified by the CDCRC. While the CDCRC is supportive of the submission being uploaded on to the CIQPS website, the confidential appendices cannot be publicly released as they contain confidential information about deceased children and their families.

To facilitate the public release of this submission, the CDCRC has provided one version with confidential information included and a second version with the confidential information removed.

Yours sincerely

Elizabeth Fraser
Chairperson
Child Death Case Review Committee

enc

Key Messages

The child death case review jurisdiction emerged from the child protection system failures highlighted by the Queensland Ombudsman in its 2001 and 2003 investigations into the deaths of Brooke Brennan (aged 3 years) and baby “Kate” (aged 10 weeks). These investigations highlighted critical failings in both the government’s service delivery and internal child death review processes. The Ombudsman’s findings and recommendations were reinforced, contextualised and strengthened in the findings of the 2004 Crime and Misconduct Commission report *Protecting children: an inquiry into abuse of children in foster care*, which made recommendations that led to the establishment of the Child Death Case Review Committee (the CDCRC).

The cases reviewed by the CDCRC demonstrate the ongoing need for independent scrutiny to be applied to child death reviews. The child death jurisdiction enables the CDCRC to identify and respond to cases where there has been a link identified between the child’s death and the Department’s service delivery. Prior to the establishment of the CDCRC, professional learnings from analysis of these cases would have been lost and departmental accountability would only have occurred through establishing one-off processes. While the Department now has a better established internal review process, in some cases the CDCRC continues to raise concerns about the sufficiency of analysis being undertaken by the Department, and therefore recommends that independent scrutiny of departmental reviews should remain a key element of oversight of the child protection system.

While the capacity of the Department to conduct child death reviews has increased since 2004, the CDCRC findings demonstrate that the quality of the Department’s reviews remains variable and that there is an ongoing need for external scrutiny. Without the independent reviews conducted by the CDCRC, serious service system failures may be overlooked, or endorsed as appropriate practice.

The CDCRC provides an efficient and effective value-add to the oversight of child protection service delivery. Its reviews provide clarity about service system links to deaths and help shed light on the need for improvements.

The reviews conducted by the CDCRC provide the families and friends of children who have died, the notifiers who referred concerns about the children’s safety during their lifetime, as well as the general public, confidence that the service delivery to the deceased children will be reviewed, and that any issues will be identified and responded to.

This submission provides information about the child death case review jurisdiction in Queensland, and in particular the role of the Child Death Case Review Committee (CDCRC). It highlights the findings made by the CDCRC in recent years and outlines some key service delivery areas which the CDCRC has identified that require strengthening, including:

- Intake
- Investigation and Assessments
- service delivery to Aboriginal and/or Torres Strait Islander children and young people
- service delivery to pregnant women and their unborn children
- service delivery to children and young people with mental health issues, and
- service delivery to children and young people with disabilities.

Additionally, the submission provides options about how the jurisdiction could be refined to better focus resources on complex cases where the Department of Communities, Child Safety and Disability Services (the Department) had involvement or should have had involvement with the child.

A number of confidential case studies have been included in appendices at the end of the submission (**Confidential Appendices 3–8**) to provide detailed evidence of the seriousness of the issues identified by the CDCRC and the complexity of the cases. Due to the sensitive and identifying nature of the information contained in the case studies, the confidential appendices are not for public release.

Some of the service delivery areas referred to in this submission are reported on in detail in the CDCRC Annual Report 2011–12, which is due to the Minister for Communities, Child Safety and Disability Services by 31 October 2012 and is to be tabled in parliament within 14 sitting days after that date. Additionally, the CDCRC will proactively release individual summaries of all cases reviewed during the 2011–12 reporting period on its website to coincide with the tabling of its Annual Report.

A copy of the CDCRC Annual Report 2011–12 and details of how to access all summary reports will be provided to the Queensland Child Protection Commission of Inquiry once the Annual Report has been tabled in parliament.

The Queensland child death case review jurisdiction

Queensland has a mandated two-tiered child death case review jurisdiction which provides the Queensland public and government with a strong accountability framework. The framework requires the Department to conduct reviews of all child deaths where the child was known to the Department within the three years prior to their death (the first tier), and for this review to undergo rigorous, independent scrutiny by an externally appointed multi-disciplinary committee chaired by the Commissioner for Children and Young People and Child Guardian (the Children's Commissioner). The CDCRC constitutes the second tier.

The child death case review jurisdiction emerged from the child protection system failures highlighted by the Queensland Ombudsman in its 2001 and 2003 investigations into the deaths of Brooke Brennan (aged 3 years) and baby "Kate" (aged 10 weeks). These investigations highlighted critical failings in both service delivery and the Department's internal child death review processes. The Ombudsman's findings and recommendations were reinforced, contextualised and strengthened in the findings of the 2004 Crime and Misconduct Commission report, *Protecting children: an inquiry into abuse of children in foster care*, which made recommendations that led to the establishment of the CDCRC.

The CDCRC consists of the Children's Commissioner as Chair, the Assistant Children's Commissioner and seven appointed members with expertise in the fields of mental health, paediatrics, youth justice and social work, as well as a representative from the Queensland Police Service and Aboriginal and Torres Strait Islander cultural representatives.

The Department is required to conduct an internal child death case review (the Department's review) about its involvement with a child if in the three years prior to their death, the Department:

- became aware of alleged harm or alleged risk of harm to the child, or
- took action under the *Child Protection Act 1999* (the Child Protection Act) in relation to the child, or
- before the child was born, reasonably suspected that the child might be in need of protection after he or she was born.

The Department decides the terms of reference of its review, which can include consideration of any of the following:

- compliance with legislation and policies
- adequacy and appropriateness of the Department's involvement with the child and child's family
- sufficiency of the Department's involvement with other entities in the delivery of services to the child and the child's family
- adequacy of legislative requirements and the Department's policies relating to the child, and
- recommendations relating to the above and strategies to put into effect the recommendations.¹

The CDCRC considers all of the Department's reviews by assessing them against a set of gazetted review criteria that are required by the *Commission for Children and Young People and Child Guardian Act 2000* (the CCYPCG Act) to be developed in collaboration with the Department (**see Appendix 1**). These review criteria consider:

- service system actions/inactions linked to the child's death
- risk factors relevant to the child's death
- service system issues identified as adversely affecting the child
- recurring risk factors and service system issues, and
- the quality of the Department's review.

The level of the Department's involvement with the children reviewed by the child death case review jurisdiction ranges from minimal contact (responding to the death incident) to significant involvement over many years.

Since its inception, the CDCRC has reviewed the deaths of 456 children and young people. The focus of the CDCRC from 2004 to 2008 was building the capacity of the Department to conduct reviews. Much of the CDCRC's early review work confirmed failings evident in the Ombudsman's and CMC's reports. In 2008 a review of the child death case review jurisdiction was conducted. The review acknowledged that the capacity of the Department to conduct reviews had increased since 2004. As a result the CDCRC developed revised review criteria, which are still in place today.

One of the key responsibilities of the CDCRC is to identify if there have been any instances in which the Department's actions or inactions may have been linked to the death of a child, and to ensure that service system issues are able to be promptly addressed. The CDCRC's findings in relation to such cases are discussed in more detail below.

¹ Section 246B (1) and (2) of the *Child Protection Act 1999*

While a child death review involves a detailed assessment of service delivery provided to a particular deceased child, the CDCRC collates its findings for every case and uses this evidence to make broader recommendations aimed at strengthening service delivery across the Department.

A further strength of the CDCRC is that it collates data from the qualitative analysis of service delivery to the children and young people within its jurisdiction. The collated data provides a greater understanding of the reasons behind some of the service delivery issues. This information enables the CDCRC to make effective recommendations which are better able to address the reasons behind the service delivery issues. A discussion of some of the key service system issues identified by the CDCRC in recent years is outlined below and will also be discussed in the CDCRC Annual Report 2011–12 to be tabled in parliament after 31 October 2012. A copy of this report will be forwarded to the Commission of Inquiry once it has been tabled.

Findings of the Child Death Case Review Committee

Action or inaction of the Department linked to the death

A predominant focus of the CDCRC's review criteria is identifying those cases where there may be a link between the actions/inactions of the Department and the child's death.

A link may be identified by the CDCRC if it believes the following circumstances occurred:

- the Department knew or should have known about the significant child protection concerns, and
- the Department did nothing or acted inadequately to ensure the safety of the child, and
- significant level of risks associated with the child continued or escalated until the child's death, and
- there is no reasonable excuse why the Department did not adequately protect the child, and
- the child may not have died if the Department had discharged its obligations.

When deciding whether to make the finding of a link at review criterion 1, the CDCRC also considers the family's and child's engagement with, or resistance to, the Department's service delivery.

Where the CDCRC finds a link between the actions or inactions of the service system and the child's death, the CDCRC's focus is on the accountability of the service system to respond appropriately.

Since the commencement of the review criteria in November 2008 the CDCRC has identified two cases in which it found the service system actions/inactions were linked to the death of a child. In both of these cases, the departmental reviews had identified serious deficiencies in its service delivery, however, they did not identify a link between the Department's actions or inactions and the death of either child. In one case the child died as a result of suicide. In the other case, the child died from a treatable disease (**Confidential Appendix 3**).

In addition to the two cases where the CDCRC identified a link, the CDCRC has identified a further 10 cases where it found that while there was no direct link between the actions or inactions of the Department and the child's death, there were serious deficiencies in service delivery that resulted in an inadequate response to the safety and wellbeing of the child. Examples of some of these cases can be found in **Confidential Appendix 4**.

These cases demonstrate the ongoing need for independent scrutiny to be applied to child death reviews. The child death jurisdiction enables the CDCRC to confidentially identify and respond to such cases in an efficient and constructive manner. Prior to the establishment of the CDCRC, the professional learnings from this analysis of cases would have been lost and departmental accountability would only have been able to be identified and responded to through establishing less efficient and reliable one-off processes. While the Department now has a better established internal review process, the CDCRC has continued to raise concerns as to the sufficiency of analysis being undertaken by the Department in some cases, and therefore recommends that independent scrutiny of departmental reviews should remain a key element of oversight of the child protection system.

Quality of departmental reviews

As noted previously, the Ombudsman and the CMC in their reports highlighted the limited capacity of the Department at the time to conduct child death reviews. The CDCRC's fifth review criterion requires it to consider whether the Department's reviews are comprehensive.

Since its inception in 2004, the CDCRC has played a critical role in driving the quality of departmental child death review processes as documented in its Annual Reports. The CDCRC's focus on building the Department's capacity to conduct child death reviews and establishing the required accountability remains relevant.

Since the 2008–09 reporting period the CDCRC has acknowledged in its Annual Reports that the standard of the Department's reviews has been improving. In 2011–12 the majority of the Department's reviews (63 of 73 reviews) were sufficiently comprehensive. Of those 63, the CDCRC identified eight that were of high quality. (In relation to three of these reviews, the Department engaged an external consultant to lead the review with support being provided by departmental officers).

However, the CDCRC found four of the Department's reviews were insufficiently comprehensive. A further six reviews, while sufficient, contained errors that impacted on the quality of the reviews.

In relation to one of the four departmental reviews that was not sufficiently comprehensive, the CDCRC found the departmental review did not appropriately address a number of service delivery practices, including a decision to place the child with a relative who was alleged to have perpetrated sexual abuse, without adequate investigation.

The CDCRC's finding stated that, *"the [CDCRC] does not consider that the [Department's] review sufficiently assessed the critical service system failures in this case which resulted in the Department placing children with an alleged sex offender. In order to learn from this case (and prevent similar service system issues in the future), the reasons provided by staff for the decision making needed to be critically assessed and challenged rather than accepted on face value."*

In the other three departmental reviews identified as being of insufficient quality, the CDCRC found that the reviews did not appropriately analyse information on a number of key service system issues present in the case, including one or more of the following:

- the inadequate assessment of significant domestic violence and substance misuse
- lack of critical evaluation of parents' responses to significant child protection concerns in circumstances where professional notifiers have given contradicting evidence, and
- inappropriate assessment and screening of child protection concerns.

Examples of some of these cases can be found in **Confidential Appendix 5**.

In six departmental reviews, the CDCRC found that a number of minor errors impacted on the quality of the review, including one or more of the following:

- The chronology of service delivery and risks identified were inaccurate.
- Departmental officers involved in conducting a review had potential conflicts of interest. While the potential conflict was resolved in their favour, the consideration and outcomes of the disclosures of interest were not reported in the Department's review.
- The Department did not clarify the age of a child upon receiving conflicting information from two other agencies, and
- Cultural status was not identified.

While the capacity of the Department to conduct child death reviews has increased since 2004, these cases demonstrate that the quality remains variable and that there is an ongoing need for external scrutiny. Without the independent review conducted by the CDCRC, serious service system failures may be overlooked or endorsed as appropriate practice.

Service system issues

The following sections of this submission outline the CDCRC's findings in relation to particular aspects of the Department's service delivery that require strengthening, in particular:

- Intake
- Investigation and Assessments
- Service delivery to Aboriginal and/or Torres Strait Islander children and young people
- Service delivery to pregnant women and their unborn children
- Service delivery to children and young people with mental health issues, and
- Service delivery to children and young people with disabilities.

Intake

Intake is a critical step in the decision-making process. It is the first step towards the Department providing support to children and young people experiencing, or at risk of experiencing, harm. It is at this stage that the Department is required to gather as much information as possible to determine the appropriate response, ensuring children's and young people's risk factors are responded to appropriately and in a timely manner. Appropriate assessment and screening of concerns at Intake is a vital step to ensure assessments are conducted to then enable support services to be provided where necessary. Without this step, children and young people may "slip through the gaps" without risks to their safety being responded to or assessed.

Accordingly, the decision making at the Intake stage is crucial to ensure that appropriate action is taken to address reported concerns and prevent any actual harm or further harm from occurring.

Guiding information about when information should be recorded as an Intake Enquiry, Child Concern Report or a Notification at the Intake stage is outlined in **Appendix 2**.

It is not the experience of the CDCRC that children are being notified to the Department unnecessarily. Rather, the CDCRC observes cases where the Department should have taken action in response to the concerns raised at the Intake stage and by not doing so, the child protection risks continued and often escalated.

An example of this can be found in **Confidential Appendix 6**.

In its 2009–10 and 2010–11 Annual Reports, the CDCRC has identified Intake processes as a key area in which the Department needs to improve, and in particular, the assessment and screening of child protection concerns.

Since 2008–09 the CDCRC has reported that, based on the cases which it has considered, the assessment of concerns at the Intake stage needs improvement.

In 2008–09 the CDCRC reported that in 53% of the cases it considered, issues about the screening of concerns at the Intake phase were identified. In 2009–10, this same issue was identified in 41% of cases the CDCRC considered. In 2010–11 the CDCRC identified this issue in 39% of cases. In 2011–12, this issue was identified in 38% of cases.

Table 1 Percentage of CDCRC cases in which incorrect screening decisions at Intake were identified from 2008–2012

Reporting period	Total %
2011–12	38
2010–11	39
2009–10	41
2008–09	53

While this figure has reduced from 53% to 38% over the four reporting periods, the CDCRC considers it is still unacceptably high, particularly given that an incorrect screening decision at Intake may mean that a child continues to be at risk of being harmed, or is actually being harmed, with no support provided.

The cases considered by the CDCRC demonstrate that if concerns are not assessed and responded to appropriately at Intake, it is likely the harm will occur or will continue. The result being that the child's needs become more complex due to the ongoing harm they have been exposed to. Similarly, the parents' behaviour may become more entrenched and their willingness to receive support may be reduced. The Department is often then faced with a situation where more intrusive forms of intervention are required to address the child's protective needs.

The reasons identified by the CDCRC as to why concerns are being incorrectly screened include:

- lack of information gathered by the Intake Officer from the notifier to make an informed assessment
- failure to take into consideration the child protection history (that is, concerns are assessed in isolation without taking into account other concerns raised from a range of notifiers), and
- poor professional practice which was not always attributable to a lack of skill or expertise of officers.

A key strategy to improve the quality of the Intake process has been the Department's roll out of the Regional Intake Service which aims to:

- improve consistency and quality of Intake decision making
- streamline and simplify the process of reporting for professional and other notifiers
- improve provision of timely feedback and communication with referring agencies, and
- improve management of demand and workload pressures through separation of Intake from investigation and assessment functions.

In accordance with the implementation strategy for the Regional Intake Service, a review was undertaken in 2011 to assess its effectiveness. The Regional Intake Service Review Report identified ongoing issues in relation to some aspects of the Intake process and made recommendations aimed at addressing these issues.

In June 2012, the Department advised that all recommendations made by the RIS review which were accepted by the Department have been implemented or are in the process of being implemented.

To assist the Department in monitoring the effectiveness of the Regional Intake Service, the CDCRC plans to continue to provide data to the Department about issues which it identifies at Intake.

Investigation and Assessment

Upon recording a Notification, the Department must conduct an investigation and assessment (I&A) in response to the allegations that a child has been harmed or is at risk of harm and assess the child's need for protection.² The investigation of child protection concerns and relevant risk factors is critical in determining whether the child requires protection and intervention by the state.

In 2011–12 the CDCRC identified the following two areas of I&A as recurring service system issues over the past three years:

- delay in commencing I&As with a 10 day response priority timeframe, and
- information gathering.

These issues are discussed in more detail in the pending CDCRC Annual Report 2011–12.

Service delivery to Aboriginal and Torres Strait Islander children and young people

Aboriginal and Torres Strait Islander children and young people continue to be over-represented in the child protection system in Queensland. As at 30 June 2011 Aboriginal and Torres Strait Islander children were five times more likely to be subject to a Notification, six times more likely to be subject to a substantiation and almost nine times more likely to be subject to a protection order with the Department than non-Indigenous children.³

In the three reporting periods 2009–10, 2010–11 and 2011–12, the deaths of 62 Aboriginal and/or Torres Strait Islander children and young people were reviewed.

² Section 14 of the *Child Protection Act 1999*

³ Commission for Children and Young People and Child Guardian 2011, *Child guardian key outcome indicator: Queensland child protection report 2008–2011*, Commission for Children and Young People and Child Guardian, Brisbane, p. 55. As per page 55 of this report, a "protection order" refers to a short-term and long-term child protection order and a court assessment order.

In reviewing the 62 cases that concerned an Aboriginal and/or Torres Strait Islander child, the CDCRC identified opportunities to strengthen aspects of service delivery to ensure the cultural needs of children and young people are met, including:

- identification and recording of cultural status, and
- engagement with Recognised Entities.

This key service delivery area is discussed in more detail in the CDCRC Annual Report 2011–12.

Service delivery to pregnant women and their unborn children

Under section 21A of the Child Protection Act, the Department may become involved with a pregnant woman and her unborn child where it receives concerns, and it is assessed that the unborn child is likely to be in need of protection once they are born.

Based on the cases which come before the CDCRC, often the concerns relate to the parents' behaviours and in particular, substance misuse and/or domestic violence.

Unborn children in need of protection after birth

Under section 21A of the Child Protection Act, the Department may take action if it reasonably suspects that an unborn child may be in need of protection after they are born, including offering support to the pregnant woman. Where this is the case, the Department will record an Unborn Child Notification (UCN).

Based on the cases it has considered, the CDCRC has observed that this section of the Child Protection Act is not utilised consistently by the Department and that opportunities exist to strengthen this area of service delivery.

The key service system issues identified by the CDCRC in this area include:

- delays in screening concerns regarding unborn children at the Intake stage
- incorrect screening of concerns at Intake (that is, incorrect decision to record concerns as a CCR rather than a UCN)
- delays in commencing and completing I&As for UCNs
- insufficient assessment of child protection risks in conducting the I&A
- delays in offering support to the pregnant woman

In a number of cases the CDCRC identified that concerns should have been recorded as a UCN; however, due to insufficient information gathering at the Intake stage or inappropriate assessment of concerns, a UCN was not recorded.

An example of this can be found in **Confidential Appendix 7**.

In many cases the I&A for the UCN was either not commenced or not completed until after the child was born and no support was offered to the pregnant woman.

Further, for those cases where the I&A had been conducted and the Department substantiated the concerns, support service plans were either not developed or were lacking in substance to be able to provide practical support and assistance to the pregnant woman.

In such cases, the CDCRC is of the view that had supports been provided to the mother earlier in her pregnancy to address such issues as substance misuse problems, a healthy baby may have been born to parents with greater parental capability.

Case study 2 in **Confidential Appendix 3** is an example of delays in screening and investigating concerns regarding an unborn child. Further, despite an eventual assessment

that the child would be in need of protection after birth, no action was taken to address any risk factors present in the family.

Case study 6 in **Confidential Appendix 5** highlights the case of an unborn child who was appropriately assessed as being in need of protection after birth. However, no support was offered to help address the concerns during the pregnancy. In addition, after the birth the child protection concerns were minimised by the Department and insufficient action was taken in response to the serious concerns that continued to be raised.

Strengthening service delivery in this area

The CDCRC is of the opinion that if concerns regarding unborn children were more appropriately assessed and responded to, and supports were effectively put in place during pregnancy, there is likely to be a reduction in the number of children who come to the attention of the child protection system soon after birth.

The CDCRC notes that, for example, in the Netherlands an "at risk" pregnant woman/family is referred to an interagency panel by the managing primary care team. The interagency group comprises obstetric, midwifery, child health, hospital social work, community services and child protection staff, as well as other agency representatives as may be required, such as mental health, drug and alcohol support specialists, and cultural consultants.

Under this framework, the pregnant woman is offered a range of support services including on-going contact with child health services. It is only if and when the pregnant woman does not participate in the offered support that she is referred to the statutory child protection agency which will then record the equivalent of a Notification and conduct an Investigation and Assessment to determine the child's need for protection.

The CDCRC suggests that a framework similar to that used in the Netherlands may assist the Department in fulfilling its obligations under s 21A. Such a framework may assist the Department in utilising the services available from other secondary support services which may be better placed to engage with a pregnant woman.

Service delivery to children and young people with mental health issues

In 2011–12 the CDCRC identified service delivery to children and young people with mental health issues as an emerging issue.

Eight (11%) of the 73 children and young people whose deaths were considered by the CDCRC during the reporting period were identified as having mental health issues during their lives.

The CDCRC observed that all eight cases were characterised by the presence of multiple complex issues, in addition to that of mental health issues, and this complicated effective child protection service delivery.

The CDCRC found that overall the service system responded positively. However, difficulties were evident in the following areas of service delivery:

- identification of mental health risk factors as part of the child's overall child protection risk assessment
- ability to identify and follow-up appropriate support options for the child/young person and the family, and
- lack of capacity of the service system to deal with complex cases, for example, where adolescent mental health facilities or services are not available in certain areas in Queensland.

This area of service delivery is discussed in more detail in the pending CDCRC Annual Report 2011–12.

Service delivery to children and young people with disabilities

The CDCRC is of the view that families who require support to care for a child with a significant disability, should not have to enter the child protection system as a means of obtaining that support.

While there may be some children with disabilities who come to the attention of the Department for child protection reasons, there are others who enter the child protection system because the child's care needs are so extreme that the parents can no longer care for them.

The CDCRC is of the view that parents who are willing to care for their children, but due to the child's needs are unable to do so, should be able to access out-of-home care options for their children without having to relinquish care through the child protection system.

An example case study is included in **Confidential Appendix 8**.

Options for the child death case review jurisdiction

The CDCRC provides an efficient and effective value-add to the oversight of the child protection service delivery system. Its reviews provide clarity about service system links to deaths and help shed light on the need for improvements. In addition to the above concerns, the CDCRC has also referred a series of issues to the Commission for Children and Young People and Child Guardian (the CCYPCG) for more detailed systemic analysis and investigation.

The reviews conducted by the CDCRC also provide the families and friends of children who have died, as well as notifiers who referred concerns about the children's safety during their lifetime, confidence that the service delivery to the deceased children will be reviewed, and that any issues will be identified and responded to.

The CDCRC has considered whether refinements may be made to the child death case review jurisdiction to better focus resources on the more complex cases where the Department had involvement or should have had greater involvement with the child prior to their death.

As noted above, the Department is required to conduct a child death review where a child who has died, was known to the Department within the three years prior to their death.

The options referred to in this submission for refining the jurisdiction centre on the first tier of the jurisdiction and in particular, the level of contact between the Department and the child, as well as the three year timeframe within which the child was known to the Department prior to their death. This submission also outlines options for refining the second tier of the jurisdiction, namely the cases considered by the CDCRC.

First tier amendment

Involvement of the Department

A child is considered "known" to the Department if, at a minimum, a Child Concern Report was recorded about the child within three years prior to their death.

To assist in analysing the Department's level of involvement in each case, the CDCRC categorises this involvement into four categories which are outlined below.

“Death incident” refers to cases where the involvement by the Department with the child was only in response to the incident causing the death of the deceased child. In such cases there is often a period of a few days between the incident and the death during which the child is in hospital.

“One previous concern received” refers to cases where the Department had been notified about child protection concerns for the child, on one occasion prior to the death of the child, and where the concerns either did not meet the threshold for a Notification or were not substantiated when they were investigated.

“Repeated concerns raised” refers to cases where child protection concerns had been repeatedly raised in relation to the deceased child, but where such concerns did not meet the threshold for a Notification or were not substantiated when they were investigated.

“History of involvement” refers to cases where the deceased child had significant involvement with the Department, with at least one Notification having been substantiated.

The table below details the Department’s level of involvement with those children and young people whose deaths have been reviewed over the past four reporting periods between 2008 and 2012.

Table 2 Level of involvement of the Department with the child by reporting period 2008–2012

Reporting period	Death incident	One previous concern received	Repeated concerns raised	History of involvement	Total <i>n</i>
2011–12	4 (5%)	22 (30%)	21 (29%)	26 (36%)	73
2010–11	1 (2%)	25 (38%)	22 (34%)	17 (26%)	65
2009–10	3 (4%)	22 (27%)	25 (30%)	32 (39%)	82
2008–09	2 (3%)	21 (28%)	17 (23%)	34 (46%)	74
Total	10 (3%)	90 (31%)	85 (29%)	109 (37%)	294

The CDCRC suggests that, in future, where the level of contact with the Department was only in response to the death incident, or where one previous concern was received, the Department need not conduct a child death case review.

However, the CDCRC further suggests that if there is a public interest in the Department reviewing a case which otherwise would not be reviewed, then the Department may have discretion to conduct a review.

Under this proposed model, the child death case review jurisdiction would focus on cases where the Department had significant involvement with the child, or where it potentially should have had greater involvement with the child.

Three year timeframe

Given the Department’s policies and procedures are constantly evolving, the CDCRC suggests it may be appropriate to reduce the period of time within which the child is required to have been known to the Department prior to their death. By reducing the period known from three years to two years or one year, the jurisdiction will be able to focus on more recent service delivery where relevant policies and procedures are still in place.

The following table outlines the period of time within which children and young people reviewed from 2008–2012 were most recently in contact with the Department.

Table 3 Most recent contact between the Department and the child prior to death, by reporting period 2008–2012

Reporting period	One year	Two years	Three years	Total <i>n</i>
2011–12	61 (84%)	8 (11%)	4 (5%)	73
2010–11	53 (82%)	8 (12%)	4 (6%)	65
2009–10	67 (82%)	8 (10%)	7 (8%)	82
2008–09	57 (77%)	13 (18%)	4 (5%)	74
Total	238 (81%)	37 (13%)	19 (6%)	294

Second tier amendment

Currently every child death review that is conducted by the Department is required to be reviewed by the CDCRC.

Given the findings outlined above, the CDCRC suggests that every departmental review still requires being subject to independent external scrutiny. However, it is suggested that this role could, in the first instance, be undertaken by the Commission for Children and Young People and Child Guardian (the Children’s Commission).

Once the Children’s Commission has received the reviews it could assess what cases would warrant further independent scrutiny and, if appropriate, convene a multidisciplinary expert panel (such as the present CDCRC) to review the service system issues. These cases would be those of the greatest seriousness and concern to both the government and the public and may include:

- children who died of suicide, fatal assault and neglect
- cases where multidisciplinary expertise would be valuable including those cases requiring cultural consideration relevant to the over-representation of Aboriginal and Torres Strait Islander children in the child protection system
- cases that have been referred to the CDCRC by the Minister, or
- cases in which it would serve the public interest for them to be considered by the CDCRC.

The framework as to which cases would be referred to the CDCRC could be developed by the CDCRC in consultation with the Children’s Commission.

Appendix 1

Review Criteria

Commission for Children and Young People and Child Guardian Act 2000

Section 133

Review Criteria for Child Death Case Review Committee

14 November 2008

The review criteria to be used by the Child Death Case Review Committee (CDCRC) in reviewing an 'original review' are to determine the following:

1. Were any actions or inactions of the service system linked to the child's death?
2. What risk factors were relevant to the child's death?
3. Were any service system issues relevant to any adverse outcomes experienced by the child (while he or she was living)?
4. Are there any recurring or unrectified risk factors or service system issues that require further action?
5. Was the original review of sufficient quality to enable timely responses to any relevant risk factors or service system issues or is further action required?

Appendix 2

When information is received by the Department at Intake, it is either:

1. recorded as an Intake Enquiry, or
2. screened using the Structured Decision Making tools and recorded as a:
 - (a) Child Concern Report, or
 - (b) Notification.

Recording an Intake Enquiry

The Child Safety Practice Manual states that an Intake Enquiry is recorded when:

- information is provided in relation to a child but there are no allegations of harm or risk of harm, or
- information is being requested in relation to child protection matters but there are no allegations of harm or risk of harm to a specific child or unborn child.

An Intake Enquiry may also be recorded when information is reported about alleged harm or risk of harm to a child that:

- relates to extra-familial abuse, where the parents are assessed as able and willing to protect the child
- relates to a child who lives in another jurisdiction and the information is forwarded to that jurisdiction
- relates to the non-accidental or suspicious death of a child where there are no siblings, or accidental death where there are no suspicious circumstances.

The Child Safety Practice Manual further states that by recording an Intake Enquiry, no further action will be taken by the Department. In particular, pre-notification checks will not be conducted.⁴

Therefore, if the reported information does not contain allegations of harm or risk of harm to the child (unless the child is in another jurisdiction or the concerns relate to extra-familial abuse and the parents are assessed as able and willing), it is appropriate to record the information as an Intake Enquiry. However, where the reported concerns contain allegations of harm or risk of harm (other than the exclusions referred to above), the matter must be screened using the Structured Decision Making tools and recorded as either a Child Concern Report or Notification.

Information about Child Concern Reports and Notifications is outlined below.

Recording a Child Concern Report

The Child Safety Practice Manual states that a Child Concern Report is recorded when there are child protection concerns *“that do not meet the threshold for [recording a] Notification”*.⁵

A Child Concern Report is recorded once departmental history has been checked, pre-notification checks completed where required and the Recognised Entity contacted where relevant.⁶

⁴ Department of Communities, Child Safety and Disability Services 2012, *Child Safety Practice Manual*, Brisbane, Chapter 1.

⁵ Department of Communities, Child Safety and Disability Services 2012, *Child Safety Practice Manual*, Brisbane, Chapter 1–2.6.

⁶ Department of Communities, Child Safety and Disability Services 2012, *Child Safety Practice Manual*, Brisbane, Chapter 1.

By recording a Child Concern Report, the Department may then select one of the following options in response to the notified concerns:

- i. information and advice
- ii. referral to another agency
- iii. information provision

Information about each of these options is outlined below.

Information and advice

This option involves the Department providing general information and advice to the notifier with the aim of preventing the need for further involvement by the Department. It may include discussion with the notifier about the concerns raised and strategies to deal with the situation, or ways to talk to the family to encourage and assist them to explore alternative sources of support.

Referral to another agency

The Department may refer the family or notifier to another agency to assist them in accessing prevention, early intervention and support services. Where considered appropriate and where the eligibility criteria are met, the Department may refer the family to a Referral for Active Intervention service, an Aboriginal and Torres Strait Islander Family Support Service or to another secondary service.

Information provision

In some circumstances, it may be appropriate (and at times, a legal requirement) for the Department to refer information provided by the notifier to another agency, e.g. referral of criminal activity to QPS.⁷

As noted above, if the reported concerns contained allegations of harm, or risk of harm, either a Child Concern Report or a Notification is to be recorded. Information about Notifications is outlined below.

Recording a Notification

A Notification is recorded when there is an allegation of harm or risk of harm to a child, and a reasonable suspicion that the child is “in need of protection”.

A child in need of protection is a child who:

- a) has suffered harm, is suffering harm or is at unacceptable risk of suffering harm, and
- b) does not have a parent able and willing to protect the child from harm.⁸

⁷ Department of Communities, Child Safety and Disability Services 2012, *Child Safety Practice Manual*, Brisbane, Chapter 1–2.6.

⁸ A child in need of protection is defined in s 10 of the *Child Protection Act 1999*

Appendix 3: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.

Appendix 4: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.

Appendix 5: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.

Appendix 6: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.

Appendix 7: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.

Appendix 8: CONFIDENTIAL—NOT FOR PUBLIC RELEASE

Information from this appendix has been removed as it contains details about deceased children and their families that are not for public release.