

Queensland Child Death Case Review Panels

# Annual Report

## 2014–15





Queensland Child Death Case Review Panels  
**Annual Report 2014–15**

The Honourable Shannon Fentiman MP  
Minister for Communities, Women and Youth  
Minister for Child Safety  
Minister for Multicultural Affairs

Dear Minister

In accordance with section 246HL of the *Child Protection Act 1999* (the Act), I am pleased to present the inaugural annual report of Child Death Case Review Panels for the period 1 July 2014 to 30 June 2015.

You will note the report addresses the operations of the panels under chapter 7A of the Act during the financial year, and actions taken during the financial year in response to reports given to me under section 246DC.

Yours sincerely

Tony Hayes  
**A/Director-General**  
**Department of Communities, Child Safety and Disability Services**



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# Message from the Director-General

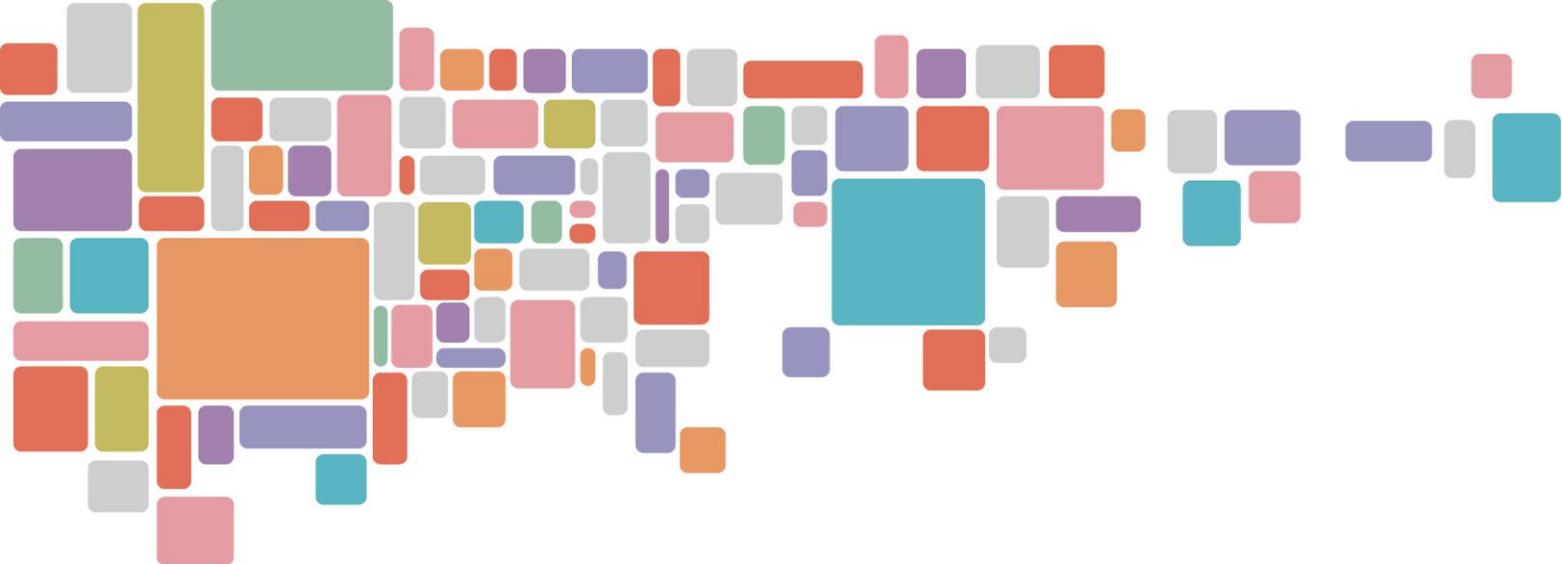
On behalf of the Department of Communities, Child Safety and Disability Services (the department) and Child Death Case Review Panel members, I would like to offer my sincere condolences to the parents, families, carers and friends of those children and young people whose deaths and serious physical injury were considered by the panels during the 2014–15 period. In this period, the Child Death Case Review Panels considered departmental involvement with 54 children and young people who died, and one young person who suffered a serious physical injury.

This annual report provides a summary of findings from Child Death Case Review Panels during 2014–15 and highlights a range of actions that have been taken by the department in response to the panel findings, including training and opportunities to improve recordkeeping and information sharing with our partners. The establishment of the Child Death Review Panels represents an important step in the implementation of the department's response to the Queensland Child Protection Commission of Inquiry report, *Taking Responsibility: A Roadmap for Queensland Child Protection*. The findings from these independent panels provide the department with information regarding the quality of services delivered to Queensland children, young people and families and identify opportunities for strengthening the system. The department is committed to continual learning and values critical reflection to grow and develop practice. Child Death Case Review Panel findings help inform ongoing improvement in service delivery by identifying areas that require strengthening and capability development in staff and systems. Additionally the Panel findings are used to inform the department in its broader reform activities.

While none of the children or young people considered by the panel died as a result of domestic and family violence, it was a significant feature in the families of a large number of the cases reviewed. During 2014-2015 in Queensland a spotlight has been placed on this issue through the *Not now, Not ever* report into Family and Domestic Violence. As a department we acknowledge the importance of ensuring that our child protection practice is informed by and cognisant of the dynamics and issues of family and domestic violence. We welcome the Panels' insights into this area and the opportunity to learn from each of the cases reviewed this year. This department will contribute to the Whole-of-Government Program and lead reforms to promote the safety and wellbeing of children in the community. This includes delivery of joint training opportunities and working with contemporary experts in this complex area.

In presenting these findings I would like to acknowledge the hard work and commitment of departmental staff who work each day with vulnerable children, young people and families. This work takes knowledge, skill and commitment and I thank them for their willingness to critically reflect on their practice and share their views of systemic challenges. I would also like to thank the panel members for their time and dedication to best practice outcomes. Panel member expertise and commitment to this important area of work is instrumental to our collective vision of creating a child protection system that responds early and effectively to vulnerable children, young people and their families.

Michael Hogan  
**Director General**  
**Department of Communities, Child Safety and Disability Services**



# Executive summary

## Background

The Child Death Case Review Panel was established in response to recommendations made by the Queensland Child Protection Commission of Inquiry. The commission recommended that an effective review system be implemented by the department to review departmental involvement with children and young people who have died or suffered a serious physical injury. It was recommended that findings be used to inform policy, practice and professional development.

On 1 July 2014, amendments to the *Child Protection Act 1999* came into effect and made the following changes to the case review system:

- introduced reviews of children and young people known to the department who have suffered a serious physical injury — serious physical injury had not previously been in the scope of the review process
- requires a review to be undertaken in cases where there has been departmental involvement with a child in the 12 months prior to child's death or serious injury — formerly a review was required if the child was known to the department in the previous three years
- introduced the capacity for the Minister to request a review of a child or young person who has died or suffered a serious physical injury where the circumstances may be relevant to the department's operations — this capacity had not previously been available to the Minister
- decommissioned the former Child Death Case Review Committee and introduced Child Death Case Review Panels.

The amended review process for children known to the department who have died or suffered a serious physical injury includes an internal Systems and Practice Review conducted by the department and consideration of the department's review by an independent Child Death Case Review Panel.

The purpose of both reviews is to facilitate ongoing learning and improvement in the provision of services by the department and to promote the accountability of the department.

The department is responsible for providing secretariat support to Child Death Case Review Panels, however each panel is independent of the department and is responsible for determining how it conducts its business. This includes the conduct of meetings and the terms of reference used for its review. Child Death Case Review Panels, as independent panels, are not subject to direction by the Minister.

The *Child Protection Act 1999* requires the panels to include external expert members, departmental senior officers and senior officers from other government departments, with at least one member of every panel being an Aboriginal or Torres Strait Islander person.



## Children and young people reviewed in 2014–15

In the 2014–15 reporting period, Child Death Case Review Panels completed reviews of departmental involvement with 54 children and young people who had died and one child who had suffered a serious physical injury. All of these children were known to the department in the year preceding their deaths or injury.

### Gender

Of the 55 children and young people reviewed 51 per cent were male (28 children) and 49 per cent were female (27 children).

### Age

The majority (72 per cent) of cases reviewed during the 2014–15 reporting period involved children under the age of nine years at the time of their death or serious physical injury. Children aged under one year at the time of their death or serious physical injury were the largest group (29 per cent) followed by children aged five to nine years (27 per cent).

### Cultural background

Of the 55 cases reviewed 18 children and young people (33 per cent) identified as Aboriginal and three identified as both Aboriginal and Torres Strait Islander.

### Location

Of the 54 reviews of deaths, 42 per cent involved children and young people who resided in regional or remote areas of Queensland at the time of their deaths (23 children).

### Cause of death

Disease was the most frequent cause of death for children and young people reviewed and represented 52 per cent of all cases (28 children).

### Contact with the department

Of the 55 cases reviewed four (7 per cent) involved children or young people who were in the custody or guardianship of the department at the time of their death. All of the children and young people reviewed by panels who were subject to custody or guardianship orders had their cause of death listed as disease.

In the majority of cases (71 per cent) the department did not have any current involvement — intake, investigation or ongoing intervention — with the child or young person at the time of their death or serious physical injury.

*\* See Chapter 2 for complete profile details*

## Panel findings

Nine Child Death Case Review Panels completed reviews during the 2014–15 reporting period. Child Death Case Review Panels considered departmental involvement with children and young people at differing points on the child protection continuum. These children and young people were from diverse cultural, family and community backgrounds and had different life experiences and challenges.

Each panel was responsible for producing a report outlining the findings of their individual review. Based on consideration of the cases allocated, each panel made findings aimed at systemic improvement. While panels identified examples of high quality service delivery from departmental staff, recurring areas for improvement appeared across multiple panels and these are detailed further below. No panel found that the action or inaction of the department contributed towards the death or serious physical injury of the children and young people reviewed. However, panels did



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identify areas of improvement in the delivery of service to children, young people and their families and interagency coordination.

Panels noted the significant resources provided by the department in conducting its Systems and Practice reviews and identified instances where the review analysis was of a high standard. Panels identified that departmental reviews focused on individual casework decisions made in the context of service delivery and suggested reviews could be improved by including more analysis of how the system responded to families overall; how families experienced the child protection system; and greater consideration and analysis of culturally appropriate practice.

Panels noted that poor interagency communication, coordination and collaboration between government departments and non-government agencies at times led to fragmented service delivery to vulnerable children and young people.

Panels that reviewed departmental involvement with Aboriginal and Torres Strait Islander children and young people frequently identified the importance of quality partnerships and collaborative decision making with Recognised Entities.

A number of findings were made by panels in relation to improving service delivery during intake, the point at which the department receives child protection concerns about children and young people. Panels were of the view that departmental officers need to more actively seek clarification and detailed information from those who contact to report concerns.

Panels which considered departmental investigations and assessments, the processes used to assess levels of harm and a child's need for protection, identified that improvements could be made by more holistic consideration of the family's circumstances and ensuring that the focus remained on the child/ren.

Panels noted that there is an expectation placed on departmental officers to have an extensive and in-depth understanding of domestic violence, mental health issues, substance misuse and all forms of child abuse and neglect. Panel members expressed the view that this expectation is unrealistic given the depth of knowledge required and the complexities of the families within the child protection system. Panels particularly identified that departmental officers could be better supported through the development of practice resources in service delivery to children with disabilities and chronic medical conditions and domestic and family violence.

Although no deaths were identified as resulting from domestic and family violence, its prevalence in many of the families considered in these reviews was significant. The reports collectively highlighted the importance of staff having a reasonable level of knowledge of the dynamics of domestic and family violence, and the impact on all family members to adequately and accurately assess risk and plan appropriate interventions.

## Departmental response to findings

Each Child Death Case Review Panel provided a final report outlining their findings to the Director-General of the department. The reports were considered by key areas in the department. A report was then provided to the Minister outlining the action the department has taken, or intends to take, in response to the findings in the panel's report.

Key activities undertaken by the department in response to panel findings include amending the System and Practice Review methodology to strengthen the robustness of the review process. These amendments to Systems and Practice Reviews have also been aimed at balancing the focus on both accountability and individual and systemic learning and development.



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In relation to working with families and children with chronic medical conditions or disabilities and families experiencing domestic and family violence, the department recognises the complexities associated with these areas of child protection practice. The department will continue to strengthen child protection practice in these areas through building stronger relationships with key partners, strengthening the resources available to our staff and enhancing staff access to specialist expertise.

The department is currently leading a significant reform program based on the findings and recommendations from the Queensland Child Protection Commission of Inquiry. Congruencies between panel findings and the department's Child and Family Reform activities have been frequently identified and the department has utilised panel findings to inform implementation of the reforms. Child and Family Reform activities are detailed further in Chapter 4 of the report.

In addition to the child and family reform program, a number of other related reforms are currently underway including the government's response to the *Not Now Not Ever*, Bryce report for domestic and family violence reform; the Royal Commission into Institutional Responses to Child Sexual Abuse; and Community Affairs Reference Committee inquiry into out-of-home care in Australia. The department is utilising discussions, findings and recommendations from these reforms to inform the strengthening of the Queensland child protection system.

### Report structure

This report is structured as follows:

**Chapter 1** provides a summary of the Queensland Child Death and Serious Physical Injury review system including the department's internal Systems and Practice Review and the independent Child Death Case Review Panel review process.

**Chapter 2** provides an overview of the children and young people subject to review including demographic information, departmental involvement at the time of their death or serious physical injury and causes of death.

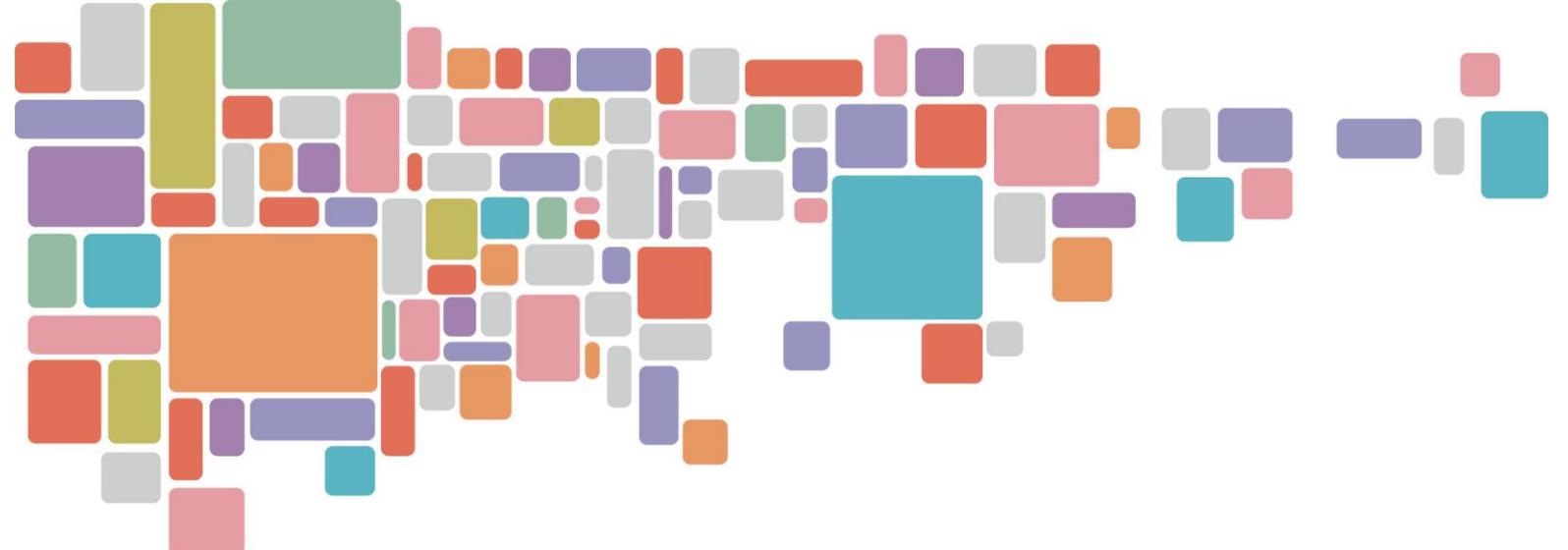
**Chapter 3** provides an outline of the findings from Child Death Case Review Panels over the 2014–15 reporting period.

**Chapter 4** provides an outline of the department's response to findings from Child Death Case Review Panels over the 2014–15 reporting period.

**Appendix A** provides an overview of similarities and differences between the previous Child Death Case Review Committee and the current Child Death Case Review Panels.

**Appendix B** provides an overview of panel themes, membership and key dates for Child Death Case Review Panels convened during the 2014–15 reporting period.

**Appendix C** provides an overview of membership of the pool of approved members for the 2014–15 reporting period.



# Chapter 1

## Queensland case review system

### Background

The Department of Communities, Child Safety and Disability Services is the statutory child protection agency in Queensland. The department works closely with other government departments, non-government agencies and the community to support families to keep children and young people safe from abuse and neglect.

Since 2004, Queensland has utilised a two-tiered review system for reviewing involvement with children and young people known to the department who have died.

In the system's current iteration, the department undertakes Systems and Practice Reviews of its involvement following the serious physical injury or death of a child who is known to the department in the year prior to their injury or death or at the request of the Minister. Systems and Practice Reviews are conducted in accordance with Chapter 7A of the *Child Protection Act 1999*, and focus on facilitating ongoing learning and improvement in the provision of services by the department and promoting the accountability of the department.

Child Death Case Review Panels were established on 1 July 2014 to replace the Child Death Case Review Committee in overseeing the department's reviews as recommended by the Queensland Child Protection Commission of Inquiry. Appendix A provides a comparison of the previous Child Death Case Review Commission and the current Child Death Case Review Panels.

### Queensland Child Protection Commission of Inquiry

The Queensland Child Protection Commission of Inquiry was established on 1 July 2012 with the Honourable Tim Carmody SC appointed as Commissioner. It was instituted to review Queensland child protection services, design a new child protection system and develop a roadmap for the next decade. The report, *Taking Responsibility: A Roadmap for Queensland Child Protection*, was handed down on 1 July 2013 and made 121 recommendations for comprehensive systemic reforms to achieve the best possible outcomes for children, young people and families.

On 16 December 2013, the former Queensland Government released its response to the report, accepting all 121 recommendations (115 accepted and six in-principle). The department has responsibility for 82 of these recommendations.



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Among the recommendations, the inquiry recommended the department:

- establish a specialist investigation team to investigate cases where children in care have died or sustained serious injuries (and other cases requested by the Minister for Communities, Child Safety and Disability Services)
- set the timeframe for such a child being 'known' to the department at one year
- provide reports of investigations to be reviewed by a multidisciplinary independent panel appointed for two years.

The *Child Protection Reform Amendment Act 2014* was passed on 20 May 2014 and included the legislative amendments necessary to enable the new child death and serious injury review processes. These amendments came into effect on 1 July 2014.

The establishment of the Child Death Case Review Panels represents an important step in the implementation of the Child and Family Reform Program. The aim of the program is for children and young people to live in safe and supportive families and communities. This will be achieved by ensuring:

- children and families have timely access to high-quality services
- Queensland's child and family support system is efficient, effective, client-centred and focussed on prevention and early intervention
- over representation of Aboriginal and Torres Strait Islander children in the child protection system is significantly reduced
- communities have confidence and trust in the Queensland child protection system.

The Queensland Government has committed \$406 million over five years to implement the reforms. Key reforms include:

- establishing 18 new **Family and Child Connect** centres throughout Queensland to provide additional pathways to offer assistance to children and families that include a specialist domestic and family violence worker
- expanding **intensive family support services** to keep children in safe and supportive families
- expand the network of **specialist domestic and family violence services** to be able to accept referrals from the new Family and Child Connect and Intensive Family Support services
- establishing a new **Office of the Public Guardian** to support children in care through the community visitor child advocacy program
- establishing the **Queensland Family and Child Commission** to provide expert oversight of Queensland's family and child support system
- reforming **services for Aboriginal and Torres Strait Islander children and families** to improve access to culturally appropriate programs and services and reduce the number of children and families in the child protection system, especially out-of-home care
- implementing the **Strengthening Families Protecting Children Framework for Practice**, which balances strengths-based and safety-orientated approaches to working with families.

Findings from Child Death Case Review Panels are used by the department to inform the implementation of this reform program. In addition to the child and family reform program, a number of other related reforms are currently underway, including the government response to the *Not Now Not Ever* Bryce report for domestic and family violence reform, the Royal Commission into Institutional Responses to Child Sexual Abuse and Community Affairs Reference Committee inquiry into out of home care in Australia. The department is utilising discussions, findings and recommendations to inform system improvement.

The department has commenced a review of the *Child Protection Act 1999*, as recommended by the Queensland Child Protection Commission of Inquiry. This review aims to design a



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contemporary legal framework for the child protection and family support system. The department is undertaking a public consultation for the review and in September 2015 released a discussion paper, *Supporting families and protecting children in Queensland: a new legislative framework*, outlining key foundational issues underpinning legislation and posing questions for discussion. Public consultation will occur from September 2015 to March 2016 and will include public information sessions held in a number of locations across Queensland. Findings from Child Death Case Review Panels will be used as a key source of information informing the review.

In July 2015, the Minister requested the department undertake an external review of the Queensland Case Review system. In August 2015, the department engaged *Quality Innovation Performance Consulting* (QIP Consulting) to undertake the review. QIP Consulting provides consulting services in the fields of continuous quality improvement, process review, resource development and accreditation services to organisations in the Australian government and health care environment. The review of Queensland's current case review system will examine both the department's internal Systems and Practice Review and the operation of Child Death Case Review Panels and aims to:

- provide advice on the suitability of the current processes
- provide recommendations for alternative approaches, if required
- give particular attention to any discrepancies in the findings between the internal Systems and Practice Reviews and the Child Death Case Review Panels
- identify any issues in the Systems and Practice Review that may require further exploration.

The review is scheduled to be completed by the end of 2015 and will be used to inform the operation of Queensland's case review system in the future.



## Queensland's child death jurisdiction history

Prior to 2002	Child death reviews were conducted by the department and were not externally reviewed.
2002–03	Queensland Ombudsman conducted major investigations into the deaths of Brooke Brennan and Baby 'Kate', finding: <ul style="list-style-type: none"><li>• the department's service delivery failed these children</li><li>• the department's child death review processes were inadequate because they either failed to identify service delivery issues or did not ensure recommendations were actioned to prevent future deaths.</li></ul>
2004	Crime and Misconduct Report <i>Protecting Children: an Inquiry into the abuse of children in foster care</i> reinforced the findings of the Queensland Ombudsman stating that decisions and actions should be independently examined to promote accountability and improve future decision making.
2004	The Child Death Case Review Committee established, administered by the Commission for Children and Young People and Child Guardian to provide independent and external oversight and to review departmental reviews.
2004–13	The Child Death Case Review Committee examined the deaths of 532 children and young people including five cases where the actions and/or inactions of the child protection system were linked to the child's death.
2013	The Queensland Child Protection Commission of Inquiry recommended cases where children in out-of-home care have died or sustained serious physical injuries the department investigate with a specialist investigation team, overseen by a multi-disciplinary panel, which includes departmental officers, replacing the Child Death Case Review Committee.
1 July 2014	<i>Child Protection Act 1999</i> amendments, as recommended in the Queensland Child Protection Commission of Inquiry, came into effect.
27 July 2014	Appointments of inaugural members to the pool of approved members for Child Death Case Review Panels.
14 October 2014	Inaugural Child Death Case Review Panel meeting occurred.



# Current review framework

## Requirement to conduct a review

The *Child Protection Act 1999* (the Act) includes provisions requiring the department to carry out a review of its involvement with any child who dies or is seriously physically injured if:

- at the time of the child's death or serious physical injury, the child is in the chief executive's custody or guardianship or
- within one year before the child's death or serious physical injury, the chief executive became aware of alleged harm or alleged risk of harm to the child in the course of performing functions under or relating to the administration of the Act or
- within one year before the child's death or serious physical injury, the chief executive took action under the Act in relation to the child or
- the child was less than one year old at the time of death or serious physical injury and, before the child was born, the chief executive reasonably suspected the child might be in need of protection after he or she was born or
- the Minister requests a review.

The Minister may ask the department to carry out a review if the Minister considers the circumstances of the child's death or serious physical injury may be relevant to the chief executive's functions under or relating to the administration of the Act.

### Serious injury

Serious physical injury is defined in the Act as:

- the loss of a distinct part or an organ of the body or
- serious disfigurement or
- any bodily injury of a nature that, if left untreated, would endanger or be likely to endanger life, or cause or be likely to cause permanent injury to health.

## Internal review

### Systems and Practice Review

The department takes the death and serious physical injury of any child or young person seriously and seeks, through its review process, to identify opportunities to continuously improve child protection service delivery to Queensland's children and young people. The department is responsible for undertaking a Systems and Practice Review of its involvement with children and young people who have died or suffered a serious physical injury. The department's review is the first tier of Queensland's two-tiered case review system.

### Purpose of departmental review

The purpose of the review is to facilitate ongoing learning and improvement in the provision of services by the department and to promote the accountability of the department.



## Types of review

A Systems and Practice Review seeks out learning and development opportunities for continuously improving the child protection system. To achieve this, the reviews are transparent, inclusive and constructively focused on systems and practice improvements for children. There are three types of Systems and Practice Review that the department carries out — detailed; limited; and brief. The type of review undertaken is based on the nature and circumstances of departmental involvement and the likely educative value of conducting a review.

### Systems and Practice Review types

A **detailed review** is conducted when:

- a reasonable person, knowing all of the facts, may believe there is a connection between the decision making or the associated practice of the department and the injury or death of the child and this needs to be tested in the review process
- it is identified that there is no direct connection between departmental decision making or practice and the injury or death of the child and, the departmental decision making or the associated practice may have significantly impacted on the department's service delivery to the child under the *Child Protection Act 1999* in the two years prior to the child's injury or death
- when further information gathering is needed, via discussions with relevant parties, to ascertain whether departmental decision making or associated practice significantly impacted on the department's service delivery to the child under the *Child Protection Act 1999*
- when there is significant educative value in conducting a review within a learning and development framework.

A **limited review** is conducted when it has been assessed that there is limited potential for identifying and modifying decision making or practice issues, there is limited educative value in conducting a more detailed review and it is considered an unjustifiable use of resources to conduct a detailed review.

A **brief review** may be conducted where there is no probable link between departmental decisions or practice and the injury or death of the child and in the last year any of the following applied:

- the child was only listed as an 'other child' in all events
- the child had a client profile recorded but it was not linked to any events
- the child was only known to the department in relation to Intake Enquiries
- involvement with the family primarily occurred under the *Adoption Act 2009* but placement of the child may have occurred under the *Child Protection Act 1999*
- the only involvement that occurred was limited to one Child Concern Report
- the only action taken by the department resulted from the incident leading to the child's death or serious physical injury.



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## **Terms of reference**

The department is responsible for determining the terms of reference for the review and the extent of the review.

The term of reference for detailed and limited reviews is to:

*Review Department of Communities, Child Safety and Disability Services' service delivery to the Subject Child under the Child Protection Act 1999 in the two years prior to the child's injury or death with a focus on ensuring continuous improvement of service delivery, public accountability and improved outcomes for children.*

For Aboriginal and Torres Strait Islander children, the Systems and Practice Review will also consider whether practice decisions enabled the child to receive services in a culturally appropriate manner.

The term of reference for brief reviews is to:

*Summarise the Department of Communities, Child Safety and Disability Services' service delivery to the child under the Child Protection Act 1999 in the two years prior to the child's death or serious physical injury.*

## **Systems and Practice Review Committee**

The Systems and Practice Review Committee oversees Systems and Practice Review outcomes and has responsibility for making findings and recommendations in Systems and Practice Review reports. The committee considers all Systems and Practice Reviews prior to them being finalised and provided to the Child Death Case Review Panel Secretariat.

The committee is chaired by Executive Director, Child and Family Practice and Service Improvement, and has membership from across key departmental areas including:

- Workforce Capability
- Complex Case Advice and Practice Support
- Case Review Unit
- Child Protection and Adoption Design and Commissioning
- Aboriginal and Torres Strait Islander Child Family and Community Services Programs
- Disability Services, Clinical Governance
- Domestic Violence Reforms
- the regional director for each review being discussed.

The aims of the Systems and Practice Review Committee are:

- increasing sector collaboration
- strengthening practice
- systems improvement
- increasing and growing cultural capability
- accountability
- recognising high quality practice.



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The Systems and Practice Review Committee uses the following terms of reference when considering Systems and Practice Reviews:

- whether there is a link between the department's practice or decisions and the serious physical injury or death of the child
- the accountability of officers involved in the case and whether any identified practice issues amount to misconduct and require referral to Ethical Standards
- whether there are learnings identified that could be used to inform reform activities
- how any learnings from the Systems and Practice Review could be used to strengthen frontline practice
- whether there are opportunities identified to improve the child safety service system more broadly
- whether there are opportunities identified for enhancing internal and external collaboration
- whether there is high quality practice identified in the review that merits recognition.

In addition, for reviews relating to Aboriginal or Torres Strait Islander children, the committee considers the cultural integrity of the service provided to the child and family.

### Departmental report

As soon as practicable, and not more than six months after being notified of the death, serious physical injury or Minister's request for a review, the department must:

- complete the review
- prepare a report about the review
- provide a copy of the report and any documents obtained by the chief executive, and used for the review, to the Child Death Case Review Panel.

## External review

### Child Death Case Review Panels

Child Death Case Review Panels are the second tier of Queensland's case review system and provide important accountability and oversight of Queensland's child protection system. The panel considers the departmental reviews of all child deaths and children who suffered serious physical injuries if they were in the department's care or were known to the department in the 12 months prior to their death. The *Child Protection Act 1999* contains provisions for Child Death Case Review Panel in relation to:

- the purpose of review
- membership and panel formation
- the conduct of business by panels
- Child Death Case Review Panel reports and annual reporting.

### Purpose

The Minister is required to have the Child Death Case Review Panel, or an existing review panel, review departmental reviews for the purpose of facilitating ongoing learning and development in the provision of services by the department and to promote the accountability of the department.



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### Membership

Members of Child Death Case Review Panels are drawn from a pool of approved members. A person is eligible to be a member of the Child Death Case Review Panel if they have expertise in the field of paediatrics and child health, forensic pathology, mental health, investigations or child protection or because of their qualifications, experience or membership of an entity are likely to make a valuable contribution to the work of the panel. A member of the pool can hold office for no longer than two years.

Each review panel must include:

- at least three people who are not public service employees who the Minister is satisfied have specialist experience in child protection issues
- at least one, and no more than three, departmental employees
- at least one public service officer who is employed as a senior officer or senior executive officer in a different department
- at least one panel member who is an Aboriginal or Torres Strait Islander person.

### Forming panel

The Minister is responsible for approving the composition of a panel and the cases assigned to a panel for its consideration. Cases were grouped into themes and allocated to members according to their areas of expertise.

### Conduct of business and independence

A panel can conduct its business, including meetings, in any way it considers appropriate and is not subject to direction by the Minister about the way it performs its functions. Panels typically meet and discuss the allocated cases. The panel critically reflects on the department's Systems and Practice Review, departmental involvement and the circumstances of the family.

### Terms of reference for review

Child Death Case Review Panels must decide the extent and terms of reference for their review. The section 246DB (3) of the *Child Protection Act 1999* states the Child Death Case Review Panels may decide to consider:

- a matter within the terms of reference of the chief executive's review
- ways of improving the department's practices relating to the delivery of services to children and families
- ways of improving the relationship between the department and other entities with functions involving children and families
- whether disciplinary action should be taken against a public service employee of the department in relation to the department's involvement with a child.

### Child Death Case Review Panel reports

Following the panel meeting a final report is prepared by the panel chair, with support from the Child Death Case Review Panel Secretariat, outlining the views and findings of the panel. This report typically contains the panel's consideration and findings for each departmental Systems and Practice Review. It also includes any collective themes and findings identified by the panel considering the cases allocated to them.



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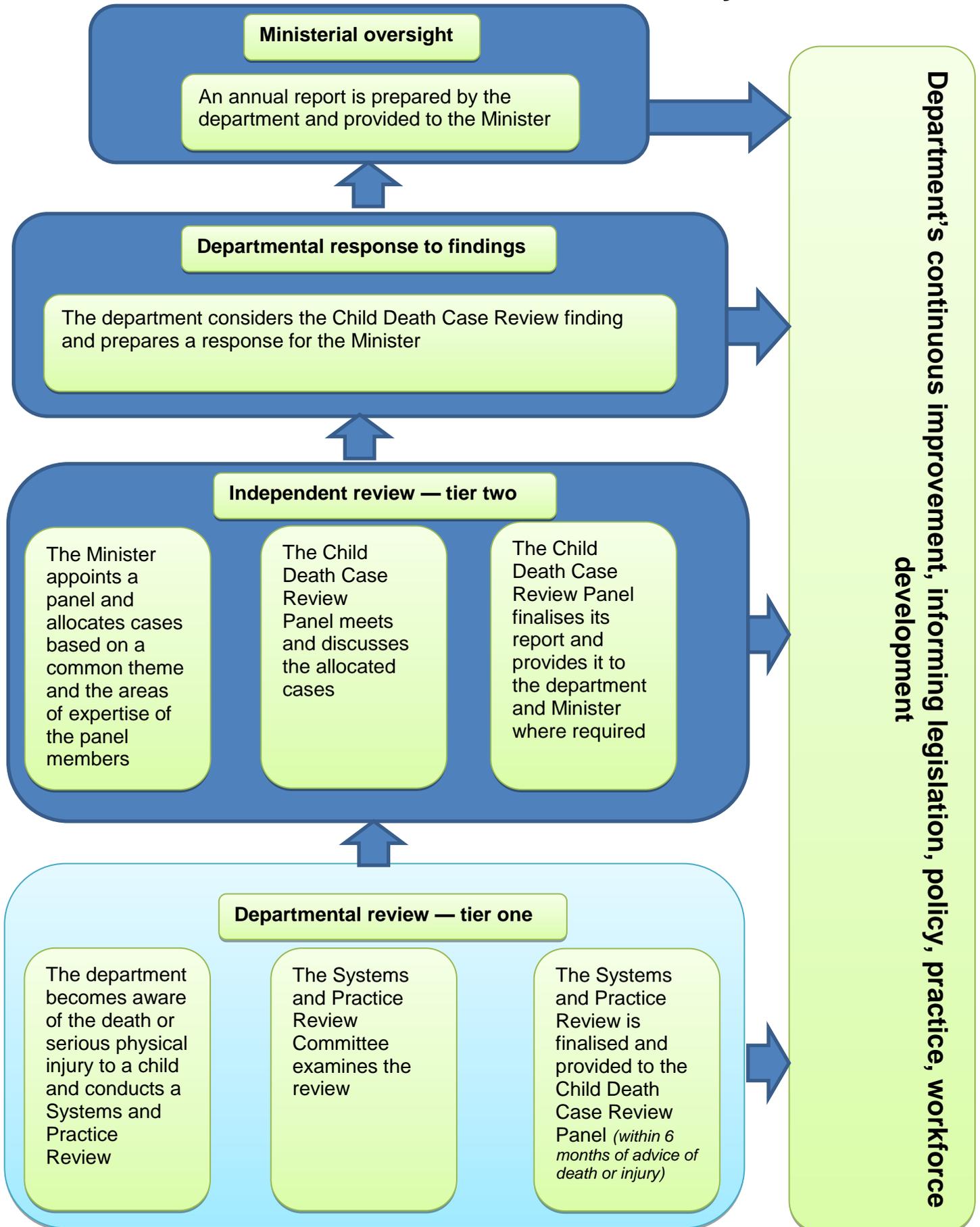
Within six months of receiving the department's review report, the Child Death Case Review Panel must complete its review, prepare a report and provide it to the chief executive. The chief executive must give a copy of the report to the Minister if the review was initiated by a request from the Minister or if the Minister requests a copy.

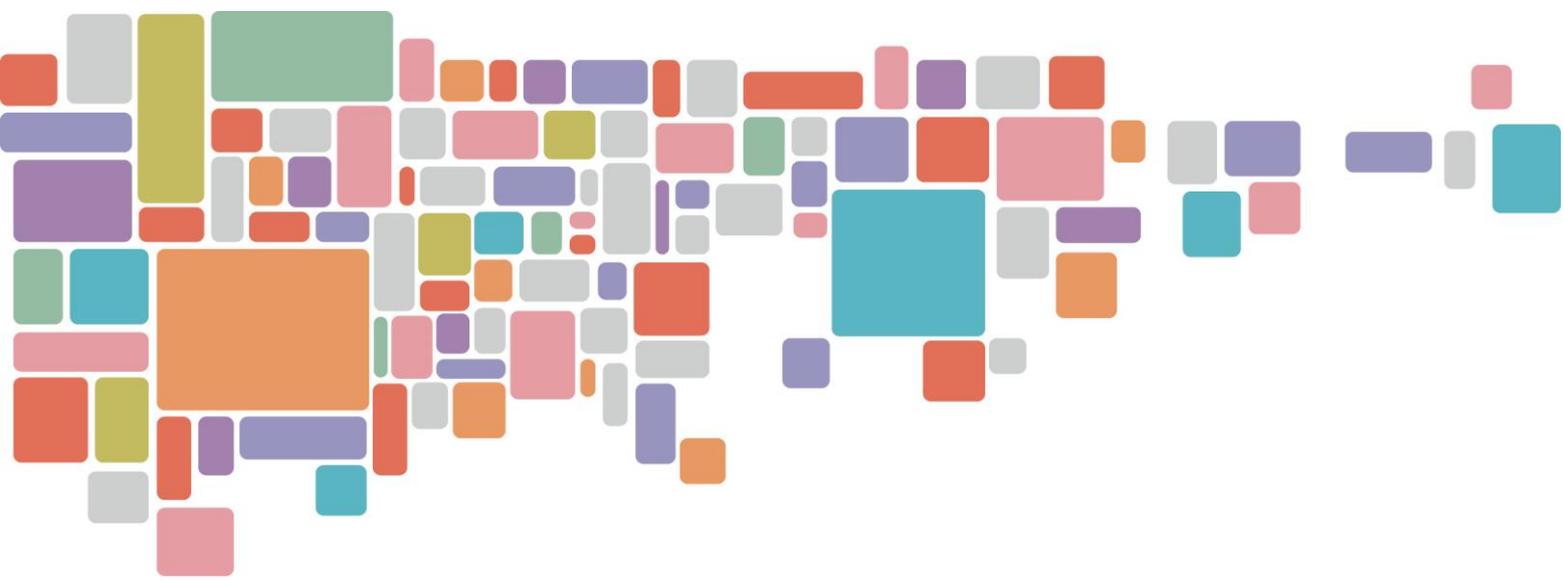
## **Annual reporting**

Within three months after the end of each financial year, the department must prepare, and give to the Minister, a report about the operation of the Child Death Case Review Panel during the financial year and actions taken in response to Child Death Case Review Panel review reports.



## The Queensland Child Death Case Review system



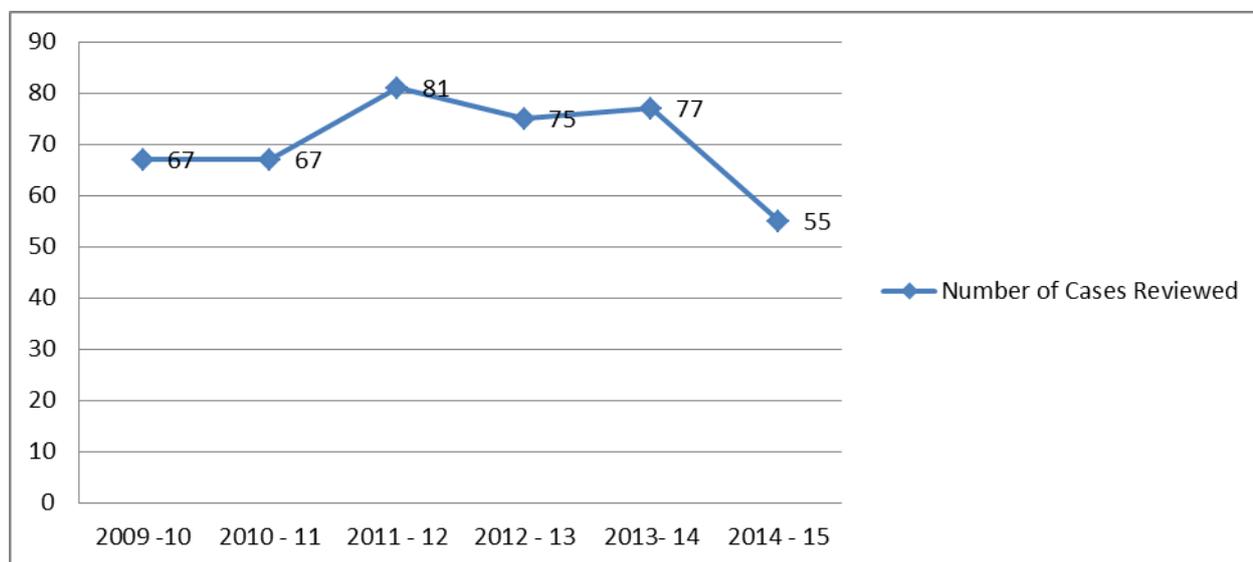


# Chapter 2

## Profile of children and young people subject to reviews 2014–15

In the 2014–15 reporting period, Child Death Case Review Panels completed reviews of departmental involvement with 54 children and young people who had died and one child who had suffered a serious physical injury. All of these children were known to the department in the year preceding their deaths or injury. Figure 1 shows the number of cases reviewed each year from 2009–10 to 2014–15. Please note: 1 July 2014 legislative changes reduced the timeframe for cases requiring review from three years to one year and included the serious physical injury cohort.

**Figure 1. Number of cases subject to review in Queensland.**



### Age and gender

As shown in Table 1 below, the majority of cases reviewed (72 per cent) during the 2014–15 reporting period involved children under the age of nine years at the time of their death or serious physical injury. Children aged under one year at the time of their death or serious physical injury were the largest group (29 per cent) followed by children aged five to nine years (27 per cent).



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Of the 55 children and young people reviewed, 28 were male and 27 were female. In cases involving 15-17 year olds, males were represented at a higher rate than females. Conversely, for cases involving children aged under one year, females were represented at a higher rate.

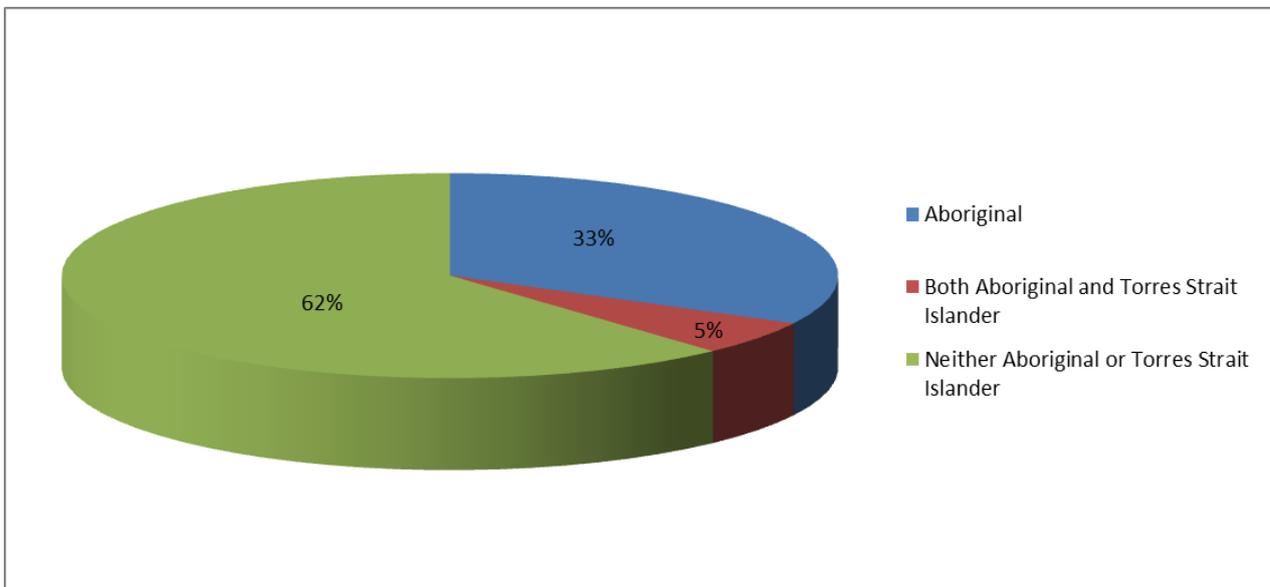
**Table 1. Cases reviewed by gender and age category 2014–15**

Age	Male	Female	Total
< 1 Year	5	11	16
1–4 years	6	3	9
5–9 years	7	8	15
10–14 years	3	3	6
15–17 years	7	2	9
<b>Total</b>	<b>29</b>	<b>27</b>	<b>55</b>

## Aboriginal and/or Torres Strait Islander children and young people

Of the 55 cases reviewed 18 children and young people (33 per cent) were identified as Aboriginal and three were identified as both Aboriginal and Torres Strait Islander (5 per cent). Figure 2 shows the proportion of cases reviewed that involved Indigenous children. For comparative purposes, during the 2013–14 financial year departmental data indicates that 22 per cent of intakes received involved a child or young person who were identified as Indigenous and 41 per cent of all ongoing intervention work undertaken by the department involved a child or young person who were identified as Indigenous.

**Figure 2. Proportion of cases reviewed involving Indigenous children and young people**



## Geographic distribution

As detailed in Table 2 below, 23 reviews (42 per cent) involved children and young people who resided in regional or remote areas of Queensland at the time of their deaths. Of the 54 cases involving child deaths reviewed 31 (57 per cent) involved children who resided in metropolitan areas at the time of their death.



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**Table 2. Cases reviewed by gender and the location of the child or young person’s residence at the time of their death or injury**

ARIA+ <sup>1</sup> Classification	Male	Female	Total	Total %
Metropolitan	16	15	31	57%
Regional	9	9	18	33%
Remote	2	3	5	9%

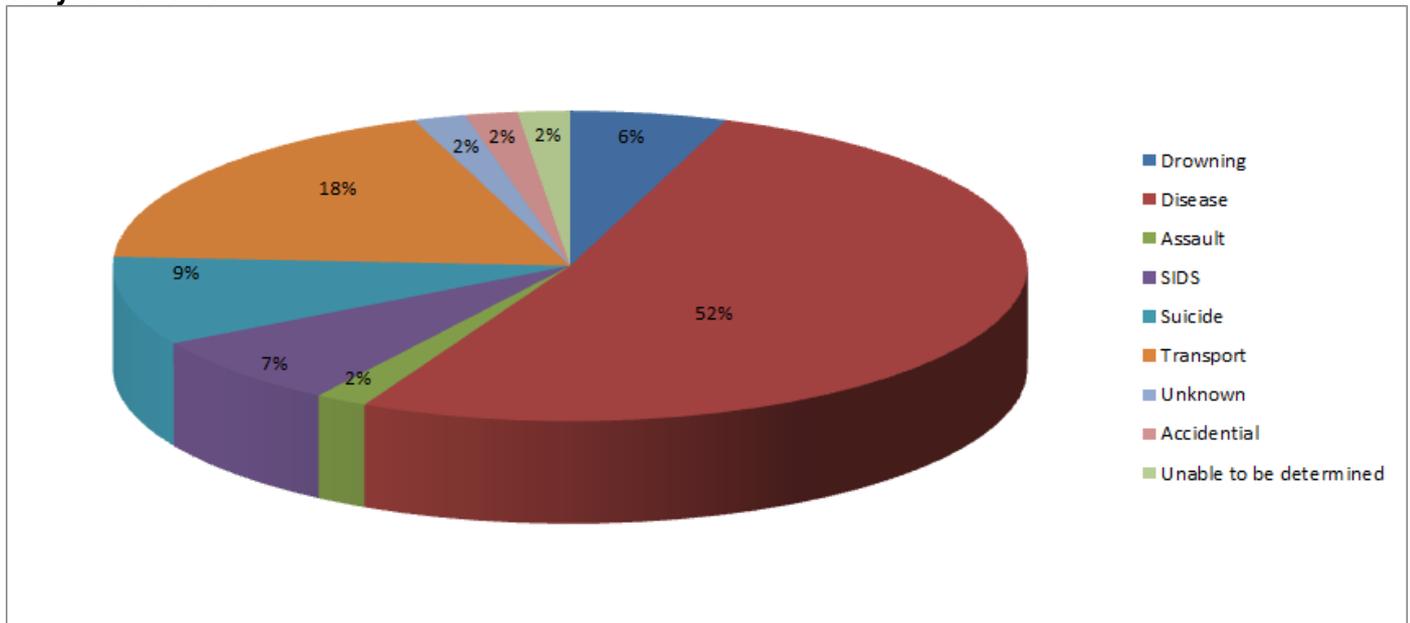
## Characteristics of serious physical injury

During the reporting period one review of a child suffering a serious physical injury was conducted. This case involved a non-Indigenous male under the age of one year being shaken by a caregiver. The department had no involvement with the family at the time of the injury occurring.

## Characteristics of child and young person deaths

As outlined in Figure 3, the leading cause of death<sup>2</sup> for children and young people subject to review was disease followed by transport-related accidents. Deaths occurring as a result of transport accidents involved passenger vehicles, scooters or bicycles. Three deaths were categorised as drownings.

**Figure 3. Causes of death as a proportion of all deaths of children and young people subject to review**



In relation to deaths classified as suicides, all were a result of hanging and, as outlined in Figure 4, all but one involved young people in the 15 to 17 years age bracket.

Children under the age of one year were more likely to die as a result of disease or SIDS.

<sup>1</sup> Accessibility/Remoteness Index of Australia

<sup>2</sup> The department has categorised causes of death based on the known circumstances of the child or young person’s death and available findings from Coroners. Some cases were still under the consideration of a Coroner at the time of compiling this report.

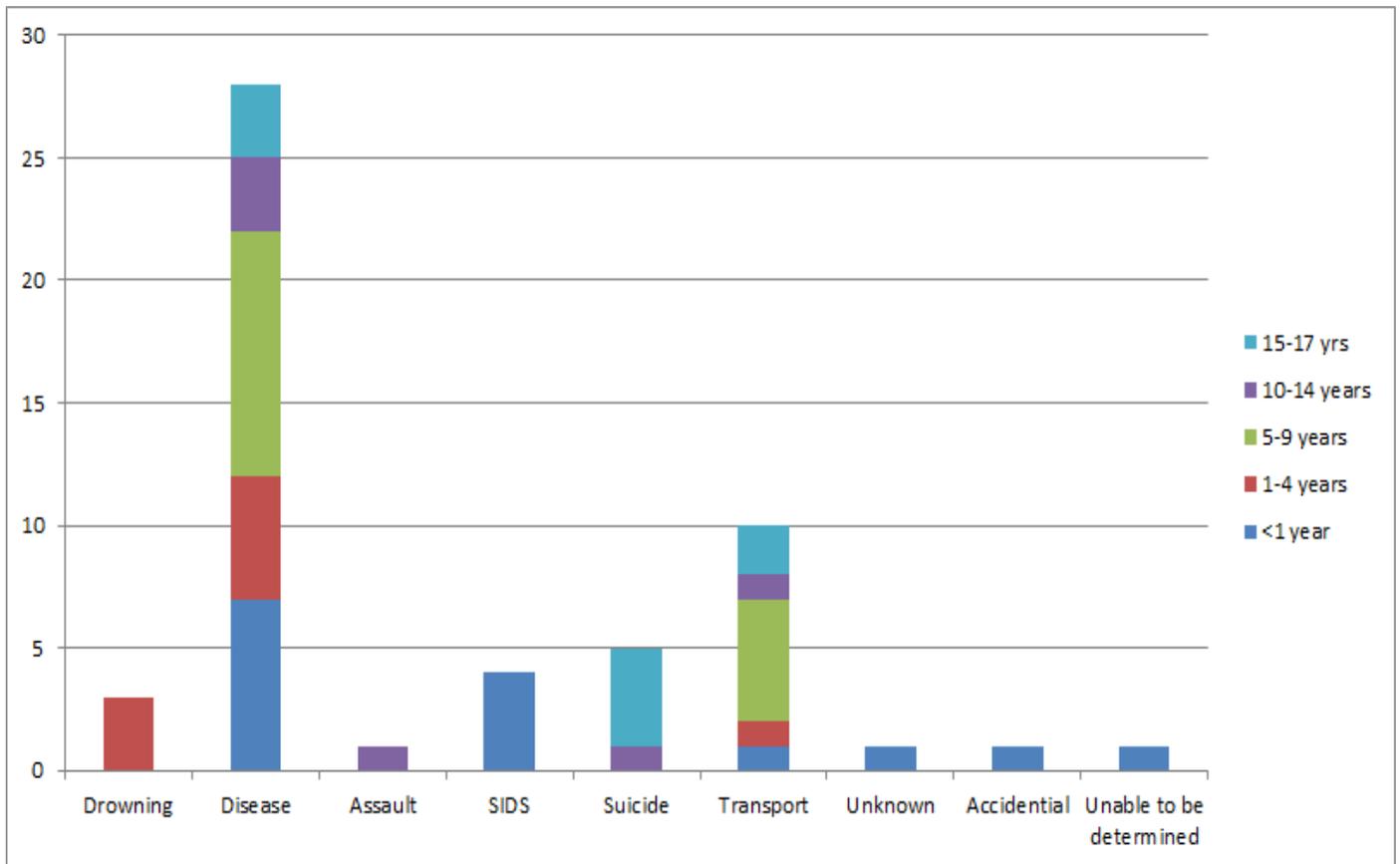


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Causes of death as a result of disease for all children and young people reviewed included:

- Cancer (20 per cent)
- Cerebral Palsy and associated complex medical conditions (16 per cent)
- Complex pre-existing medical conditions associated with genetic disorders (18 per cent)
- Congenital heart conditions (12 per cent)
- Extreme prematurity (12 per cent)
- Asthma (11 per cent).

**Figure 4. Causes of death per age bracket**



As shown in Table 3, 28 of the 54 (52 per cent) cases reviewed involved a child or young person who died as a result of disease. This was the most common cause of death. Overall, there were few differences between males and females based on their cause of death.



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**Table 3. Cases reviewed by gender and cause of death**

Cause of death	Male	Female	Percentage	Total
Drowning	2	1	6%	3
Disease	15	13	52%	28
Fatal Assault	0	1	2%	1
SIDS	1	3	7%	4
Suicide	3	2	9%	5
Transport	6	4	18%	10
Unknown <sup>3</sup>	0	1	2%	1
Accidental	0	1	2%	2
Unable to be determined <sup>4</sup>	0	1	2%	1

Table 4 shows causes of death as a proportion of the total deaths for children and young people based on their indigenous status.

**Table 4. Cases reviewed by indigenous status and cause of death as a proportion of each group**

Cause of Death	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Drowning	2	1	10%	3%
Disease	11	17	51%	52%
Fatal assault	0	1	0%	3%
SIDS	1	3	5%	9%
Suicide	1	4	5%	12%
Transport	4	6	19%	18%
Unknown	0	1	0%	3%
Accidental	1	0	5%	0%
Unable to be determined	1	0	5%	0%
Total	21	33	100%	100%

### Involvement with the department

As shown in Figure 4, of the 54 cases reviewed four (7 per cent) involved children or young people who were in the custody or guardianship of the department at the time of their death. All the children and young people reviewed by panels who were subject to custody or guardianship orders had their cause of death listed as disease.

In the majority of cases (39 cases or 72 per cent), the department did not have any current involvement — intake, investigation or ongoing intervention — with the child or young person at the time of their death. The nature of non-custodial departmental involvement at the time of the death of a child or young person included: five children and young people who were subject to

<sup>3</sup> Cases classified as unknown involve children and young people where a cause of death was yet to be formally determined. The circumstances of the child's death are such that they cannot be accurately categorised without formal determination from the Coroner.

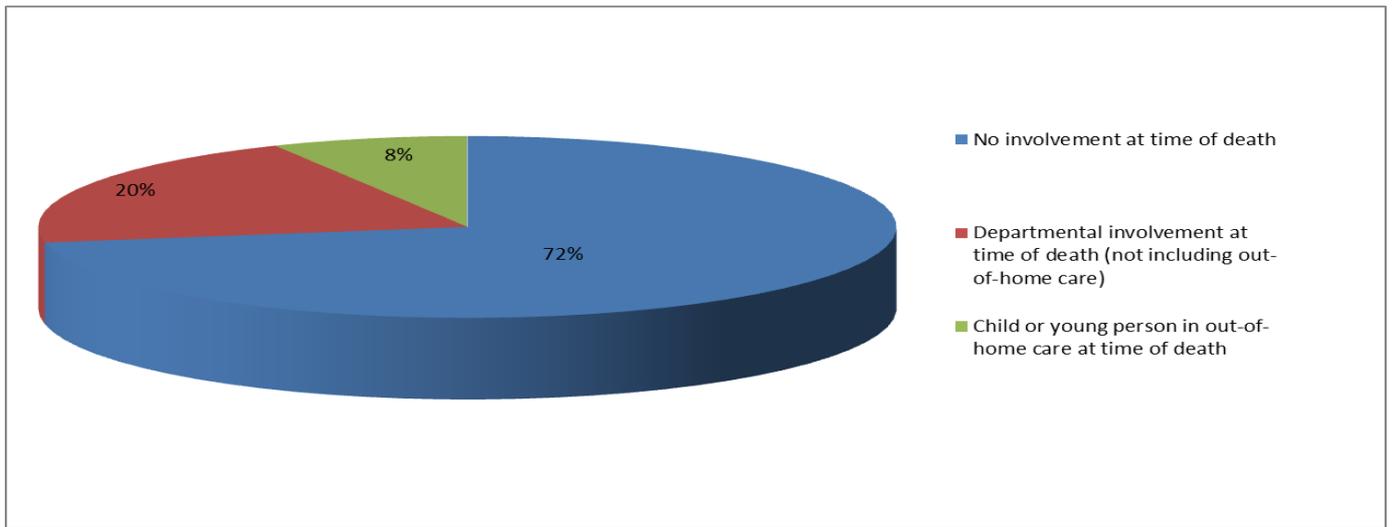
<sup>4</sup> Cases classified as Unable to be determined have had a formal finding from the Coroner that their cause of death was unable to be determined.

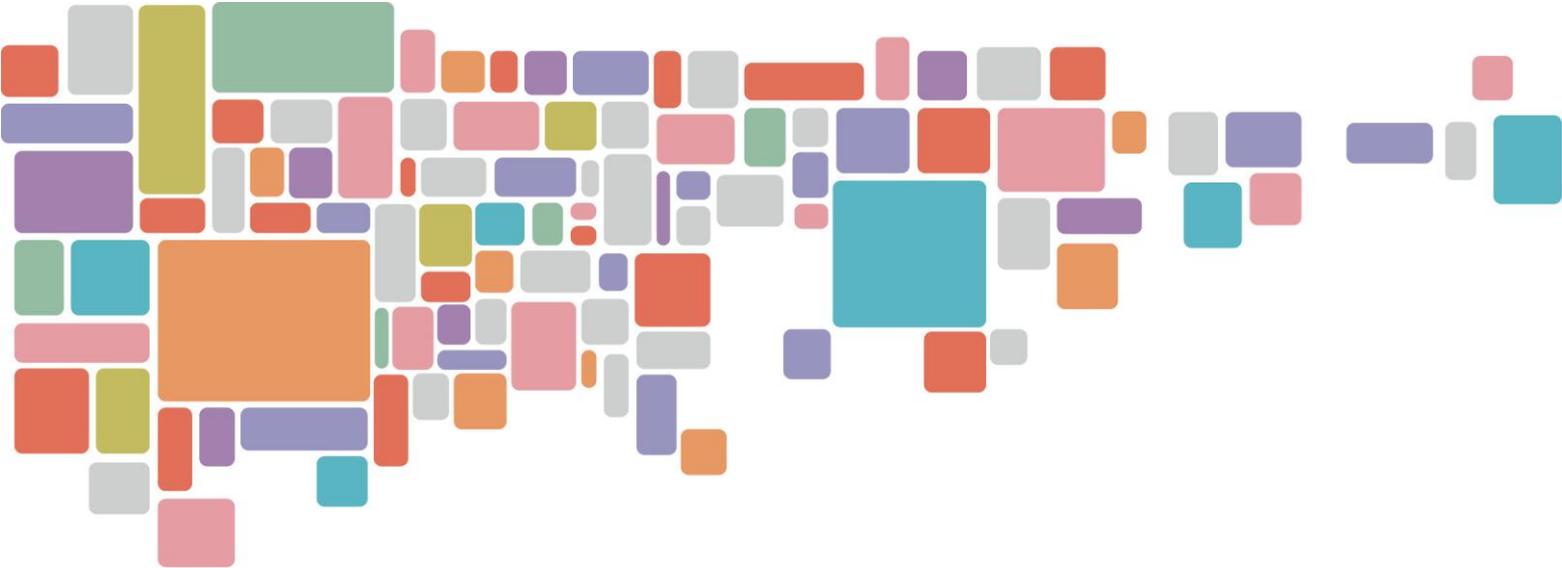


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Investigation and Assessments; three who were subject to Intervention with Parental Agreement cases; two were subject to Support Service cases; and one who was subject to a Supervision Order. The causes of death for children and young people subject to Investigation and Assessment's or departmental intervention at the time of their death, were predominately disease related (six deaths or 55 per cent), followed by two deaths attributed to SIDS (18 per cent), one drowning (9 per cent), one transport related death (9 per cent) and one death that was unable to be determined (9 per cent).

**Figure 5. Involvement at time of death**





# Chapter 3

## Child Death Case Review Panels

### Pool of approved members

In 2014, the department coordinated a recruitment process that resulted in the former Minister appointing 12 external members, seven departmental senior officers and 10 senior officers from other government departments to the pool of approved members from which Child Death Case Review Panels were formed. Panel members from the 2014 recruitment were appointed for a period of one year, with their membership expiring on 27 July 2015. Appendix B outlines members of the pool during the reporting period.

### Panel composition

The composition of each Child Death Case Review Panel and the allocation of cases to panels are approved by the Minister with assistance from the Child Death Case Review Secretariat. Each panel is chaired by an external member. The use of a pool of members with diverse expertise has provided the opportunity for cases to be themed and allocated to a panel of approved members with related expertise. This approach has enabled panels to consider multiple cases with related issues relevant to their area of expertise. Occasionally, case allocation was impacted by the legislative timeframes outlined in the *Child Protection Act 1999*, requiring cases to be reviewed by a panel within six months of the department's review being completed. Additionally, cases often had multiple issues that overlapped a number of panel themes. Wherever possible, cases were allocated based on the most significant issue in the case.

Each Child Death Case Review Panel was comprised of three external members, one member from the department and one member from another government department. Each panel had at least one member who is Aboriginal or Torres Strait Islander.



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## Panel themes

During 2014–15, panels were convened around the following themes:

- service delivery to children and young people with severe chronic or terminal medical conditions and disabilities
- service delivery to children and young people in families engaged with the department through an Intervention with Parental Agreement
- service delivery to children and young people from families where domestic and family violence was present
- service delivery to Aboriginal or Torres Strait Islander children with severe chronic or terminal medical conditions and disabilities
- service delivery to children and young people whose cause of death was suicide
- service delivery to children and young people whose cause of death was initially unknown and who were very young and vulnerable at the time of their death
- service delivery to children and young people whose cause of death was due to injuries caused by transport-related incidents
- service delivery to children and young people from families with multiple complex child protection risk factors
- service delivery to children and young people who suffered serious physical injuries
- service delivery to children and young people who have died and had limited involvement with the department.

## Panel findings

Nine Child Death Case Review Panels were convened and completed reviews in 2014–15. They considered departmental involvement with 54 children and young people who died and one young person who sustained a serious physical injury. Nine final reports were produced by panels and provided to the Director-General, Department of Communities, Child Safety and Disability Services in 2014–15.

Two additional panels met during 2014–15, however their final reports were delivered after 30 June 2015 and their findings will be captured in the next reporting period.

Child Death Case Review Panels considered departmental involvement with children and young people at differing points on the child protection continuum. These children and young people were from diverse cultural, family and community backgrounds and had different life experiences and challenges.

Each panel was responsible for producing a report outlining the findings of their review. The approaches to making findings and the types of findings made by panels varied based on panel composition and the types of cases allocated. Each panel made findings aimed at systemic improvement based on the consideration of the individual cases allocated to them. There were recurring themes and areas for improvement which appeared across multiple panels. During the 2014–15 reporting period, Child Death Case Review Panels did not find a link between the department's action or inaction and the death or serious physical injury of the children or young



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people reviewed. However, panels did identify areas of improvement in the delivery of service to children, young people and their families and interagency coordination.

## **Systems and Practice Review process**

Over the course of 2014–15 the department's Systems and Practice Reviews have been adapted based on the feedback received from panels as well as ongoing alignment to the department's reform agenda. Panels noted the significant investment by the department in conducting its internal reviews and identified many instances where the review and analysis was of a high standard.

Panels generally identified that departmental reviews focused on individual decisions and practice issues related to service delivery and could have been improved by including more analysis of how the system responded to families and how families experienced the child protection system. Panels identified on several occasions where further exploration of issues or more rigorous critical analysis of certain departmental decisions would have improved the quality of reviews.

Panels overall identified it would be beneficial to strengthen the consideration and assessment of culturally appropriate practice. Panels' commentary included the department's review of cultural practice had a tendency to focus on whether the department complied with its legislative obligations rather than whether practice was genuinely culturally appropriate. A number of panels requested that further information be included in reviews regarding the cultural background of the child or young person and, for Aboriginal and Torres Strait Islander children and young people, the nature and content of consultation that occurred with Recognised Entities.

## **Communication, coordination and collaboration**

The majority of panels identified the need for improvement in collaboration between the department and government and non-government partners. Panels noted that a lack of interagency communication, coordination and collaboration between government departments and non-government agencies led to fragmented service delivery to vulnerable children and young people. It was identified that at times child safety staff discounted the expertise of professionals while on other occasions staff placed undue weight on observations made by other professionals of children in the home.

The criticality of agencies understanding their roles and responsibilities, and articulating casework actions that are being taken, was particularly evident in cases where families had multiple complex needs. Panels identified that it is critical for the department to take a leadership role and coordinate service delivery or ensure that someone has the lead if the department is not the appropriate agency to do so, particularly with families who have multiple complex needs. Panels commented that it was important that departmental officers determine whether other agencies are providing services to families, whether that involvement provides sufficient safety to the child, and clarify the expectations of the department.

Panels identified multiple cases where service delivery to children and young people with disabilities could have been improved through strengthening working relationships between Child Safety Services and Disability Services within the department. Similarly, panels identified that there were multiple cases where stronger partnerships between the department and Child and Youth Mental Health Services could have improved service delivery. Purposeful case planning with government and non-government service providers engaging with the family were identified as areas which may assist in ensuring actions, expectations, concerns and actions are more coordinated.



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Several panels suggested that other government departments engaged with children or young people subject to Systems and Practice Reviews should participate in the review process. There is currently no requirement for officers from other government departments to be involved in reviews undertaken under the *Child Protection Act 1999*. It was acknowledged that other agencies may be considering the case under their own review mechanisms and the criticality of collaboration between review processes was highlighted. It was identified that reviews that do not include participation from other stakeholders are a missed opportunity to co-operate, learn and create common understandings and consensus regarding opportunities to work together to create a more effective service system.

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

Panels reviewing departmental involvement with Aboriginal and Torres Strait Islander children and young people frequently identified the importance of quality partnerships and collaborative decision making with Recognised Entities. Panels found that departmental staff often did not have sufficient knowledge of culturally capable practice.

One panel noted that on occasions departmental officers made decisions based on inaccurate cultural understandings, such as when it was appropriate for an older sibling to be caring for a younger sibling. It was identified in a number of cases that departmental assessment and case management practices for Aboriginal and Torres Strait Islander children, young people and their families were not holistic and therefore potentially ineffective. The panel advised that assessment of the health and wellbeing of an Aboriginal or Torres Strait Islander child or young person needs to consider key indigenous care indicators which align with the Closing the Gap initiative and include health, housing, disability, safe homes (domestic violence and substance misuse), school, economics and employment. Panels also identified the importance of non-stigmatising early intervention and prevention for Aboriginal and Torres Strait Islander families.

### **Recognised Entities**

As stated on page 28, panels identified the important and complex role of Recognised Entities. Panels that considered departmental involvement with Aboriginal and Torres Strait Islander children and young people noted that engagement with the Recognised Entities on a number of occasions was lacking, or the depth of engagement was not apparent, through the departmental review or departmental records. In some instances this was due to the Recognised Entities not being available to consult with after-hours or the Recognised Entity's response being received after the decision had been made. Panels identified that increasing the cultural competency of departmental officers requires ongoing reinforcement of mandatory participation and consultation requirements, a commitment to involving the Recognised Entity from the outset at key decision points, encouraging open information sharing and rigorous discussions and valuing the Recognised Entity as a key partner in service delivery. One panel questioned the capacity of Recognised Entities to be accountable and responsive for the services they are contracted to provide in noting some of the excessive time delays that occurred in provision of feedback to the department. Panels saw it as essential to empower Recognised Entities and provide them with sufficient resources, staff, training and authority to provide a timely, efficient and meaningful cultural service.



## Intervention stages

### Intake

A significant number of findings were made by panels in relation to improving service delivery during intake. Panels were of the view that often intake officers appeared to be passive receivers of information from notifiers and failed to ask appropriate explorative questions and gather sufficient information to make informed decisions.

A number of panels found often escalating patterns of harm, particularly harm associated with domestic and family violence, continued to be recorded as Child Concern Reports based on the absence of specific information about the child being harmed during the notified incident. Panels were of the view that improvements to intake decisions could be made by ensuring there is thorough consideration of patterns of harm and risk in families and their cumulative effects on children and young people.

Panels considered the department's policy regarding pre-notification checks prohibits intake officers from gathering sufficient information to undertake a comprehensive assessment of the notified concerns. Panels identified instances where valuable information could have been gathered by intake officers to form a more complete picture of the family's situation; however, the prerequisites for conducting a pre-notification check had not been met and therefore they were not conducted.

### Investigation and assessment

A number of panels considering departmental investigations identified that improvements could be made by more holistic consideration of the family's circumstances and may have resulted in support being provided by the department or a non-government service provider. Panels also found that improvements to information gathering and sharing during investigations could also improve service delivery to families.

Several panels commented that at times there was a lack of focus on the needs and interest of the child. They noted the complex issues faced by parents can take the focus off the needs of vulnerable children. Panels advised if there is conflict between the child's safety, wellbeing and best interests, and the interests of an adult caring for the child, the conflict must be resolved in favour of the child.

A key finding from a number of panels related to delays in commencing investigations and subsequent delays in risk assessment or service provision to children, young people and families. Panels found that when departmental officers conducted thorough assessments of concerns with a high quality of information gathering and information sharing, more robust consideration of risks for the child occurred.



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**An example of a quality investigation and assessment noted by a panel**

During the two years prior to the child's death, the department's service delivery consisted of recording an unborn child notification alleging risk of neglect and physical harm to the child after birth. An investigation and assessment followed with an outcome recorded as substantiated, child in need of protection.

In this case, the panel commended the department with regard to the outstanding and tenacious practice, which occurred during the investigation and assessment, in particular:

- challenging the mother's version of events when these conflicted with the notified information
- in-depth information gathering, including extensive liaison with multiple stakeholders
- appropriate identification and critical analysis of the risk factors.

**Intervention with Parental Agreement**

Panels considering Intervention with Parental Agreement cases noted their use carried considerable risk. They observed in these cases, children remained in the care of their parents while intervention occurred, despite a substantiation of harm and/ or unacceptable risk of harm and the absence of a parent willing and able to protect the child. Panels noted it was important for the department to examine the adequacy, quality, and sufficiency of the Intervention with Parental Agreement response particularly the intensity and urgency of the case work being undertaken.

One panel noted there were challenges associated with balancing the risk to the child with providing families with the opportunity to address the child protection issues while they continue to care for their children. The panel advised that for an Intervention with Parental Agreement response to be successful and the child to remain safe, the parents need to be engaged in and committed to the process. The panel was concerned that in some cases parents might express a willingness to be involved, but their actions were not congruent with what they are stating. They advised that the department should ensure that it takes steps to actively engage parents at all stages of assessment and casework, and to re-assess if case goals are not being achieved or the risk to the child increases to an unsafe level.

**Recordkeeping**

Panels commented on the importance of timely, accurate recordkeeping. Inconsistent and conflicting information in departmental documents were identified as problematic to practitioners and reviewers. Delays in recording information led to decisions being made on incomplete information. For example, one panel noted screening decisions at intake were not finalised in a timely manner and, when new information was received, intake officers were not able to consider the full history for the family as outcomes for earlier intake decisions were yet to be recorded.

One panel questioned whether the department's Integrated Client Management System and the Structured Decision Making tools are flexible enough to allow child safety officers to capture and assess information in a way that promotes data accuracy. For example, one panel noted while notes may be made simultaneously as information is received, references to previous events and their implications in the context of new information were not documented. This can prove to be problematic when officers are considering the cumulative effects of harm and risk factors.



## Organisational issues

Ensuring the department has the capacity to meet the care and protection needs of vulnerable children and their families requires well-resourced and supported staffing environments. Panels noted there is a challenge for departmental officers to have an extensive understanding of domestic violence, mental health issues, substance misuse and all forms of child abuse and neglect. Panels considered that having extensive and specialist understanding is unrealistic given the extent of the complexities of the families and the expertise required for each of these specialised areas. This can be compounded by inexperienced staff being asked to manage complex cases that would be challenging even for experienced practitioners. Panels identified the importance of the department having clearly documented escalation processes for complex cases that include senior departmental officers and shared responsibility and coordination with other agencies.

Panels identified that improvements could be made to systems of workload management and prioritisation, including strengthening mechanisms available to identify, monitor and respond to excessive workloads, gaps in service delivery particularly when staff members are on leave and issues with availability and allocation of resources. Additionally, panels considered the quality and sufficiency of practice resources available to practitioners. One panel identified that departmental practice papers were excellent resources however it was unclear if there is sufficient utilisation of the papers by staff or how the papers translate into practice. The panel considered there should be work undertaken to develop quick and easy resources to assist staff in applying practice papers to their everyday work.

## Disability and chronic medical conditions

A significant number of reviewed cases involved children and young people with disabilities and chronic medical conditions. Panels noted unique complexities associated with service delivery to this cohort of children and young people. These cases require a coordinated response from government and non-government service providers and effective utilisation of specialist knowledge and expert advice.

Panels noted that it is critical for departmental officers undertaking service delivery with these cases to have a solid understanding of: the impact of the child's medical conditions on the child's safety and wellbeing; the family dynamics; and how best to assess and support these children and families in the child protection framework. This includes an understanding of how having a child with significant disabilities can affect family functioning and parental stress and wellbeing, without assuming the presence of disability is in itself the sole source of stress.

Panels suggested service delivery to children and young people with disabilities and chronic medical conditions could be improved with the introduction of specific guidelines for service delivery developed in collaboration with Queensland Health and Disability Services. One panel commented the obvious links with Disability Services should be strengthened and there is an opportunity to develop a strong connection to the Disability Services' area of practice leadership. This could be a stronger source of expertise, support and training for Child Safety Services staff.

## Domestic and family violence

While none of the children or young people considered by the panel died as a result of domestic and family violence it was a significant feature in the families of a large number of the cases reviewed. Panels commented that child safety officers would benefit from training, specialised information and support to ensure cases involving domestic and family violence are appropriately assessed and child protection issues managed. Panels found there was scope for child safety



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officers to develop greater awareness and understanding of domestic and family violence and its implications for child protection.

Panels identified cases where staff tended to minimise incidents of domestic violence, in particular the risk of emotional and psychological harm to children and the flow-on effects to mental health, physical health and family functioning. Panels were concerned with the apparent weight given to advice from Queensland Police Service officers responding to domestic and family violence incidents, that children in the residence appeared 'healthy and fine'. Panels considered these descriptors should not be relied on to suggest there has been no harm to the child. Panels observed this was a recurring service system issue across multiple cases.

### **Suicide**

As stated in table 3 on page 22, five cases reviewed in the reporting period involved a young person with a cause of death listed as suicide. All of these cases were considered by one panel who identified departmental officers did not at times have sufficient understanding of key factors present in the lives of these young people who suicided, in particular, social and emotional harm, mental illness and domestic violence. The cases revealed the complex social, familial and individual issues that these young people had in their lives and the need for an intensive, committed and personalised response. The panel found that information about mental health issues of both the young people and other members of their families was not given appropriate weight in decision making about how best to support the young people affected.

The panel found the challenge of supporting and assisting high risk young people should not rest solely with child safety services. The panel identified the need for involvement from specialist agencies, both government and non-government, when these types of cases are assessed and intervention is required. The involvement is required in providing services as well as managing cases. The panel identified there was significant room for improvement in how Child and Youth Mental Health Services and departmental workers coordinate service delivery to these young people, particularly in information sharing.

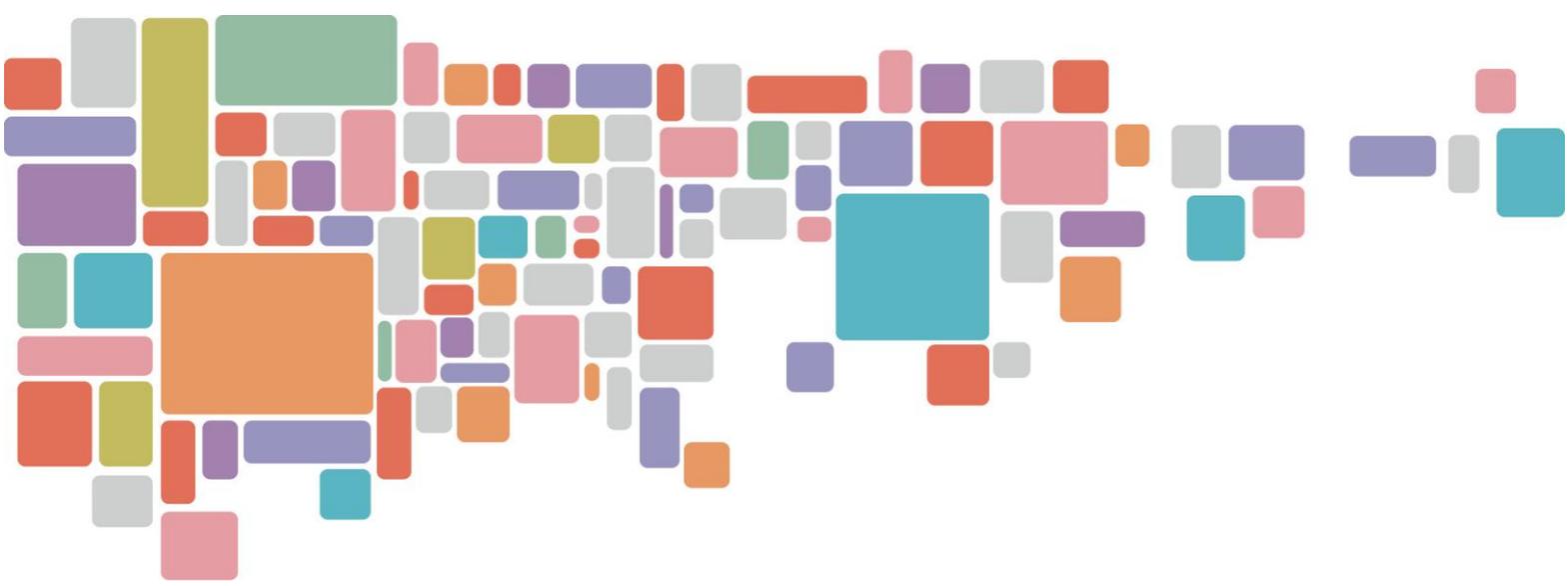
### **Unborn children**

A number of cases considered by panels involved service delivery to children who were the subject of child protection concerns before they were born. The assessment of concerns regarding unborn children and the provision of support to expectant mothers is a complex area of practice. One panel noted the difficulties faced by workers in distinguishing between their role in intervention and prevention work with the mother and investigation of the child protection concerns. The panel noted the 'dichotomy and complexity' of these roles on occasion resulted in the needs of the child being overlooked.

A common theme across panels considering cases with service provision to unborn children was the potential barrier to service delivery caused by current legislative and policy provisions. These provisions require the department to obtain the consent of the pregnant mother before undertaking an investigation or engaging Recognised Entities or other service providers. This requirement was noted to impact on the department's ability to provide timely support to families and to protect the needs of unborn children at risk after their birth.

#### **Unborn children – An example of a panel finding**

*The panel considers there is need for the department to undertake a review of the legislative and policy provisions regarding its response to child protection concerns for unborn children. The panel notes there is a review of the Child Protection Act 1999 (the Act) planned in 2015 and considers that this review could give consideration to the practice limitations resulting from the current provisions relating to unborn children (section 21A of the Act).*



# Chapter 4

## Department of Communities, Child Safety and Disability Services response

The Department of Communities, Child Safety and Disability Services wishes to acknowledge the hard work and dedication of departmental staff and Child Death Case Review Panel members involved in these cases and reviews. The department is committed to providing high quality child protection services, ongoing learning and improvement and promoting the accountability of the department. The Child Death Case Review Panels offer an opportunity for external and internal experts to come together and consider service delivery to vulnerable children and young people. The findings from panels provide the department with valuable feedback on what is working well and areas where improvements can be made in providing services to Queensland families.

Each Child Death Case Review Panel provides a final report outlining their finding to the Director-General of the department, which is considered by key areas in the department. These areas include: Workforce Capability; Child Protection and Adoption Design and Commissioning; Practice Leadership; Aboriginal and Torres Strait Islander Child, Family and Community Services; and Violence Prevention Unit. A report is then provided to the Minister outlining the action the department has taken or intends to take to address the findings in the panel's report.

## Response to Child Death Case Review Panel findings

### Systems and Practice Reviews Process

The department accepts the panel findings that regular reassessment of the methodology utilised for conducting Systems and Practice Reviews, should occur and contribute to the continuous improvement of the review process. Throughout 2014–15 a number of process changes were made to strengthen the robustness of the review process. This included involvement from: the Violence Prevention Unit; Disability Services; and Aboriginal and Torres Strait Islander Child and Family Reform in the Systems and Practice Review Committee. Other amendments to Systems and Practice Reviews have been aimed at balancing the focus of reviews on accountability and broader learning and development focus. An accountability focus requires the Systems and Practice Review to examine cases on a decision-by-decision basis whereas the broader learning and development focus ensures a more holistic assessment of service delivery to the family.



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As part of the ongoing development of the review process, the department particularly noted those matters where the Child Death Case Review Panel made findings that were not identified in the Systems and Practice Review. The department analysed these discrepancies to inform the ongoing maturation and strengthening of the department's review process.

In addition, the department commenced a review of the case review system, at the request of the Minister, to examine the current process after the first 12 months of operation since the legislative changes and identify opportunities for improvement and strengthening.

In relation to engaging Recognised Entities in the review process, and evaluating cultural competence, the department agreed this would enhance the quality of reviews and analysis of the cultural appropriateness of practice. The department accepted the panel findings in relation to incorporating Recognised Entity engagement into the review process and placing a greater focus on evaluating the cultural integrity of service delivery. The engagement of departmentally funded non-government agencies and their staff in review processes would provide a more holistic review of the system of service delivery to the children and their families.

The department agreed with the panels' recommendation that more consistent engagement in review processes across Queensland Government departments would enhance the systemic analysis of the reviews. The department noted the recent announcement regarding the government's acceptance of the *Not Now Not Ever* Special Taskforce on Domestic and Family Violence recommendation to establish an independent Domestic and Family Violence Death Review and Advisory Board and will seek opportunities to partner with the Office of the State Coroner once the board is established.

### **Communication, coordination and collaboration**

The department agreed with the panel findings regarding the recurring issue of interagency communication, co-ordination and collaboration in ensuring quality service responses to children and families. In response to panel findings, where the department has an ongoing case management role with children in need of protection, there is agreement that the Child Safety Service Centre will take a lead role in coordinating and participating in stakeholder meetings and other mechanisms for engagement and communication. It is noted that, in some cases, particularly where the department does not have an ongoing case management role, it may be appropriate for another government or non-government agency to take the lead in these stakeholder processes and the department's role may be temporary in the event that a child is assessed to not be in need of protection. There is the opportunity for these issues to be explored further through the whole-of-government mechanisms to support the Child and Family Reforms such as the Reform Leaders Group, Senior Officers Group and Regional Child and Family Committees.

The department supported the premise identified by panels that a range of specialist services, from government and non-government providers, are required to meet the needs of highly vulnerable children and young people. Panel findings will contribute to ongoing work occurring to improve interagency co-operation and staff skills in stakeholder engagement, in particular the new Framework for Practice aims to equip staff with the skills required to undertake engagement effectively.

A number of findings related to multi-agency responses and stakeholder engagement. The role and function of the Suspected Child Abuse and Neglect (SCAN) team is under review in the light of Child and Family Reforms. Panel findings related to interagency collaboration will inform this review. Findings from panels regarding multi-agency responses will be provided to relevant department business units to inform the review. Additionally, there are a number of reforms occurring in relation to building the capacity of the non-government sector and improving working relationships between the department and non-government stakeholders. This includes the



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Queensland Family and Child Commission whole-of-sector workforce plan, joint training with the sector in relation to Family and Child Connect and with key partners in relation to the Framework for Practice.

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

The department strongly supports the panels' view that cultural competence is an important aspect of responding effectively to child and families in the child protection system. The department has a significant reform agenda focused on improving service provision to Aboriginal and Torres Strait Islander children and families, which will be informed by the findings from panels. These reforms include the recent appointment of seven **Aboriginal and Torres Strait Islander Practice Leaders**. These senior roles, one based in each of the seven regions, have a range of priorities aimed at enhancing the cultural integrity of services provided to Aboriginal and Torres Strait Islander children and families. The leaders will also work closely with departmental staff to ensure more effective engagement with Recognised Entities in relation to participation in decision making and provision of cultural advice.

### **Aboriginal and Torres Strait Islander Practice Leaders**

The Aboriginal and Torres Strait Islander Practice Leaders provide regional leadership to strengthen culturally responsive and effective practice for Aboriginal and Torres Strait Islander children, young people, their families and communities. These practice leaders identify and respond to region and system-wide opportunities for improvements in the delivery of culturally responsive child protection practice.

The role operates as part of a statewide network of practice leaders and works collaboratively with the Regional Practice Leader. The role works closely with the Practice Leadership Unit to strengthen statewide practice.

Additionally, the department has funded the Queensland Aboriginal and Torres Strait Islander Child Protection Peak to employ two identified Aboriginal and Torres Strait Islander Practice Leaders to drive culturally responsive practice within the sector and build partnerships with departmental practitioners to improve the outcomes for Indigenous children and families in the child protection system.

Current Child and Family reforms focused on early intervention include the establishment of **Family and Child Connect** services, which aim to increase access to services for all families including Aboriginal and Torres Strait Islander families. Through the introduction of Family and Child Connect and the strengthening of intensive family support services, a more holistic needs assessment will occur for a broader range of families, including Indigenous families.

The department is working to improve child protection practice to better meet the needs of Aboriginal and Torres Strait Islander communities and ensure support and responses for Indigenous children and families are:

- more culturally appropriate
- strongly evidence-based
- appropriate for local contexts.



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To achieve this, the department and its partners are trialling three new Aboriginal and Torres Strait Islander family-led decision making and shared practice models designed to empower families to make informed choices about their children, while the department works with families to ensure the safety of children. These alternative models will recognise the needs and strengths of families and their development will be informed by panel findings. They will place Aboriginal and Torres Strait Islander families at the centre of decision making and ensure the process that is undertaken to reach a plan of support is led by Aboriginal and Torres Strait Islander people.

In other strategies to increase culturally responsive practice, the department is offering cadetships, to support Aboriginal and Torres Strait Islander university students in their final year of study in either a Bachelor of Human Services or Bachelor of Social Work. The cadetships provide financial and academic support, field placements and assistance with applying for employment with the department following graduation.

The department has also implemented a scholarships program, in collaboration with various Queensland universities, to support permanently employed Aboriginal and Torres Strait Islander staff of the department to complete a human services or social work degree. Having more qualified Indigenous staff working in child protection will improve our delivery of culturally appropriate services and support Aboriginal and Torres Strait Islander families to live safe, healthy and strong lives.

In relation to holistic and culturally sensitive assessment and planning for children and families, it is noted that structured decision making and current case planning tools capture the domains raised as key Indigenous care indicators.

### **Recognised Entities**

The department agrees with panel findings regarding the level of engagement with Recognised Entities during decision-making processes. The seven recently appointed Aboriginal and Torres Strait Islander Practice Leaders have a focus on the cultural integrity of the department's practice with Aboriginal and Torres Strait Islander children and families. This includes working with staff to more effectively engage with Recognised Entities in participative decision making and the provision of cultural advice.

The significant work in implementing the Child and Family reforms includes: a focus on the development of Aboriginal and Torres Strait Islander Integrated services; reviewing the training needs of Recognised Entities; and developing a shared practice model to allow Recognised Entities to work more closely with departmental officers. It is anticipated that these reforms will improve the capacity of Recognised Entities and Family Support Services to participate in decision making and provide culturally appropriate services for children and families and will be informed by panel findings regarding Recognised Entities. The review of the *Child Protection Act 1999* will also provide an opportunity to consider the role of Recognised Entities and whether any changes are needed.

In response to findings from panels, the department will investigate options for the provision of cultural advice for service delivery which occurs outside regular working hours. Such options will be considered as part of an Integrated Service Model.



## Stages of intervention

The department agreed with panels in recognising the complexities of working with vulnerable children and families and proposes to improve child protection practice through: building stronger relationships with key partners; strengthening resources available to staff; and through the implementation of the new Strengthening Families Protecting Children Framework for Practice. Panel reports are provided to relevant departmental officers responsible for the child and family reforms to inform work in a number of areas.

As part of the current Child and Family Reform program, the department, in partnership with the Children's Research Centre and Sonja Parker Consultancy, developed the new Strengthening Families Protecting Children Framework for Practice. The framework focuses on deliberate and purposeful work with children and families to assist case planning and case work and increasing the skills of workers in engaging with children and families. In relation to working directly with children, the Strengthening Families Protecting Children Framework for Practice includes a suite of tools that provides staff with enhanced ways to directly engage children.

Consistent with panel findings, the engagement of families in child protection work has been identified as an area that requires greater attention. In particular, meaningfully engaging fathers is critical to increasing safety for children. Forums to support departmental staff and sector partners to understand the benefits of engaging fathers in child protection work and to strengthen skills in this area have been delivered in five regions. Further forums will be held in 2015–16 in North Queensland Region and Far North Queensland Region.

## Strengthening Families Protecting Children Framework for Practice

The development of a new Framework for Practice is a key milestone in a reformed child and family support system in Queensland. The Strengthening Families Protecting Children Framework for Practice provides a transparent strengths-based, safety-oriented approach to work undertaken by Child Safety through all phases of the child protection process. The framework and its supporting resources:

- define the parameters and focus of work undertaken by Child Safety
- place a greater emphasis on working collaboratively with children, families and carers during assessment, safety planning and case planning processes
- identify and support the development of safety networks around children, their families and carers
- strengthen partnerships with agencies
- promote enduring safety and positive change in the lives of children and families in contact with Child Safety.

## Intake

The department supports panel findings about good decision-making practices, including gathering sufficient information to make informed decisions. This is reflected in the Child Safety Practice Manual in section 1.1:



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*The quality of the decisions made during the intake phase depends on the quality of information gathered about the child or unborn child, their family and the child protection concerns. A child and their family should receive a consistent response from the department, regardless of the location.*

Further, section 1.5 states that pre-notification checks can be made in circumstances when further information is required to determine whether the concerns reach the threshold for a notification response. The Case Review Unit will be working with Regional Intake Service managers and senior team leaders across the state in relation to recent findings from child death reviews. The issue of proactively seeking information to inform decisions will be highlighted.

In relation to staff understanding of cumulative harm and the impacts of intergenerational maltreatment, the department agreed with panel findings that this area requires ongoing focus. The department recognises that high quality intake work is critical and is committed to: strengthening the tools available and developing skills to support staff in collating and analysing history as well as considering cumulative harm and patterns. Implementation of the Family and Child Connect services has provided an alternative pathway for notifiers to refer matters with child protection concerns that do not meet a significant harm threshold.

## Family and Child Connect

In January 2015, the first stage of new community-based services, known as Family and Child Connect, was established across Queensland to support families who are at risk of entering or re-entering the child protection system.

Families in need of support can contact Family and Child Connect for assistance. Where professionals, such as teachers, health workers and police, and members of the community have concerns about a child's wellbeing, they can refer the family to Family and Child Connect for information, advice and engagement.

A specialist domestic and family violence practitioner works in each service to advise and assist on domestic and family violence matters.

Also, a senior child safety officer is based at each Family and Child Connect to assist with identifying and responding to those concerns that may require intervention by Child Safety.

Family and Child Connect leads a local alliance of government and non-government services in the community to ensure that vulnerable families receive the right mix of services at the right time.

Another six Family and Child Connect services were opened in July 2015.

At the conclusion of the roll out, scheduled for 2016, a total of 18 services will provide support across 20 catchments throughout Queensland.

## Investigation and assessment

In line with panel findings, the department is committed to timely service delivery and holistic assessment of the needs of vulnerable children and young people. The department supported the panel findings recognising stakeholder engagement and co-ordination as a key process required for successful service delivery for complex families. The department accepts the panel finding that agencies involved with families should be advised when the department is closing a case and the department will consider opportunities to strengthen practice in this area. As noted on page 28, the



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new Framework for Practice aims to equip staff with enhanced skills to effectively engage with partners.

In response to the broad reforms, the department has commenced a new initiative to redesign the service model and responses for families who come to the attention of the tertiary system. This work will be informed by panel findings in relation to Intake, Investigation and Assessment.

In relation to concerns about decision making, the department's approach is to utilise a range of Structured Decision Making tools, in conjunction with professional judgement. The implementation of the Strengthening Families Protecting Children Framework for Practice aims to further strengthen the knowledge and skills of staff in exercising professional judgment and engaging effectively with children and families. The framework incorporates a range of tools for analysing complex practice issues and engaging creatively with families.

### Structured Decision Making (SDM)

Structured Decision Making (SDM) is a major practice initiative, implemented across Queensland in 2005 to assist the department practitioners in making decisions about children, young people and families.

Developed by the Children's Research Center (CRC), SDM incorporates a set of evidence-based assessments and decision-making guidelines designed to provide a higher level of consistency and validity in the assessment and decision-making process. It also is a method for targeting resources to families that are most likely to subsequently abuse or neglect their children. The term practitioner is used to reflect that SDM assessments are to be used by professional departmental officers.

SDM is not intended to make decisions. It assists decision making by allowing practitioners to organise facts and evidence gathered, and is used in conjunction with the practitioner's professional judgement. This leads to a recommendation for action that must subsequently be approved by a senior team leader.

### Intervention with Parental Agreement

The Commission of Inquiry recommended a review of the Intervention with Parental Agreement program which is scheduled to occur in 2015–16. The department acknowledges the issues identified by panels in relation to risk reassessment, departmental contact with children and families and closure of Intervention with Parental Agreement cases and these issues will be considered in the 2015–16 review. Panel findings related to service provision during Intervention with Parental Agreement Cases will inform this review. In managing families where parents are reluctant to engage in voluntary intervention the department's reform activity is examining how to better engage parents through the use of directive and supervision orders. The current implementation of the Strengthening Families Protecting Children Framework for Practice complements this work as it provides staff with additional skills and tools to support engagement and work with families.

### Recordkeeping

The department accepts concerns raised by panels about accurate recordkeeping. The department acknowledges the role that accurate, timely recordkeeping plays in ensuring vulnerable children and young people remain safe. The department also acknowledges the importance of Senior Team Leaders' quality assurance activities to reduce errors and improve decision making and recording. Consistent with panel findings, the department will continue to work with departmental officers to



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strengthen recordkeeping practices and identify opportunities for technological solutions to assist staff manage the considerable recording keeping requirements of their roles. The department is working on transitioning from its current paper-based documents and physical files to an electronic recordkeeping framework. Examples of technology currently being trialled with frontline staff to improve recordkeeping includes the use of iPad by service delivery staff and voice-to-text software.

In relation to panel concerns about potential limitations of the Integrated Client Management System (ICMS) and Structured Decision Making tools, the department has continued to invest in developing enhancements to ICMS aimed at delivering new functionality and improving the useability of the system for staff. In August 2015, the department delivered enhancements to ICMS that:

- improved the departmental history reports available to departmental staff
- added new case note types
- allowed education support plan information to be recorded in a more intuitive location in ICMS.

The department will continue to gather feedback from officers using ICMS on how the system can be improved and further enhancements will occur to align ICMS with the Framework for Practice and reform activities.

The department acknowledges the findings from panels regarding the flexible use of Structured Decision Making tools. The department's suite of Structured Decision Making tools has been integrated into the department's new framework for practice. The Structured Decision Making tools help to ensure the framework is guided by valid and reliable tools that are based on research and evidence. The integration of the tools in the Framework for Practice also ensures that the tools are not simply forms to be filled out but decision-support tools that guide professional judgement.

## Organisational issues

The department acknowledges, along with panels, the commitment and dedication of its staff as well as the challenges and complexity of their roles. The department recognises the importance of having a highly skilled and engaged workforce and is committed to supporting and developing staff. The department is finalising a Child and Family Reform Operational Workforce Plan 2015-2019, which focusses on building, sustaining, and strengthening the department's workforce into the future as part of the sectorwide child and family reform agenda.

The department continues to evolve its learning and development program for child safety staff. The department's entry point Child Safety Officer training program has recently been revised. The GRO program is the Department of Communities, Child Safety and Disability Services' learning development program for Child Safety Officers. Additionally, extensive ongoing training is available in specialist areas and many of these resources will be reviewed in the next twelve months in the light of panel findings. Strategies are also being considered to ensure access to and uptake of training and improved use of other resources.



## GRO — Getting started in child protection

The department recognises that to perform in their role new Child Safety Officers need support to learn fundamental child protection knowledge, build their practical skills and develop the personal attributes that they need. GRO is divided into three sections and incorporates a range of learning experiences; including completing self-paced resources and participating in face-to-face sessions. The sections are:

- ***Getting started in child protection practice***, which aims to familiarise new staff with their role and responsibilities
- ***Readiness for child protection practice***, which provides new staff with job specific skills and knowledge in order to build role capacity and confidence
- ***Ongoing practice development***, which provides a suite of learning activities staff can access for practice development on specialist topic areas.

The department is aware of the challenges, as identified by the panels, of inexperienced staff managing complex cases. Given the nature of tertiary child protection work, most cases are complex, as they involve significant harm and risk. A number of support mechanisms are available to assist staff, including professional supervision with their senior team leader, access to senior practitioners, practice leaders and other specialist staff, and the use of practice panels and complex case clinics to inform decision making and share accountability.

Additionally, over the 2014–15 reporting period, the department presented an extensive suite of training for staff in the new Framework for Practice since its implementation in March 2014. Details of these training sessions are presented below.



## Strengthening Families, Protecting Children Framework for Practice training program

The department started its Strengthening Families, Protecting Children Framework for Practice training program in March 2015. The training program included:

- **Foundational Training** — a two-day program exploring the Framework for Practice’s values, principles, knowledge bases, core skills and application tools. The training equips participants with knowledge of the framework’s elements and the skills to apply the tools in working with children, young people and families. By the end of June 2015, 2815 departmental staff and partners from non-government organisations and other government agencies had attended the training.
- **Family Group Meeting Facilitator Training** — a three-day advanced training on facilitation skills and integration of the Framework for Practice and practice tools into family group meetings. The workshop introduces and demonstrates techniques and provides participants with opportunities to practise and enhance their skills. By the end of June 2015, 69 departmental convenors and 16 Recognised Entity representatives had attended the training.
- **Leading Practice Training** — a two-day workshop for leadership staff to provide a comprehensive study of the Collaborative Assessment and Planning (CAP) Framework. CAP is the questioning approach that sits beneath the framework and is used to facilitate case consultation in connection with the Structured Decision Making (SDM) system. Participants are provided opportunities to focus on the overall Framework for Practice and how it links to leadership and implementation. Also discussed are the next steps for the participants practice. By the end of June 2015, 443 departmental supervisors had attended the training with a further session to run in September 2015.
- **Foundational Training (one day)** — a one-day program exploring the Framework for Practice’s values, principles, knowledge bases, core skills and application tools. This program provides participants with an opportunity to explore solution-focused and appreciative inquiry and how these types of inquiry can be applied across the organisation. By the end of June 2015, four one-day sessions had been delivered to 99 staff members and partners from non-government organisations and other government agencies.

This training will be built on in 2015–16 with:

- Intensive Practice Modules — a series of seven intensive two-day workshops covering 14 modules of practice. The workshops are targeted at practice leaders to equip them with in-depth knowledge of strengths-based, safety-oriented practice, aligned with the Framework for Practice.
- Advanced Leading Practice training
- Advanced Family Group Meeting Convenor training
- Coaching for senior team leaders and managers
- Coaching for family group meeting convenors.

The department agreed with panel findings regarding the benefits of staff having access to high quality information resources to inform child protection practice. The department is reviewing



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resources and training available to staff both online and face-to-face. The department recognises staff need to be equipped with information and resources on best practice approaches to child protection. In response to panel findings, the department will review its resources and training related to:

- risk indicators and appropriate responses to self-harm and suicidal ideation
- domestic and family violence
- working with children with a disability or complex medical condition
- responding to high risk infants and unborn children.

Also consistent with panel findings related to supporting staff, the department's REACH program has been developed to improve staff supervision, coaching and mentoring. The program provides a comprehensive supervision framework to enable structured engagement between managers and staff. It also includes an ongoing development program to enhance leaders' capabilities to conduct effective supervision discussions.

### REACH — Supervision framework

The REACH Supervision Framework includes five aspects for the supervision approach with staff:

- **Relationships** — building teams, building partnerships, self-awareness, engaging others
- **Ethics** — integrity, leading ethical behaviour, setting boundaries, valuing diversity
- **Acumen** — planning and organising, managing resources, information literacy, working with change
- **Clinical** — improving practice, case management/project management, performance management, coaching and mentoring
- **Health** — resilience, supportive strategies, managing workloads

Staff are also supported through the Staff Support Strategy, including the SUPPORT capability development programs, which was launched in early 2015. The strategy focusses on embedding a supportive culture through leadership and business processes. It is a priority for the department that each staff member is supported by the organisation, their supervisor and peers. Resources range from fact sheets on change, to interactive webinars, and e-learning programs on resilience. Resources and assistance are also provided to leaders in responding to particularly challenging situations, such as when a service centre is recovering from a critical incident. The new resources and learning programs are developed based on the needs of staff, for example, the Recognise Respond Refer, Domestic Violence and the Workplace e-learning program.

Staff have access to counselling through the Employee Assistance Service, which is a confidential and voluntary short-term counselling service available to all departmental employees and their immediate family members. In addition to short-term counselling sessions, the Employee Assistance Service can provide staff with:

- on-site support, coaching and risk management following a workplace incident
- confidential telephone advisory service for managers and supervisors dealing with difficult or complex people issues



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- an online health and wellbeing portal providing access to information, articles, self-assessment tools, videos and podcasts.

The department agreed with panels regarding the importance of workload management strategies. The Queensland Commission of Inquiry recommended the department reduce caseloads for Child Safety Officers to 15 children and young people per officer. The department is committed to continuing to reduce workloads across all direct service delivery staff and allow child safety officers to dedicate more time to the children and families they are working with. During the 2014–15 reporting period, an additional \$6.5 million was allocated by the department to employ an extra 77 direct service delivery staff across Queensland. Additionally, as the new Framework for Practice continues to be implemented, it is anticipated there will be shifts in workloads with increased engagement work with families. This will continue to be monitored closely to ensure staff resourcing can be aligned effectively to enable caseloads and workloads to be decreased.

### **Disability and chronic medical conditions**

The department agreed with the panels' findings that children with complex medical needs and/or disabilities are an important cohort receiving services through the child protection system due to the unique challenges and issues they face. The department recognises these complexities and will continue strengthening child protection practice in this area through building stronger relationships with key partners, improving the resources available to our staff and enhancing staff's access to specialist expertise.

In response to panel findings, it is recognised that departmental staff need additional support and resources in understanding cultural perspectives on disability and medical conditions, and how to best support and respond to the needs of Indigenous families, including parents, where there is a disability or chronic medical condition. The department will review the current resources and training available to staff, and revise and develop further resources where required. Child Safety remains committed to co-ordinated service delivery to clients who are also engaged with Disability Services. The department is also conscious of the need to consider how coordinated services delivery can continue to be delivered after the implementation of the National Disability Insurance Scheme.

### **Domestic and family violence**

The department agreed with panel views that domestic and family violence is a serious problem for the Queensland community. Consistent with findings from panels, the department recognises domestic and family violence is a complex issue in child protection practice and often a significant risk factor, especially in relation to unborn infants and high risk infants. The department plays a key role in supporting individuals and families affected by domestic and family violence both directly and indirectly through funding to non-government agencies.



## Special Taskforce on Domestic and Family Violence

The Special Taskforce on Domestic and Family Violence in Queensland (the Taskforce), chaired by The Honourable Quentin Bryce AD CVO, was established on 10 September 2014. The taskforce's role was to investigate domestic and family violence in Queensland and make recommendations to strengthen responses to domestic and family violence and to work towards its prevention.

The taskforce's final report was delivered to the Premier of Queensland The Honourable Anastacia Palaszczuk MP on 28 February 2015 and outlined 140 recommendations. The Queensland Government accepted or supported all of the recommendations and the department will play a key role in their implementation.

The government's response to the taskforce report commits to strong action to address and prevent domestic and family violence. As part of its response, the government has released a draft Domestic and Family Violence Prevention Strategy. The strategy provides a framework for action across government and in partnership with all levels of the community, to work toward a shared vision of a Queensland free from domestic and family violence. The resulting reforms will contribute to improvements in responding to the needs of children and families in contact with the child protection system and strengthen the links across the domestic violence, family support and child protection service systems.

In July 2014, the Systems and Practice Review Committee membership was expanded to include the department's Violence Protection Unit. The inclusion of the Violence Prevention Unit has strengthened the committee's consideration of domestic and family violence in Systems and Practice Reviews. The practice issues identified through this process are informing staff training related to domestic violence as well as the broader child protection and domestic and family violence reform agendas.

The department acknowledges the findings from panels regarding the importance of robust assessment of the impact of domestic and family violence on children and young people as well as the adult victim. The department is undertaking a number of reform activities to enhance child protection practice in the area of family and domestic violence, including the establishment of new Family and Child Connect (community intake) and Intensive Family Support (IFS) services. Both service types include a domestic and family violence specialist worker to enhance risk assessment and case planning and establish strong working relationships with other community based domestic violence services. Additionally, the Practice Leadership Unit is working with the department's domestic and family violence reform area to identify a set of practice priorities to be targeted for improvement. These priorities will then be a focus for a learning and development strategy including cross-sector training. Integrated into all the reform work in the area of domestic and family violence is a recognition that work with fathers — often the perpetrator of violence and responsible for harm to children — needs to be strengthened. There is an increasing focus on the importance of this work and on the skills and knowledge necessary to improve practice with a focus on the safety of adult victims and children.

The framework for this work is informed by the Safe and Together Model, established by David Mandel and Associates. In May 2015, the department hosted a number of workshops with David Mandel, a United States-based expert on domestic and family violence. These were offered to Family and Child Connect, domestic violence services and departmental staff. The event was



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arranged around a first day 'lecture' for around 250 people followed by three, one-day workshops with 40 people in each workshop. The training aimed to:

- improve collaboration and develop shared practice frameworks across child protection, family support and domestic and family violence agencies
- target learning towards the new Family and Child Connect (FACC) and Intensive Family Support (IFS) locations
- improve partnerships and engagement with families affected by domestic violence
- improve risk assessments and safety planning for children and their families
- improve casework practice for all participants
- support and strengthen families to increase safety and wellbeing for their children at home
- improve engagement with fathers with the aim of preventing violence in families
- improve the parenting contribution of fathers while still prioritising victim safety.

As part of the government's response to the Bryce Report, the department is also leading work across government agencies to trial domestic violence integrated response models in three Queensland communities: an urban community; regional community with outreach to outlying areas; and a discrete Indigenous community. This work is consistent with panel findings and will build on other integrated response initiatives already in place, such as Project PRADO in Caboolture (see description in box below). The trials will provide further opportunities to streamline and integrate responses to vulnerable families where domestic and family violence are issues. It will also allow the department to deliver more timely and holistic responses to family members so victim safety and child wellbeing are prioritised.

### Project PRADO (Partnership Response at Domestic Violence Occurrences)

Caboolture District Police, Caboolture Probation and Parole, Caboolture Regional Domestic Violence Service, Caboolture Magistrates Court and staff from the department's North Coast Region initiated Project PRADO to assist clients at high risk of ongoing domestic violence through regular information sharing, risk assessment and management, case conferencing and referral to community services for further assistance.

The safety of children is one of the main drivers behind Project PRADO, and monthly meetings of senior representatives from Caboolture Probation and Parole, Queensland Police and Child Safety are held to discuss and monitor domestic violence cases where either the victim or perpetrator is subject to supervision by Queensland Probation and Parole, and children were present at the incident.

## Suicide

The department acknowledges the complexities of working with children and young people with high risk behaviours and those at risk of suicide. Over a number of years, the department has invested in strengthening its policies, procedures and responses to young people at risk of suicide and with suicidal ideation. The department is committed to looking to embed current research best practice into its responses. With any death from suicide, there is the necessity for reflection and analysis of the nature of the intervention. In response to panel findings, and from staff's own reflections, the department will review resources and training available in this area. The link between exposure to domestic and family violence and other Negative Life Events (NLE), and the



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emotional impact on children and young people, particularly where these are recurring in their lives, will be a focus of this review.

The department supports the premise that a range of specialist services, government and non-government need to be involved in meeting the needs of these highly vulnerable young people. Ongoing work is occurring to improve interagency cooperation and staff skills in stakeholder engagement. The department will meet with Queensland Health staff to discuss panel findings particularly in relation to Child and Youth Mental Health Services.

## **Unborn children**

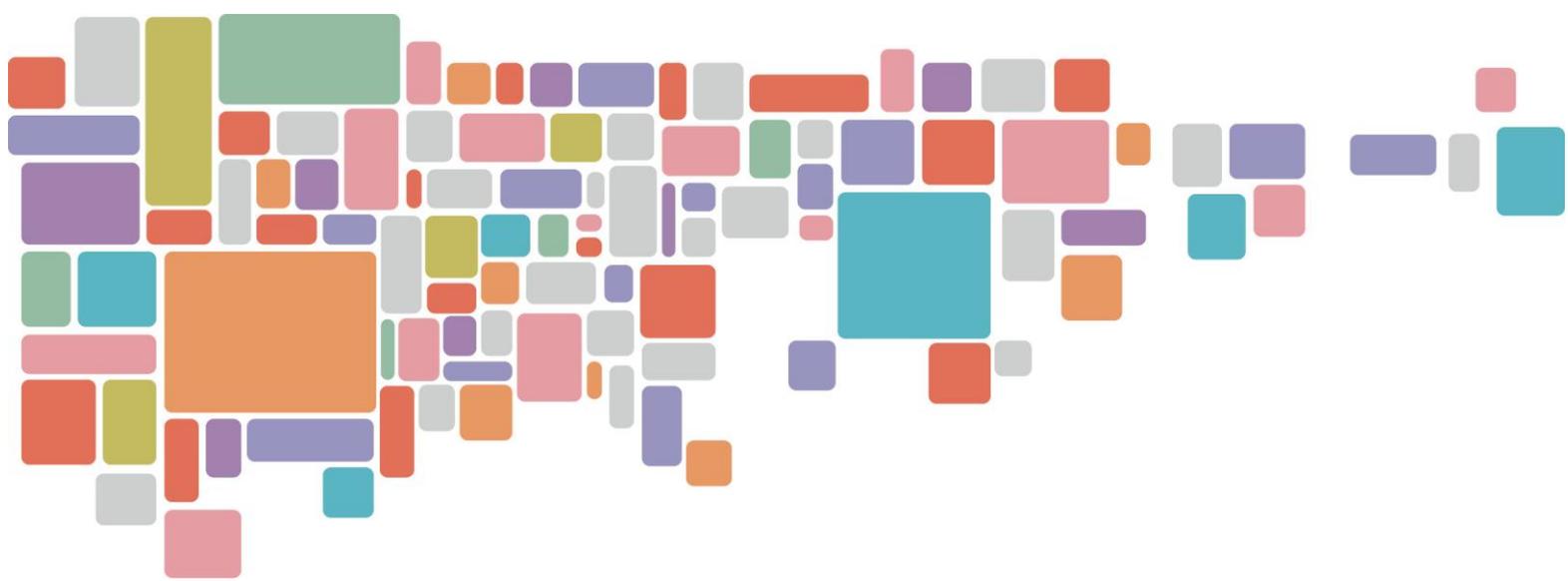
The department agreed with panels regarding the criticality of undertaking high quality holistic assessments of unborn children who are likely to be at risk of harm following their birth, especially where domestic violence is an issue given the link between pregnancy and violence. The department is committed to providing support to families of unborn children to reduce the assessed risk of harm to children after their birth. This is a complex area in child protection practice with the challenge of balancing the rights of expectant mothers and safety needs of children following their birth.

In relation to panel findings regarding legislative and policy provisions impacting on service delivery to unborn children, the department will include this area for consideration in the legislative review. The assessment and intervention with families of unborn children is sensitive and complex work. The department will review the current resources and training available to staff, revise and develop further resources where required, and ensure that a focus on practice in relation to unborn children is built into the training plan over the next 12 months.

Given panels identified recurring issues associated with work with high risk infants, including the significant risk factors of co-sleeping and domestic and family violence, the scope and content of the High Risk Infants training package is also under review and a strategy developed to ensure the available training has been provided statewide.

## **Conclusion**

The department acknowledges the challenges of addressing child abuse in the broader context of intergenerational, social and economic disadvantage. The government is committed to the Child and Family Reform Program and believes it provides the architecture and funding support to deliver significant benefits for the Queensland community and provides supports and services to families when they need them. The department is committed to the vision that Queensland children and young people are cared for, protected, safe and able to reach their full potential.



# Appendix A

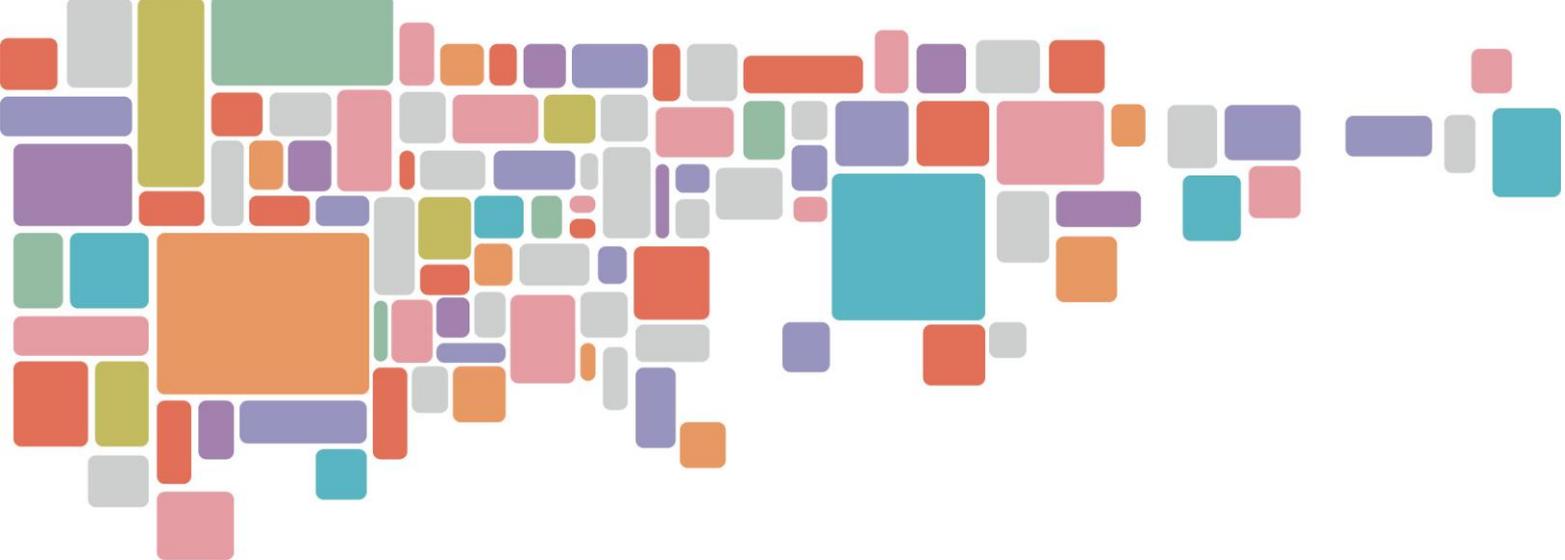
## Comparison of Child Death Case Review Committee and Child Death Case Review Panels

Child Death Case Review Committee (2004 — 2014)	Child Death Case Review Panel (2014 — ongoing)
<p>The Committee was legislated to act independently.</p> <p>Review criteria were gazetted and developed by the committee in collaboration with the department.</p> <p>There was one committee and members are the same for all reviews.</p> <p>Committee membership — Children’s Commissioner, 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.</p> <p>The Committee was chaired by the Children’s Commissioner.</p>	<p>Panel are legislated to act independently.</p> <p>Review criteria are determined by individual panels.</p> <p>Multiple panels are convened each year with differing membership based on the characteristics of the cases being considered.</p> <p>A pool of members is approved by the Minister which includes experts who are not public service employees, department senior officers and senior officers from other government departments. Each panel must have at least three external members, one but not more than three departmental officers and at least one senior officer from another government department. At least one member must be an Aboriginal or Torres Strait Islander person.</p> <p>Each panel is chaired by a non-public service expert.</p>



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Child Death Case Review Committee (2004 -2014)	Child Death Case Review Panel (2014 — ongoing)
<p>The committee considered all reviews of departmental involvement with children who have died and were known to the department in the three years preceding their death.</p> <p>Committee review reports outline findings and recommendations for individual cases and broader recommendations aimed at improving the child protection system.</p> <p>Committee review reports were provided to the department</p> <p>The Committee must prepare an annual report about the performance of the committee's functions.</p> <p>The annual report was tabled in Parliament.</p>	<p>The panels consider all reviews of departmental involvement with children who have died or suffered a serious physical injury and were known to the department in the year preceding their death or injury.</p> <p>Panel review reports outline findings for individual cases and broader findings aimed at improving the child protection system.</p> <p>Panel review reports are provided to the department who provide them to the Minister.</p> <p>The Chief Executive must prepare an annual report outlining the operation of review panels and actions taken by the department in response to panel reports.</p> <p>The annual report is provided to the Minister who has undertaken to table it in Parliament.</p>



# Appendix B

## Panel themes and composition

<p><b>Panel 1</b></p>	<p>Theme: Children with severe medical conditions and/or disability requiring departmental services</p> <p>External members: Ms Gwenn Murray (Chair) Dr Anne Pattel-Gray Ms Beverley Fitzgerald</p> <p>Other government agency: Mr Graham Kraak</p> <p>Departmental officer: Professor Karen Nankervis</p> <p>Meeting date: 17 October 2014</p> <p>Date report delivered to Director-General: 18 December 2014</p>
<p><b>Panel 2</b></p>	<p>Theme: Children who were subject to Intervention with Parental Agreement</p> <p>External members: Professor Clare Tilbury (Chair) Ms Margie Kruger Professor Anna Stewart</p> <p>Other government agency: Mr Ron Weatherall</p> <p>Departmental officer: Ms Kylie Phipps</p> <p>Meeting date: 1 December 2014</p> <p>Date report delivered to Director-General: 7 January 2015</p>



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<b>Panel 3</b>	Theme: Aboriginal and Torres Strait Islander children with severe medical conditions and/or disability requiring child protection services
External members:	Dr Anne Pattel-Gray (Chair) Mr Simon Kelly Mr Greg Upkett
Other government agency:	Mr Wally Tallis
Departmental officer:	Professor Karen Nankervis
Meeting date:	18 November 2014
Date report delivered to Director-General:	7 January 2015
<b>Panel 4</b>	Theme: Domestic and Family Violence as factors requiring departmental consideration
External members:	Ms Annette Sheffield (Chair) Mr Bryan Cook Mr Clinton Shultz
Other government agency:	Inspector George Marchesini
Departmental officer:	Ms Bernadette Harvey
Meeting date:	26 November 2014
Date report delivered to Director-General:	19 December 2014
<b>Panel 5</b>	Theme: Children with severe medical conditions and/or disability requiring departmental services
External members:	Ms Gwenn Murray (Chair) Dr Anne Pattel-Gray Ms Beverley Fitzgerald
Other government agency:	Mr Graham Kraak
Departmental officer:	Ms Bernadette Harvey
Meeting date:	11 February 2015
Date report delivered to Director-General:	6 March 2015



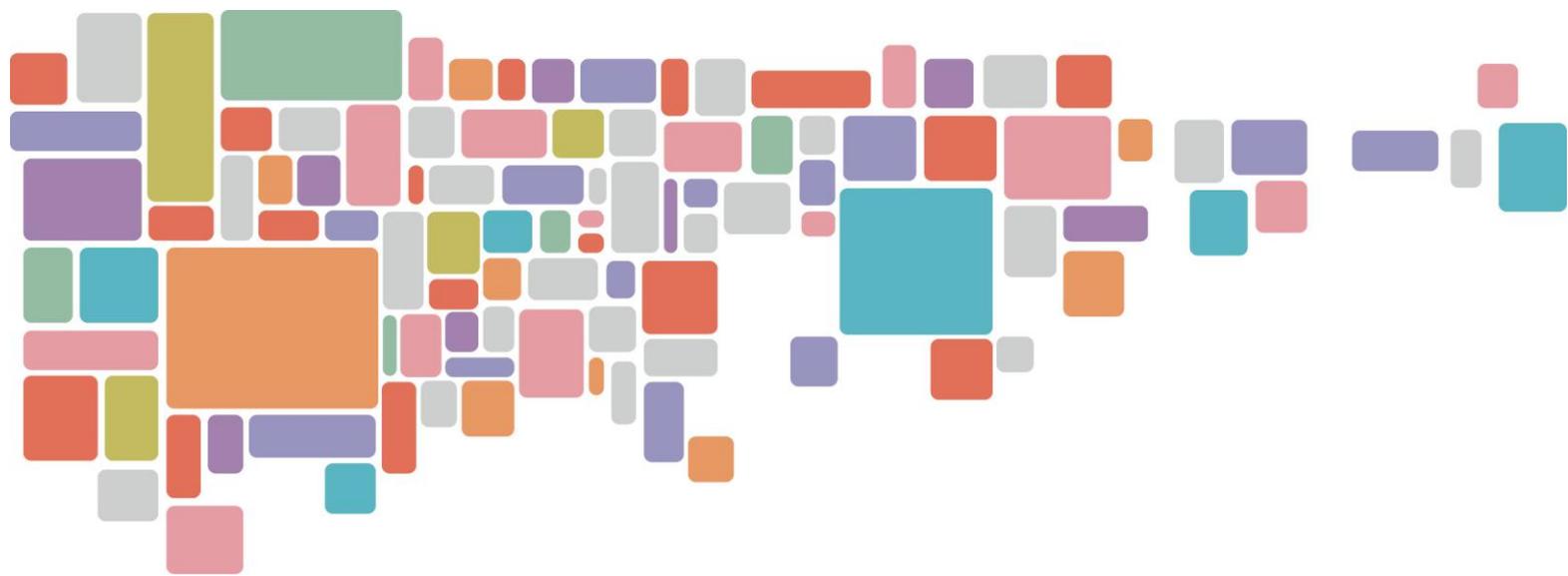
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<b>Panel 6</b>	Theme: Children who died from suicide
External members: Mr Clinton Schultz (Chair) Mr Greg Upkett Mr Bryan Cook	
Other government agency: Associate Professor John Allan	
Departmental officer: Ms Barbara Shaw	
Meeting date: 3 February 2015	
Date report delivered to Director-General: 6 March 2015	
<b>Panel 7</b>	Theme: Children who have died from unknown causes
External members: Ms Annette Sheffield (Chair) Mr Greg Upkett Professor Clare Tilbury	
Other government agency: Inspector George Marchesini	
Departmental officer: Ms Kathy Masters	
Meeting date: 17 February 2015	
Date report delivered to Director-General: 18 March 2015	
<b>Panel 8</b>	Theme: Children who have died as a result of transport - related incidents
External members: Professor Anna Stewart (Chair) Ms Beverley Fitzgerald Ms Kathryn McMillan	
Other government agency: Mr Ron Weatherall	
Departmental officer: Ms Nicola Jeffers	
Meeting date: 2 April 2015	
Date report delivered to Director-General: 21 April 2015	



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<b>Panel 9</b>	Theme:	Children from families experiencing multiple child protection risk factors
	External members:	Ms Annette Sheffield (Chair) Professor Clare Tilbury Dr Anne Pattel-Gray
	Other government agency:	Mr Graham Kraak
	Departmental officer:	Ms Kathy Masters
	Meeting date:	14 May 2015
	Date report delivered to Director-General:	9 June 2015



# Appendix C

## External Members

### Ms Kathryn McMillan

Ms McMillan is a Barrister in private practice and Queens Counsel practising primarily in the areas of alternative dispute resolution, civil and human rights/discrimination, family law and child protection law as well as Coronial Inquests and work on behalf of the Australian Health Practitioner Regulation Agency and the medical and other statutory boards in the Queensland Civil and Administrative Tribunal. Ms McMillan was Senior Counsel assisting the Commissioner in the Queensland Child Protection Commission of Inquiry.

### Mr Bryan Cook

Mr Cook is a consultant who conducts and manages workplace investigations for state and local government authorities. This includes undertaking complex investigations into suspected official misconduct; grievances (bullying and harassment) and complex workplace issues involving senior management, as well as professional misconduct, particularly in the health sector. Previous work included being an Investigator/Reviewing Officer at the Crime and Misconduct Commission and investigating organised crime, child abuse and juvenile crime.

### Ms Margie Kruger

Ms Kruger is a lawyer with a particular interest in family law including child related matters and financial matters, as well as defacto relationship law and discrimination matters. Ms Kruger is a member of the Queensland Law Society's Children's Law Committee and former member of the Queensland Children Services Tribunal. Prior to commencing practice, Ms Kruger worked in what is now known as the Department of Communities, Child Safety and Disability Services in various roles including social worker, policy advisor and senior advisor in child protection in the Court Services division.

### Professor Anna Stewart

Professor Stewart is the former Head, School of Criminology and Criminal Justice at Griffith University and founder and the co-Program Leader of Justice Modelling. In 2007–08, Professor Stewart was the Deputy Dean (Learning and Teaching) in the Faculty of Humanities and Social Sciences. Professor Stewart received her PhD from University of Queensland in 1994. The topic of her thesis was 'An investigation of decision-making by child protection workers'. Professor Stewart has published more than 50 peer-reviewed publications, government reports and non-peer reviewed publications.



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### **Ms Annette Sheffield**

Ms Sheffield is a part-time member of the Social Security Appeals Tribunal, which sits weekly to hear applications for review of Centrelink decisions. Applicants include young people appealing decisions such as youth allowance rejections or breach of participation payment requirements, and 'unreasonable to live at home' cases. Since 2003, Ms Sheffield has completed approximately 30 case reviews for the department on a consultancy basis. Ms Sheffield holds a Master of Social Administration (University of Queensland).

### **Mr Simon Kelly**

Mr Kelly is an accredited Mental Health Social Worker registered with Medicare Australia, whose areas of special interest spanning more than 25 years of professional practice include: child, adolescent and family therapy; family group conferencing; focused psychological strategies; and individual and couple therapy. Mr Kelly holds a Bachelor of Arts and a Bachelor of Social Work.

### **Professor Clare Tilbury**

Professor Tilbury is currently a Professor with the School of Human Services and Social Work at Griffith University and has 30 years' experience as a social work practitioner, researcher and educator. Professor Tilbury has worked in a range of positions with children, young people and families as well as with governments and universities. Her research interests include child protection outcomes that focus on children's wellbeing in care. Professor Tilbury holds a doctorate in Philosophy.

### **Ms Gwenn Murray**

Ms Murray is a consultant in private practice for 12 years with specialist skills in child protection. She has conducted child death reviews for the Department of Child Safety in Queensland and the Australian Capital Territory. Ms Murray undertook the audit of foster carers in Queensland in 2003 during the Crime and Misconduct Commission's inquiry into the abuse of children in care. Ms Murray is currently a part-time sessional member of the Queensland Civil and Administrative Tribunal, hearing reviewable decisions of Child Safety Services, Blue Cards and in disciplinary matters concerning health practitioners. Prior to private practice, Ms Murray was the Director of the Youth Advocacy Centre, a specialist community legal service for young people. She was also the Chair of the National Children's and Youth Law Centre. Her qualifications include a Masters Degree (with Distinction) in Criminology, post-graduate qualifications in Social Science and Human Service Management and legal studies, and she is a trained mediator.

### **Dr Anne Pattel-Grey**

Dr Pattel-Grey is an Indigenous Australian theologian and academic. Dr Pattel-Grey has been the Executive Secretary of the National Aboriginal and Torres Strait Islander Ecumenical Commission of the National Council of Churches in Australia, and a Research Fellow at the University of Sydney. She has represented Aboriginal Australia on various international bodies and organisations throughout the world. Her PhD and thesis was in relation the influence the Catholic Church had over Aboriginal people.



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### **Ms Beverley Fitzgerald**

Ms Fitzgerald currently works in private practice as a consultant. She was the inaugural President of the Children Services Tribunal and served from 2002–2006; the Executive Director and Director of Clinical Program at The Abused Child Trust (ACT for Kids) (1986–1992); and has previously worked for the Departments of Health and Child Safety in Queensland and Legal Aid Queensland (1979–1992). Ms Fitzgerald received the 2003 Child Protection Award (Public Sector) in September 2003. She holds a Bachelor of Social Work (Hons), Developmental and Child Psychology and a Bachelor of Arts, literature and history.

### **Mr Clinton Schultz**

Mr Schultz is a registered psychologist, currently employed by Griffith University School of Public Health as Lecturer of Aboriginal and Torres Strait Islander Health. Mr Schultz is a Lead Facilitator of the Australian Indigenous Psychologists Association's Cultural competence training for mental health practitioners. He is the author and facilitator of 'Forming Culturally Responsive Practice', a Royal Australian College of General Practitioners' accredited cultural competence training package. Mr Schultz is currently undertaking his PhD with Griffith University, focusing on 'The risk and protective factors of social emotional wellbeing for Aboriginal and Torres Strait Islander Health professionals: A grounded theory investigation'. He has an honours degree in psychology.

### **Mr Greg Upkett**

Mr Upkett is the Manager of the Indigenous Family and Child Support Service, which provides support and care to some of the most vulnerable members of the community by seeking suitable care arrangements for children and families who are in need. Mr Upkett has previously worked as a foster and kinship care support worker to provide appropriate placements for Aboriginal and Torres Strait Islander children under the care of Child Safety Services. He was also a Liaison Officer for Aboriginal and Torres Strait Islander Legal Service.

## **Government members**

Government members were appointed to the pool of approved members on the basis of their position rather than as individuals. The incumbent holder of the position appointed to the pool of approved members was eligible to be a panel member.

### **Departmental members**

The following positions within the Department of Communities, Child Safety and Disability Services were appointed to the pool of approved members:

- Centre Director, Centre of Excellence for Clinical Innovation and Behaviour Support
- Executive Director, Practice Leadership Unit, Child Safety
- Regional Director, North Coast Region
- Regional Director, Central Queensland Region
- Regional Director, North Queensland Region
- Regional Director, South East Region
- Executive Director, Community Services and Industry



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## **Government members**

The following positions from other Queensland Government departments were appointed to the pool of approved members:

- Department of Justice and Attorney-General
  - Director, Strategic Policy and Child Safety Director
  - Executive Director, Youth Justice Services
- Department of Aboriginal and Torres Strait Islander and Multicultural Affairs
  - Deputy Director-General
  - Executive Director, Economic Participation/Senior Indigenous Officer
- Queensland Health
  - Director, Strategic Policy Priority Areas
  - Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch
- Department of Education, Training and Employment
  - Director, State Schools Operations
  - Director, State Schools Operations
- Queensland Police Service
  - Operations Manager, Child Safety and Sexual Crime Group, State Crime Command
  - Operations Manager, Child Safety and Sexual Crime Group, State Crime Command