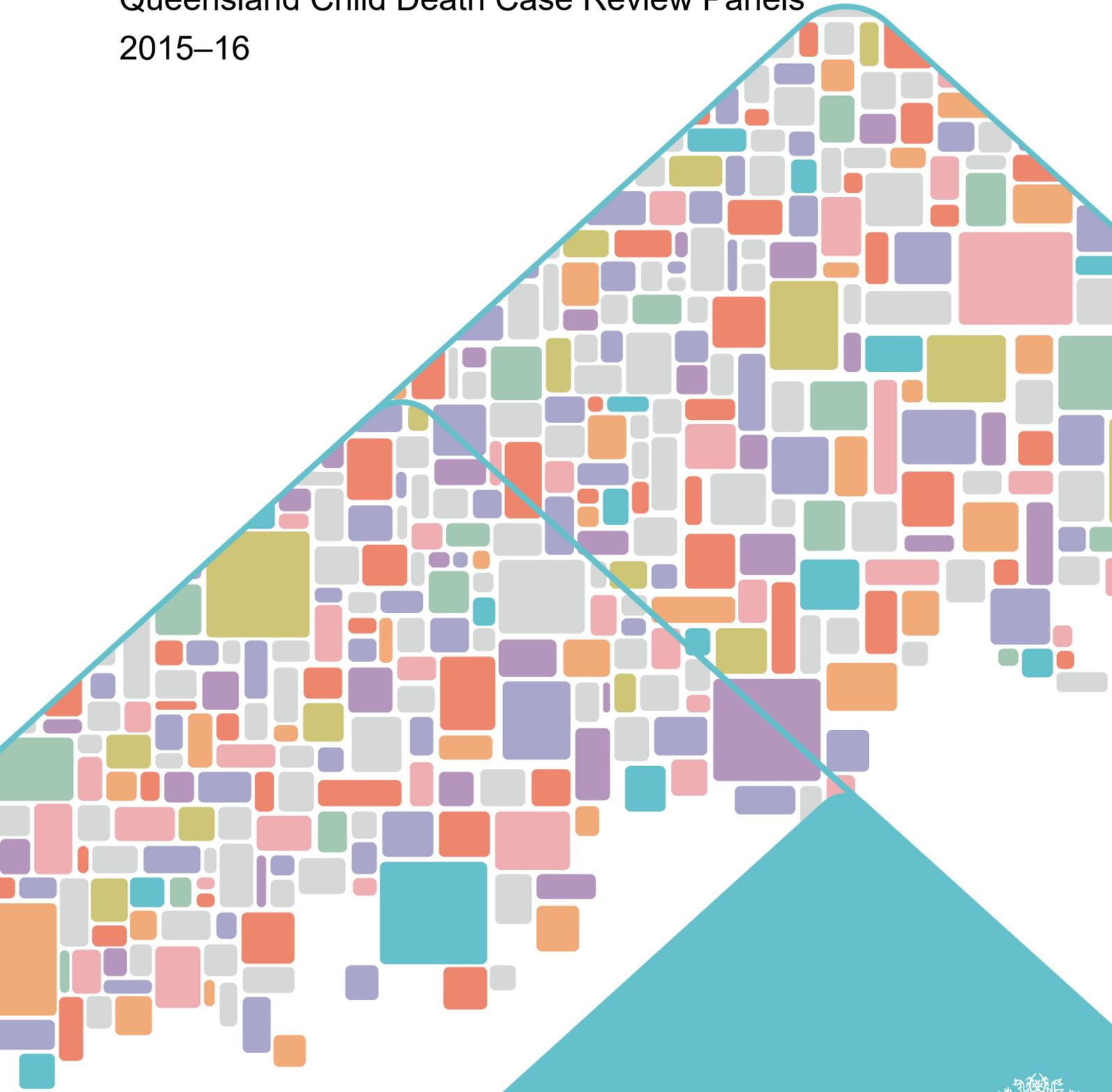


Annual Report on the

Queensland Child Death Case Review Panels
2015–16





Queensland Child Death Case Review Panels
Annual Report 2015–16

The Honourable Shannon Fentiman MP
Minister for Communities, Women and Youth
Minister for Child Safety
Minister for the Prevention of Domestic and Family Violence

Dear Minister

In accordance with section 246HL of the *Child Protection Act 1999* (the Act), I present the annual report about the work of Child Death Case Review Panels under chapter 7A of the Act and departmental responses for the period 1 July 2015 to 30 June 2016.

Yours sincerely

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



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Message from the Director-General

This report summarises the findings from, and departmental responses to, the child death reviews undertaken in 2015–16. It is a critical account of what can be learned and what can be improved as we drive to make Queensland’s child protection system better.

The subject matter of this report is difficult. One of the toughest things we deal with as a department, and as a child protection system more broadly, is the death of a child known to us. We are very mindful that a young life has tragically been lost. I acknowledge the devastating grief and loss experienced by the family, carers and close community, and by those who worked directly or indirectly with the child. Serious injuries to children also are accompanied by hurt and grief.

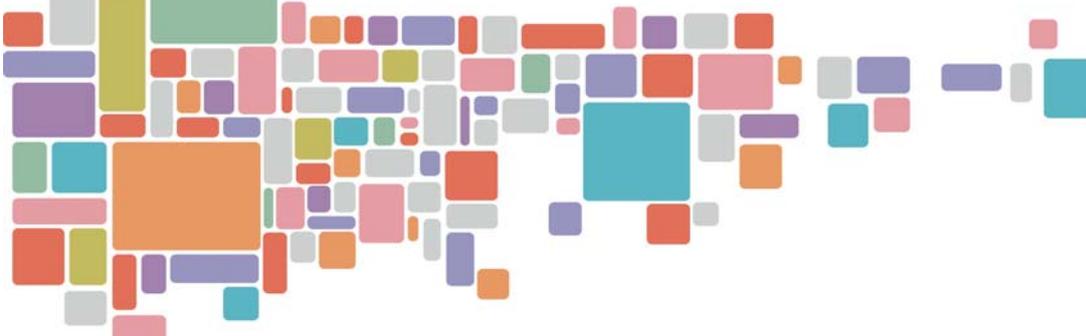
In such situations, we are committed to thoroughly reviewing our work with the child and their family or carers. This is part of our accountability. By investing in a robust two-tiered review system, we seek to honour each of these children by identifying strengths and weaknesses as well as learnings that come from exploring the department’s involvement in their life, and by acting on them through departmental responses at both practice and systems levels.

I thank the reviewers and panel members for their time, diligence, expertise and investment in these cases, and for their contributions to better child protection in Queensland. I thank departmental and other agency staff for their participation. This is very demanding and often distressing work.

I take the findings and learnings of the reviews seriously. I am pleased to see the growing maturity in both tiers of the review system. The reviews will continue to influence our ambitious Child and Family reforms.

I encourage all those engaged in child protection to reflect on this report and use it to further improve practices and systems for services to children and families. I will share this knowledge with the government’s Inter-departmental CEOs Committee, the Reform Leaders Group and Regional Child and Family committees to ensure the system as a whole continues to improve.

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



Executive summary

Background

When a child who is known to the Department of Communities, Child Safety and Disability Services (the department) dies or suffers a serious physical injury, a two-step review process is undertaken. The first is an internal Systems and Practice Review conducted by the department. The second is a review of the department's review by an independent Child Death Case Review Panel. The purpose of both reviews is to identify and encourage improvements in the provision of services by the department and promote accountability.

Children 'known to the department' encompass all those children who come to the attention of the department through an intake, an Investigation and Assessment, are subject to an Intervention with Parental Agreement or on a Child Protection Order. In the 12 months to 31 March 2016, the department had received 96,976 'intakes', of which 75,052 were recorded as 'child concern reports', 21,924 required an Investigation and Assessment, and 4109 children were found to be as in need of protection, in accordance with the *Child Protection Act 1999* (the Act). As at 31 March 2016, there were 9103 children in out-of-home care, of whom 8024 children were placed with foster and kinship carers.

It is estimated that around 80,510 Queensland children were 'known' to the department over the period in scope for this report.

In the 2015–16 reporting period, panels completed 66 reviews of the department's involvement with cases of children and young people who had died or suffered a serious physical injury.

Panel findings

Thirteen panels completed reviews during the reporting period. Panels considered departmental involvement with children and young people at a number of points on the child protection continuum — from intakes, Investigation and Assessment, Intervention with Parental Agreement and on Child Protection Orders. The children and young people were from diverse cultural, family and community backgrounds, and had many different life experiences, opportunities and challenges.

Each panel produced a report outlining broad findings relating to the cases reviewed and detailed findings for each individual case. Each panel made findings aimed at systemic improvement based on the individual cases reviewed. The panels identified examples of high quality service delivery by departmental staff. The panels also identified key or recurring themes and a range of areas for improvement.

Panels noted the significant resources provided by the department in conducting Systems and Practice Reviews and identified improvements that had occurred, or were in progress, in the quality of analysis contained in reviews. Panels also noted that the quality of the reviews could be further enhanced by reference to current research and latest child welfare policy and practice.

Panels noted cases where a lack of communication, coordination and collaboration between government departments and non-government agencies led to fragmented service delivery to vulnerable children and young people.

Panels reviewing departmental involvement with Aboriginal and Torres Strait Islander children and young people identified the importance of quality partnerships and collaborative decision-making, and the need for more meaningful engagement with Recognised Entities.



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Panels made findings in relation to improving service delivery during intake, the point at which the department receives concerns about the protection of children and young people, and during Investigation and Assessment phases. Panels identified departmental officers need to more actively seek clarification and detailed information from those who report concerns.

Panels noted that departmental officers are expected to have an extensive and in-depth understanding of a wide range of issues, including domestic and family violence, mental health issues, substance misuse and all forms of child abuse and neglect. Panel members noted the view that this is unrealistic, given the depth of knowledge required and the complexities of the families within the child protection system. Panels found from such cases that inter-disciplinary teams could achieve the best outcomes for children.

The prevalence of domestic and family violence in many of the families considered in these reviews was significant. The reports highlighted the importance of staff having an understanding 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 panel's report is provided to the Director-General of the department, and considered by key divisions in the department. A report is prepared for the Director-General on each report, outlining the actions the department has taken, or intends to take, in response to the findings.

At a system level, key activities undertaken by the department in response to panel findings include:

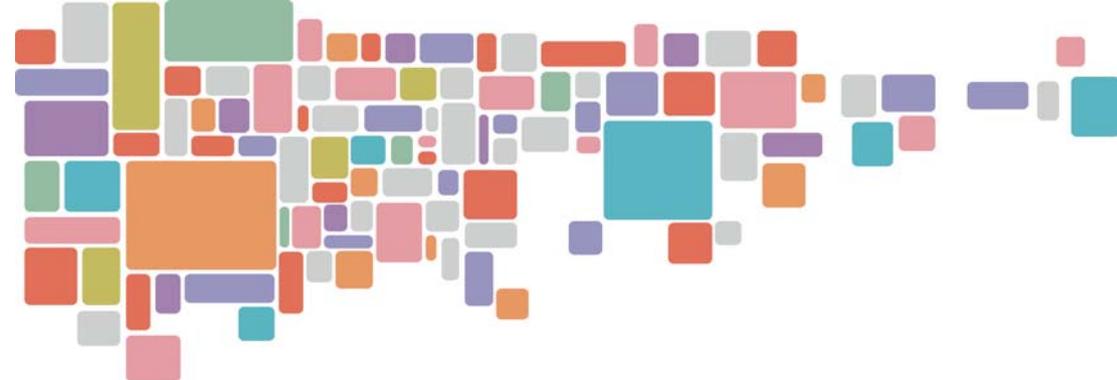
- Continuous improvement of the System and Practice Review methodology, and the Child Death Case Review Panel process, to strengthen the reviews.
- Implementation of Child and Family reforms that are transforming Queensland's child protection system, arising from the recommendations and 10-year reform roadmap from the 2013 Child Protection Commission of Inquiry.
- Development of the Government's strategic directions statement *Supporting Families, Changing Futures: Advancing Queensland's child protection and family support reforms*, released in March 2016, which addresses key panel findings by strengthening the focus on integrated responses, dealing with domestic and family violence and addressing the needs of at-risk adolescents.
- Implementation of the recommendations of the report from the Special Taskforce on Domestic and Family Violence in Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*
- Participation in the Queensland Family and Child Commission's (QFCC) review into agencies handling of children missing from out-of-home care, (which informed the QFCC's July 2016 report, *When a child is missing: Remembering Tiahleigh – A report into Queensland's children missing from out-of-home care*).
- Participation in the Royal Commission into Institutional Responses to Child Sexual Abuse and consideration of its reports from case studies and its research and policy work.
- Implementation, in conjunction with the Australian Government, of the National Disability Insurance Scheme (NDIS) in Queensland, which commenced with an early launch in North Queensland, and preparation for the three-year transition to full scheme statewide, including work on the interface of child safety and the NDIS.

At a practice level, the department has responded to, and acted on the findings of panels throughout the year. This includes informing and adjusting implementation of the new *Strengthening Families Protecting Children Framework for Practice*. In particular, the findings have



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been used to improve training and development at both foundation and advanced levels for Child Safety staff, to strengthen practice and supervision, and in reviews of policies and procedures. Findings and responses have been considered through departmental reform and performance mechanisms.



Chapter 1

Queensland child protection reforms and reviews

Background

The Department of Communities, Child Safety and Disability Services (the department) 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 or carers to keep children and young people safe from abuse and neglect.

Children 'known to the department' encompasses all those children who come to the attention of the department through an intake or the subject of 'child concern reports' received by the department, an Investigation and Assessment, subject to an Intervention with Parental Agreement or on a Child Protection Order. In the 12 months to 31 March 2016, the department received 96,976 'intakes', of which 75,052 were recorded as 'child concern reports', 21,924 required an Investigation and Assessment, and 4109 children were found to be as in need of protection in accordance with the Act. As at 31 March 2016, there were 9103 children in out-of-home care, of whom 8024 children were with foster and kinship carers.

It is estimated that around 80,510 Queensland children were 'known' to the department over the period in scope for this report.

Queensland Child and Family Reforms

The establishment of the Child Death Case Review Panels was part of the implementation of reforms arising from the Queensland Child Protection Commission of Inquiry.

The aim of the Child and Family reform 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 focused on prevention and early intervention
- disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system is addressed
- communities have confidence and trust in the Queensland child protection system.

In April 2016, the Minister for Communities, Women and Youth, Minister for Child Safety and Minister for the Prevention of Domestic and Family Violence released [Supporting Families Changing Futures: Advancing Queensland's child protection and family support reforms¹](https://www.communities.qld.gov.au/resources/gateway/stronger-families/supporting-families-changing-futures.pdf) to:

¹ See <https://www.communities.qld.gov.au/resources/gateway/stronger-families/supporting-families-changing-futures.pdf>



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- affirm the government's ongoing commitment to implementing the Commission of Inquiry's recommendations in partnership with the non-government sector, peak bodies and communities
- report on some of the key achievements of the reform program to date
- outline how the reform program is being enhanced, including new actions and initiatives aimed at: addressing Aboriginal and Torres Strait Islander over-representation; strengthening the focus on prevention and early intervention; tackling domestic and family violence; and focusing on high-risk adolescents.

An implementation schedule outlining the key priorities for the next two years was also released to better enable non-government partners and other stakeholders to plan their critical involvement in the reforms.² Implementation of 120 of the 121 recommendations has commenced, and 31 were completed as at 30 June 2016.

Achievements under the reform program to date include:

- Commencing 16 new Family and Child Connect services and 22 Intensive Family Support services across the state to provide a pathway for families under stress to access the support they need as early as possible
- Creating 230 new positions in non-government organisations supporting families and children since early 2015
- Developing the new *Strengthening Families Protecting Children Framework for Practice* and training more than 3750 government and non-government staff in its use
- Launching the Next Step After Care service and the Sortli mobile app to help young people transition to independence
- Establishing the Director of Child Protection Litigation and the Office of the Child and Family Official Solicitor
- Completing the review of more than 4000 cases as part of an out-of-home care audit to ensure current child protection orders are appropriate
- Improving engagement with fathers in child protection processes through increased staff development and programs specifically designed to work with fathers, such as the Walking with Dads initiative
- Recruiting Aboriginal and Torres Strait Islander Practice Leaders to drive culturally responsive practice through all levels of the department
- Providing domestic and family violence training for frontline child protection, family support and domestic and family violence specialist service workers
- Commencing a comprehensive review of the Act, including the release of a discussion paper to inform a consultation process across the state.

² See <https://www.communities.qld.gov.au/gateway/supporting-families/background/advancing-the-reforms-in-2016-and-2017>



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In addition to the child and family reform program, a number of other related reforms are underway, including:

- Implementation of the recommendations of the final report from the Special Taskforce on Domestic and Family Violence in Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*.
- Participation in the Queensland Family and Child Commission's (QFCC) review into agencies handling of children missing from out-of-home care, (which informed the QFCC's July 2016 report, *When a child is missing: Remembering Tiahleigh – A report into Queensland's children missing from out-of-home care*).
- Participation in the Royal Commission into Institutional Responses to Child Sexual Abuse, and consideration of reports from its case studies and research and policy work, and
- Implementation of the NDIS, in conjunction with the Australian Government, which commenced with an early launch in North Queensland, and preparation for the three year transition to full scheme statewide, including work on the interface of child safety and the NDIS.

Findings from Child Death Case Review Panels are used by the department to inform the implementation of the reform program.

Review framework

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

The department undertakes Systems and Practice Reviews of its involvement following the death or serious physical injury 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 for Child Safety. Systems and Practice Reviews are conducted in accordance with Chapter 7A of the Act, 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 under the Act to replace the Child Death Case Review Committee (supported by the former Commission for Children and Young People and Child Guardian) in overseeing the department's reviews as recommended by the Queensland Child Protection Commission of Inquiry.

The Act includes provisions under Part 7A 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.

Systems and Practice Reviews may occur in addition to criminal investigations and proceedings, coronial investigations and inquests, and reviews by other agencies.



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In May 2016, the *Director of Child Protection Litigation Act 2016* and the *Child Protection Reform Amendment Act 2016* were passed by Parliament. The establishment of the Director of Child Protection Litigation on 1 July 2016, and amendments to the *Child Protection Act 1999* (the Act) which commenced on 1 July 2016, will have a direct impact on the operation of the child death and serious injury review system. The Act *requires* the Director of Child Protection Litigation to conduct an internal review on matters where a child has died or suffered a serious injury and the Director of Child Protection Litigation has performed a litigation function in relation to the child within one year before the child's death or serious injury.³

Tier 1: Internal Systems and Practice Reviews

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 improve child protection service delivery to Queensland's children and young people. The department is responsible for undertaking an internal 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.

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. 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.

The term of reference for 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 the child received services in a culturally appropriate manner.

The Systems and Practice Review Committee (SPRC) 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 the 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
- 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

³ Section 246AA Child Protection Act 1999 (Qld)



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- the Regional Director/s for each review being discussed.

The SPRC 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 whether the service delivery ensured that the child received services in a culturally appropriate manner.

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.

Tier 2: 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 Act contains provisions for Child Death Case Review Panels 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.

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.

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.



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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.

The Minister is responsible for approving the composition of a panel and the cases assigned to a panel for its consideration.⁴ Cases were grouped into themes and allocated to members according to their areas of expertise.

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.⁵ 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 leading up to the death or injury.

Child Death Case Review Panels must decide the extent and terms of reference for their review. Section 246DB (3) of the Act states that 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.

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.

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.⁶ 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.

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Within three months after the end of each financial year, the Director-General must provide 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.⁷

⁴ Section 246HF *Child Protection Act 1999*

⁵ Section 246HG *Child Protection Act 1999*

⁶ Section 246DC *Child Protection Act 1999*

⁷ Section 246HL *Child Protection Act 1999*



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External assurance review

In July 2015, the Minister requested the department commission an external review of the Queensland Child Death and Serious Injury Review system to assess its effectiveness 12 months after the establishment of the new review system.

The department engaged Quality Innovation Performance Consulting (QIP Consulting) to undertake the review. The review examined both the department's internal Systems and Practice Reviews and the operation of Child Death Case Review Panels, with the aim 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 process that may require further exploration.

The review was finalised in December 2015. It identified a number of strengths of the current system, including:

- the department is clear in its operations with effective practices in the review process in both the case review process and in the SPRC
- the review process has become more engaging with staff, increasing reflection and responsiveness
- the SPRC clearly identifies actions for improvements and themes across the reform context and communicates those to the relevant areas
- the SPRC has an appropriate membership mix to influence change in the department
- the themed approach to the Child Death Case Review Panels enables targeting of appropriate expertise in panel membership, deepening discussion and learnings
- the diversity and experience of members of the Child Death Case Review Panels brings a range of experience and perspectives to the consideration of cases, and
- the quality of the Secretariat support provided to the Child Death Case Review Panels in its development.

The review also identified a number of areas for improvement, including:

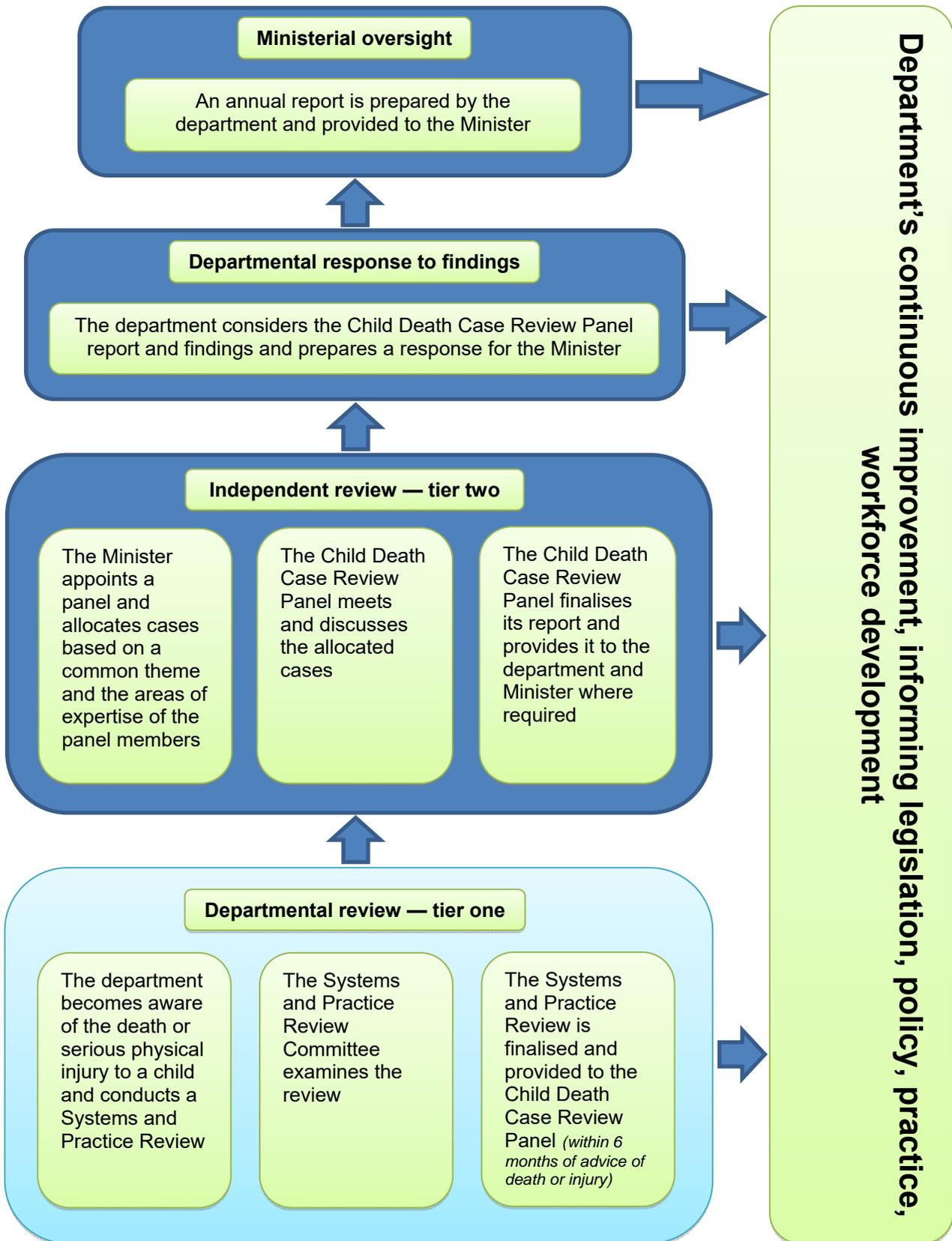
- the need for an identified structure or person to be responsible for overseeing the operation of the panels and clearer decision-making authority for the panel
- the need to define how the different components of the review system (i.e. case review process, SPRC and the Child Death Case Review Panels) achieve the purpose of accountability, learning and improvement and specifically clarify the role and approach of the panels in relation to these purposes
- the need for improved arrangements with respect to the communication of panel outcomes and departmental responses, and
- once the *Supporting Families, Changing Futures* reforms are fully implemented to consider expanding the scope of the reviews to include other entities (such as the Recognised Entity).

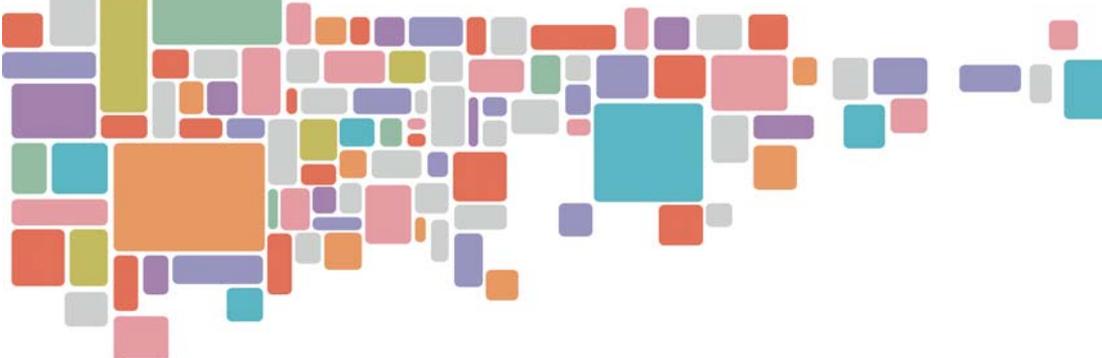
The review made 26 recommendations for improvements to the child death case review system. All of the recommendations have been accepted by the department and an action plan implementing the responses has been developed and approved by the Minister. The action plan will see the implementation of the majority of recommendations by the end of 2016.



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Figure 1. The Queensland Child Death Case Review system





Chapter 2

Profile of children and young people subject to reviews

Snapshot

In the 2015–16 reporting period, Child Death Case Review Panels completed reviews of cases involving 66 children and young people.⁸

Information about all children who died in the 2015–16 year is found in *The Annual Report: Deaths of children and young people, Queensland, 2015–16*, prepared by Queensland Family and Child Commission (QFCC).

Of the 66 children and young people reviewed, 35 were male and 31 were female. Fifteen of the children and young people identified as Aboriginal (23 per cent) and two identified as Aboriginal and Torres Strait Islander (three per cent). Six related to children or young people of culturally and linguistically diverse backgrounds.

Figure 2 shows the number of cases reviewed each year from 2009–10 to 2015–16. It should be noted that legislative changes came into effect on 1 July 2014, reducing the timeframe for cases requiring review from three years to one year, and including the serious physical injury cohort.

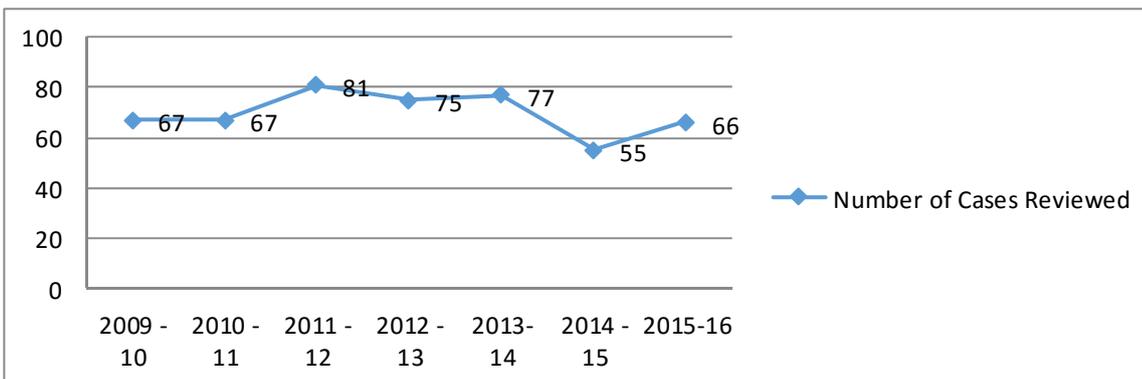


Figure 2. Number of cases subject to review in Queensland.

Characteristics of cases

The most frequent cause of injury was assault, accounting for three of the seven cases (42 per cent). Two cases related to unknown causes. Five cases related to children under the age of one (71 per cent of the total).

⁸ A completed review is defined as a panel which has submitted a completed report to the Director-General between 1 July 2015 and 30 June 2016.



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Figure 3 shows the causes of death in the cases reviewed in the 2015–16 reporting period.

The leading cause of death was suicide, accounting for 16 of the 59 child death cases reviewed (27 per cent).⁹ Nine males and seven females died by suicide. Young persons aged between 15 and 17 were the highest representation of suicide cases.

Disease and morbid conditions accounted for the second highest number of deaths (13 cases or 22 per cent). This category includes children and young people who died due to disease or illness, disability or prematurity. At the time of reporting, 15 cases were categorised as unknown or pending. In these cases, the cause of death remains subject to finding by the Coroner and, therefore, unable to be classified.

Children under the age of one were the highest represented group in child death cases, accounting for 32 per cent of cases reviewed. Young people aged between 15 and 17 were the next highest representation, followed by children aged between one and four.

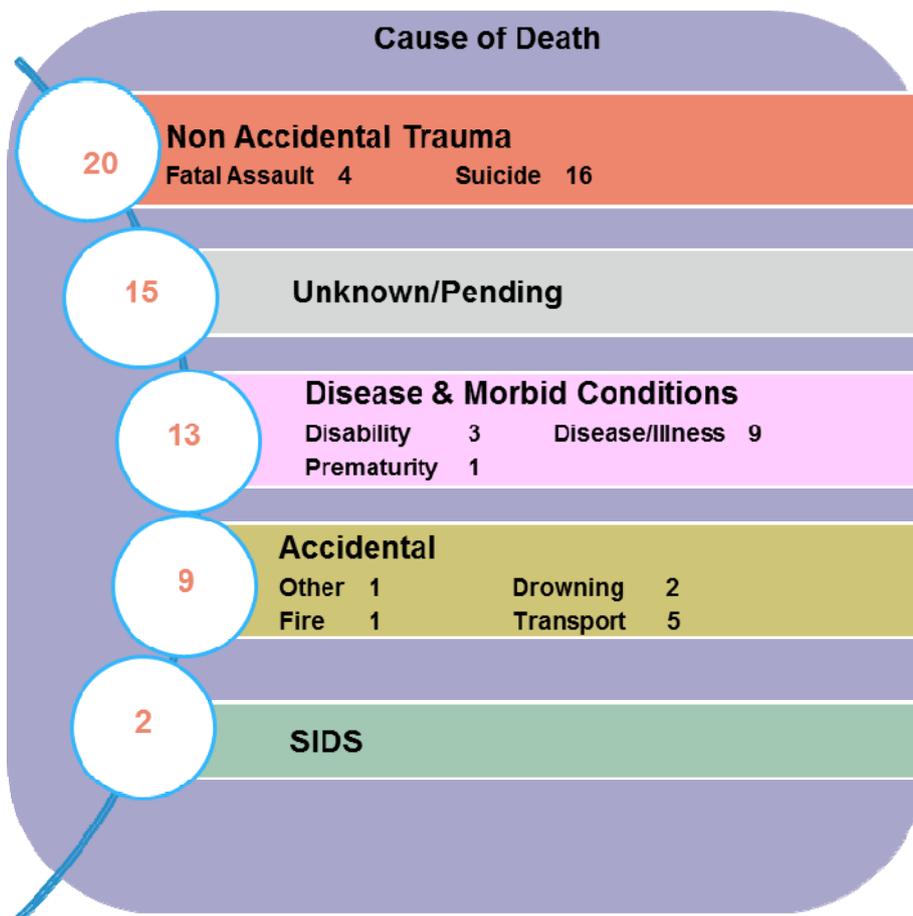
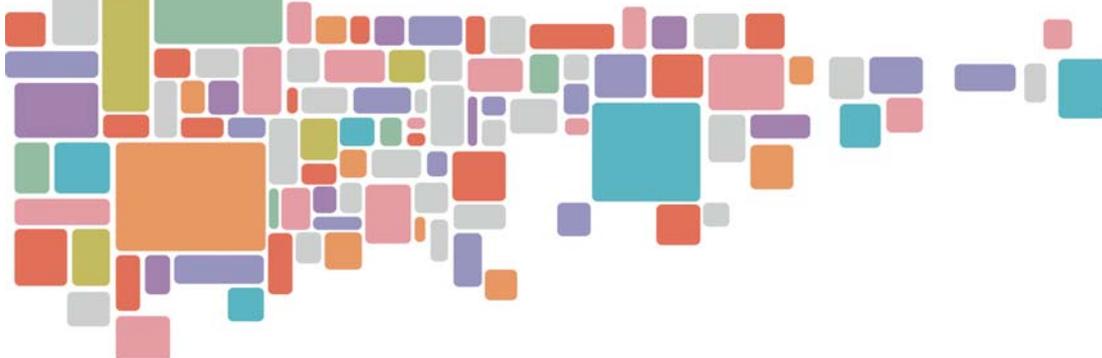


Figure 3. Cause of death of children and young people in the 2015–16 reporting period.

⁹ 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.



Chapter 3

Panel operations, findings and key focus areas in 2015–16

Panel composition

In July 2015, the department coordinated a recruitment process that resulted in the Minister appointing a pool of 38 members to the 2015–16 Child Death Case Review Panels for two years. Twenty-six members are external to government, seven are senior officers of other government agencies, and five are departmental representatives. Ten members had previously been appointed to the pool of members for the 2014–15 reporting period. Four members are Aboriginal. Currently, there are no Torres Strait Islander members. Twenty-eight of the 38 members are female.

The composition of each panel and the allocation of cases to panels were approved by the Minister, with assistance from the Child Death Case Review Panel Secretariat. Each panel was chaired by an external member. The use of a pool of members with diverse expertise provided the opportunity for cases to be themed and allocated to a panel with relevant expertise. Occasionally, case allocation was affected by legislative timeframes in the Act, which requires review of cases 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 panel comprised at least three external members, one member from the department and one member from another government department. Each panel had at least one Aboriginal member. Appendix B provides more detailed information on the members of each panel.

Panel themes

During 2015–16, panels were convened around the following themes relating to service delivery to children and young people:

- with severe chronic or terminal medical conditions and disabilities
- whose cause of death was suicide
- who were very young and vulnerable at the time of their death
- whose cause of death was due to injuries caused by accidental incidents
- from families with multiple complex child protection risk factors
- whose cause of death was non-accidental or unknown
- who suffered serious physical injuries
- who were in care
- who had limited involvement with the department before their death.



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Panel findings

The 13 panels (Panels 10 – 22) completed 66 reviews in the 2015–16 financial year. They considered cases involving 59 children and young people who died and seven children who sustained a serious physical injury. Panels considered departmental involvement with children and young people at a number of 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.

The panels produced reports outlining the findings of their reviews, which were submitted to the Director-General of the department. The approach and nature of findings of the panels varied based on panel composition and the types of cases allocated. Each panel made findings aimed at systemic improvement based on the individual cases allocated to them. There were recurring themes and areas for improvement that appeared across multiple panels.

Panels identified areas of improvement in the delivery of services to children, young people and their families, and interagency coordination. Panels acknowledged the reforms underway to change practice and service delivery, arising from the implementation of Child and Family reforms, and noted that benefits may not be manifest at the time of the child death or injury or during the review process. In most instances, the death or serious injury occurred at least seven to nine months before being reviewed by a panel. System and practice improvements made as a result of panel findings may take time before they are observed in subsequent child death or serious injury case reviews.

The final report of each panel was considered by key areas in the department and a report was provided to the Director-General outlining the action the department has taken, or intends to take, to address the findings in each panel's report.

The department also took steps to make the findings from the SPRC and Child Death Case Review Panels available to departmental staff. The Child and Family Practice and Service Improvement team, Workforce Capability, Regional Directors, the Regional Practice Leaders and Aboriginal and Torres Strait Islander Practice Leaders are making these learnings more visible across the department and ensuring that actions are followed through to embed the required changes.

Key focus area: Systems and Practice Review process

The department's Systems and Practice Reviews have continued to be adapted over the course of 2015-16, based on the feedback received from panels and the department's overall reform agenda.

Panels consistently acknowledged the significant investment by the department, in conducting its internal reviews and identified many instances where the review and analysis were of a high standard. Panel members who had participated in panel meetings in both the 2014–15 and 2015–16 reporting periods noted the significant improvement in the quality of the Systems and Practice Review reports during 2015–16.

Panels acknowledged that the focus of reviews on practice issues related to service delivery enabled greater analysis of systems and practice as a whole, as opposed to just individual decision-making. A number of panels noted that the language used in Systems and Practice Review reports sometimes could be clearer in relation to recommendations and accountability. The expertise of panel members helped identify best practice language about issues, such as suicide and risks associated with domestic and family violence.

As part 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



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Review. The department analysed these discrepancies to inform improvements to the department's review process.

Key focus area: Communication, coordination and collaboration

The majority of panels identified in the cases reviewed the need for improved communication, coordination and collaboration between the department and government and non-government partners, in particular Queensland Health and the Queensland Police Service. The importance of agencies understanding their roles and responsibilities, and accurately articulating casework actions, was particularly evident in cases where families had multiple, complex needs.

Panels acknowledged the benefits of involving other government departments and non-government organisations engaged with children or young people in the review process.

The department continues working with partner agencies to strengthen cross-agency communication and coordination, including in the review process. The department supports 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.

The department's responses to the panels' findings in this area include:

- implementation of the department's new *Strengthening Families Protecting Children Framework for Practice*, a three-year initiative, in which improving communication, coordination and collaboration are critical components
- provision of joint training with government and non-government staff in the new practice framework and development of e-training modules which will be available to other agencies
- development commencing of shared Single Case Plan tools and procedures
- deployment of an information sharing platform between the department and non-government provided Family and Child Connect services
- development of demonstration co-location models for multi-agency (government and non-government) for child safety investigations and assessments
- commitment to instigate a review in 2016–17 of Suspected Child Abuse and Neglect (SCAN) teams
- development of revamped arrangements for Comprehensive Health Assessments for children coming into care
- extension of departmental funding for specialist therapeutic mental health services
- engagement with the Queensland Mental Health Commission and Queensland Health in the development of mental health and suicide prevention strategies and plans
- consideration of child protection in the design and development of initiatives to implement the government's Queensland Domestic and Family Violence Strategy
- engagement by the department with the Australian Government in the design and preparation for implementation of the NDIS in Queensland
- facilitation of cross-sectoral Regional Child and Family Committees and engagement with local service alliances
- participation in the cross-agency Inter-Departmental CEO Committee (IDCC), the Reform Leaders Group and Senior Officers Group
- consideration of panel findings and departmental responses as part of ongoing work to improve interagency cooperation and staff skills in agency and stakeholder engagement.



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The department will continue to address findings and learnings through departmental reform initiatives and cross-agency and stakeholder mechanisms, such as the IDCC, Reform Leaders Group, Senior Officers Group and Regional Child and Family Committees.

Key focus area: Service delivery to Aboriginal and Torres Strait Islander children and young people

The panels considered the experience of 17 Aboriginal and Torres Strait Islander children who were injured or had died. In one of those cases, Aboriginal cultural heritage was only identified following the child's injury and in three other cases, the children and family did not identify their Aboriginal or Torres Strait Islander heritage. At the time of their death or injury, the department was involved with seven of the 17 families. Four of the 17 children were in departmentally-approved foster care placements, four were or had lived in shared care arrangements with aunts, uncles and grandparents, and seven children were in their parents' care.

In reviewing departmental involvement with Aboriginal and Torres Strait Islander children and young people, panels consistently identified the important and complex role of the Recognised Entity and their critical role in quality partnerships and collaborative decision-making. It was noted that the department's engagement with the Recognised Entity could be improved and greater consideration needs to be given to connecting children and their families with the most appropriate service provider.

A key priority for the government is addressing the critical issue of over-representation of Aboriginal and Torres Strait Islander children in the child protection system.

The department is working closely with Aboriginal and Torres Strait Islander partners and other agencies to trial new ways and approaches, improve the agency's cultural capability and address the challenges faces by Aboriginal and Torres Strait Islander families and communities.

Specific responses include:

- Statewide deployment of the new *Strengthening Families Protecting Children Framework for Practice*, which includes specific components related to cultural identity and connection to family, kin and community.
- Implementation of the department's *Aboriginal and Torres Strait Islander Cultural Capability Action Plan – Respectfully Journey Together*, which was launched in May 2015. In 2015–16, this included endorsement of the Aboriginal and Torres Strait Islander Workforce Strategy; development of a cultural capability maturity matrix; development of a cultural perspective lens that can be applied across all aspects of the department's activities; and introduction of a new mandatory cultural induction module *Starting the Journey*.
- Appointment of seven regionally-based Aboriginal and Torres Strait Islander Practice Leaders, along with two positions in the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), to strengthen the cultural understanding and practice of Child Safety and Recognised Entity staff through coaching, case discussions and training, and develop more effective partnerships with Aboriginal and Torres Strait Islander services.
- Strengthened engagement with the Recognised Entity by departmental staff to inform decision-making and planning for Aboriginal and Torres Strait Islander children and young people.
- Engagement of the Recognised Entity by the department's Cultural Consultant in the Case Review team as part of the child death and injury review process.
- Commencement of a review of the Recognised Entity program, with a focus on functions, capability and capacity, in partnership with QATSICPP.



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- Implementation of trials of Collaborative Family-led Decision Making, including engagement of Recognised Entity staff in training and development sessions.
- Development of a Recognised Entity training initiative to strengthen skillsets in communicating advice, undertaking assessments, effective use of practice tools, improving qualifications in the Recognised Entity workforce, and access to a variety of training opportunities.
- Involvement of Recognised Entity staff in Child Safety Officer (CSO) induction.
- Engagement of PricewaterhouseCoopers Indigenous Consulting to conduct community engagement and design for the Aboriginal and Torres Strait Islander Child Protection Service Reform initiative focused on discrete communities.

In May 2016, the Minister for Communities, Women and Youth, Minister for Child Safety and Minister for the Prevention of Domestic and Family Violence, together with the Treasurer, Minister for Aboriginal and Torres Strait Islander Partnerships and Minister for Sport, announced the development of an action plan to address the disproportionate representation of Aboriginal and Torres Strait Islander children and families in the child protection system. The department is partnering with the Department of Aboriginal and Torres Strait Islander Partnerships and Queensland Family Matters coalition to develop the action plan.

Key focus area: Intervention stages

The panels made findings in relation to improving service delivery during both the intake and the Investigation and Assessment stages of intervention.

Panels considered that further development of the skills of Intake Officers in seeking information would improve the quality of decision-making during the intake process. Panels thought that improvements to intake decisions could be made by ensuring that there is thorough consideration of patterns of harm and risk in families and their cumulative effects on children and young people.

The department's responses to panels' findings on intake include:

- Implementation of the *Strengthening Families Protecting Children Framework for Practice*, which includes targeting and encouraging broader information gathering from notifiers, and pre-notification checks with other entities, to inform the assessment of risk and need for appropriate responses from the tertiary and secondary child and family service systems.
- Training and development for CSOs and Senior Team Leaders in determining when to undertake or request a review of multiple intakes to consider patterns of harm and cumulative harm issues.
- Strengthened access for departmental staff to more senior and experienced staff, such as Senior Practitioners, Senior Team Leaders and Practice Leaders, to develop the skills and capabilities to effectively consider complex child protection histories and analyse patterns within families.
- Further development of guidance material and resources for departmental staff to assist in decision-making.
- Progressive statewide roll-out of 20 Family and Child Connect services and Intensive Family Support services to address concerns through a community-based response, improving pathways for direct referrals by families, other agencies, community services and departmental staff.



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Panels also highlighted the critical need for departmental staff to gather information from a wide range of sources and consistently challenge and verify information so that decision-making is based on evidence. The panels identified the need for CSOs to have high-level investigative and interviewing skills and the need for decisions to be informed by current research in child development and child protection practice.

It is critical for departmental staff conducting child protection investigations to have strong skills in investigative processes. There are currently resources and training available to staff to support them to undertake this work, along with significant new approaches to engaging with children and families through the Framework for Practice. The department is committed to ensuring staff have access to the most contemporary evidenced based training and advice. The department is also committed to addressing workload and case load pressures.

Specific departmental responses include:

- Deployment of additional frontline and frontline support Child Safety positions.
- Foundation training for all CSOs in investigative process.
- A specific module on Investigation and Assessments for CSOs in Investigation and Assessment roles, plus further training in relation to interviewing children and recording evidence, and training for authorised officers with advanced skills in conducting forensic interviews with children to reduce trauma for children and young people undergoing interviews, while also meeting legal requirements.
- Implementation from late 2015 of remedial actions to address demand pressures and reductions in commencement and finalisation rates for current Investigation and Assessment functions.
- Commencement of implementation of Commission of Inquiry recommendations for 'differential responses' so that not all notifications would be investigated and establishment of specialist investigation roles for some CSOs as part of the Tertiary System Redesign project.
- Strengthened engagement of families during Investigation and Assessment phases.

Key focus area: Intervention with parental agreement

Panels noted that Intervention with Parental Agreement cases carried inherent risk. They observed that the nature of these cases mean that children remained in the care of their parents while intervention occurred, in circumstances where there was a substantiated harm or a substantiated risk of harm. Panels noted that it was important for the department to examine the adequacy, quality and sufficiency of the Intervention with Parental Agreement responses, particularly the intensity and urgency of the case work being undertaken. For an Intervention with Parental Agreement response to be successful and the child to remain safe, parents need to be engaged and committed to the process.

Panels were of the view that decision-making could be improved by enhancing the Investigation and Assessment skills of staff. Panels commented on the dangers of assumptions, particularly around the ability of parents who are long-term substance abusers to change and not relapse, and the ability of young people to self-protect without due consideration of the impact of trauma or cumulative harm on the young person.

In line with recommendation 13.22 of the Commission of Inquiry, the department has made increased efforts to work with families using Interventions with Parental Agreement, including a focus on the adequacy of safety assessment and planning during the intervention. The department is improving practice through training and the implementation of the *Strengthening Families Protecting Children Framework for Practice* and associated tools, such as the Collaborative Assessment and Planning tool.



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Specific departmental responses include:

- Review of the legislative provisions around Interventions with Parental Agreement as part of the comprehensive review of the Act, which commenced in 2015–16.
- Additional training to staff to strengthen the skills and ability to engage families, to identify the supports a family and children and young people may require, to deal with the impacts of domestic and family violence, and to engage young people with high risk behaviours.
- Additional investment to non-government organisations to provide Intensive Family Support Services, Aboriginal and Torres Strait Islander Family Wellbeing Services and Domestic and Family Violence Support Services.
- Working with Local Level Alliances to improve the connections between and responsiveness of local services and better match service and need, including support to families the department is working with through an Intervention with Parental Agreement.
- Statewide roll-out of Family and Child Connect services to provide community-based gateway and referral hub for services, including self-referral by families in need.
- Additional guidance, training and supervision specifically in relation to decision-making and case work for Intervention with Parental Agreement.
- Improved engagement of fathers in assessments and casework, including training for staff and partner agencies focused specifically on engagement where domestic and family violence is identified as a concern. (This is discussed in greater detail in Chapter 4, Domestic and Family Violence.)

Key focus area: Skills and multi-disciplinary teams

The panels noted the dedication and commitment of departmental staff and the difficult role of child protection practitioners. Panels routinely noted the need for departmental staff to have an extensive understanding of domestic and family violence, mental health issues, substance misuse and all forms of child abuse and neglect. Issues relevant to the case management of children with disability or complex medical conditions require even greater expertise.

Given the complexities of these issues and family circumstances, panels considered that expecting all Child Safety staff to have extensive and specialist understanding of all issues is unrealistic. The introduction of interdisciplinary teams was recognised by a number of panels as a case management practice that could achieve best outcomes for children, particularly those with disabilities or chronic medical conditions. Panels considered this type of case management practice would also contribute to improved information sharing, coordination and collaboration with other agencies.

The department acknowledges 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, and is advancing the establishment of multi-disciplinary and multi-agency teams.

Specific responses by the department include:

- Significant investment to ensure staff receive training to support them to perform their role to the highest standard possible. The roll-out of training for the Framework for Practice has continued to be a priority, with the following training delivered during this period:
 - One and two-day Foundational Training sessions were conducted for 422 departmental staff and partners.
 - Two-day Leading Practice Training was delivered to 512 Child Safety staff in leadership positions.



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- A three-day workshop was provided to 86 departmental family group meeting convenors and Recognised Entity staff.
- Seven two-day Intensive Practice Module Series were conducted for 90 mostly senior practitioners and practice leader participants. These participants then on-deliver the training to staff in their region.
- 21 Manager and Team Leader coaching groups commenced and have been offered to approximately 300 staff.
- Specific training and practice guidance in relation to domestic and family violence (see Chapter 4).
- Conduct of a 12-month review of implementation of the Framework for Practice in March 2016, with input undertaken by over 50 departmental workgroups across the state. This identified a range of processes that are working well, including that the tools and training has been beneficial and staff reported improvements to engagement of children and young people and families. It also highlighted challenges, including the demands of high workloads and the impact of training time on workloads. Also, it identified time was required to embed the new change in practice. The department's implementation of the framework is based on a recognition that staff will require time to gain confidence in using the new tools and maintained support and coaching for those in leadership positions.
- Commencement of implementation of a Care Team approach across the state, which comprises different services and professionals who come together to address the specific needs, risks and plans for a child or young person.
- Development of demonstration co-location models for multi-agency (government and non-government) for child safety Investigations and Assessments, and for child sexual abuse investigations and responses.
- Review of the department's Workload Management Guide, in collaboration with Together Union, so it aligns with the new Framework for Practice, organisational arrangements and the progressive implementation of Child and Family reforms. The Workplace Management Guide provides clear guidance for staff at all levels about workload benchmarks and provides leadership with escalation processes and mechanisms to guide the movement of resources to respond to areas of high pressure and risk.

Key focus area: Disability and chronic medical conditions

Of the 66 cases considered by the panels, nine¹⁰ (14 per cent) involved children and young people with disability or 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 use of specialist knowledge and expert advice.

Panels noted 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; family dynamics; and how best to assess and support these children and families in the child protection framework. This includes an understanding of how a child with significant disability can affect family functioning and parental stress and wellbeing, without assuming the disability itself is the sole source of stress.

¹⁰ This figure does not include infants who died shortly after birth as a result of medical illness.



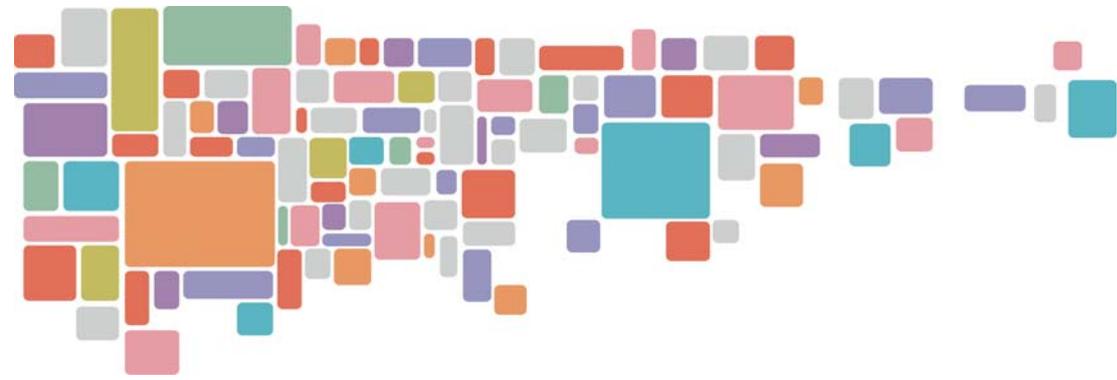
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A number of panels recommended that interdisciplinary case management practices be implemented for children with disability or chronic medical conditions. This would ensure that appropriate expertise in child protection and disability were considered during decision-making processes. Panels recognised the need for Child Safety staff to have an understanding of how the introduction of the NDIS may impact on families with children who have a disability or suffer from chronic medical conditions.

The department is working to deliver coordinated responses from government and non-government service providers and effective use of specialist knowledge and expert advice in situations involving children at risk who have significant disabilities or medical conditions. Work is progressed jointly between the department's Child and Family Practice and Service Improvement team and the Disability Practice and Service Improvement team (Centre of Excellence for Clinical Innovation and Behaviour).

Specific departmental responses include:

- Implementation of a 'Care Team' approach for working with children and young people at risk or in out-of-home care (as noted above), including multidisciplinary approaches for children and young people with disability and complex needs involving staff from Child Safety Services and Disability Services.
- Review and strengthening of resources and training materials, including Intensive Practice Module Series, for Child Safety staff on children with disabilities and complex needs.
- Engagement with the National Disability Insurance Agency to deliver integrated responses for children at risk or in out-of-home care as part of the roll-out of the early launch of the NDIS in North Queensland, and in preparation for start in July 2016 of the progressive statewide transition to full NDIS scheme over three years.
- Investment in non-government organisations to provide NDIS Participant Readiness initiatives for families with children with disability across Queensland.
- Engagement of departmental staff to build an understanding of the NDIS, including changes and opportunities for families with a child or other family member with disability.
- Trial placement of Disability Services staff in a Family and Child Connect and Intensive Family Support Service to provide early identification and support pathways for families where either the parent, child or young person has a disability. Learnings from this trial are being considered for statewide roll-out.



Chapter 4

Critical issues in 2015-16

Throughout the 2015–16 reporting period, two critical issues were identified and considered by the panels: domestic and family violence and suicide. Chapter 4 provides an analysis of the characteristics of each of these issues, the panels’ findings, and the department’s responses.

Domestic and Family Violence

Characteristics of child death and serious injury cases affected by domestic and family violence

Domestic and family violence was a significant feature in the families of 70 per cent of the cases reviewed (46 of 66 cases). Of these 46 cases, 39 involved the death of a child or young person, and seven involved serious injury of a child or young person. Domestic and family violence was present in 66 per cent of all child death cases reviewed and 100 per cent of all serious injury cases reviewed.

Children under the age of one are the highest represented age group in occurrences of death and serious injury to children. It is not surprising they are also the highest represented age group in cases affected by domestic and family violence (18 of 46 cases or 39 per cent). Domestic and family violence was present in 75 per cent of all the ‘children under one’ cases reviewed. Young people aged between 15 and 17 were the second highest represented age group, with 11 cases or 24 per cent. Domestic and family violence was present in 61 per cent of all the ‘15 to 17 aged children’ cases reviewed.

Figure 4 shows that different, sometimes multiple, factors may characterise families of children affected by domestic and family violence.

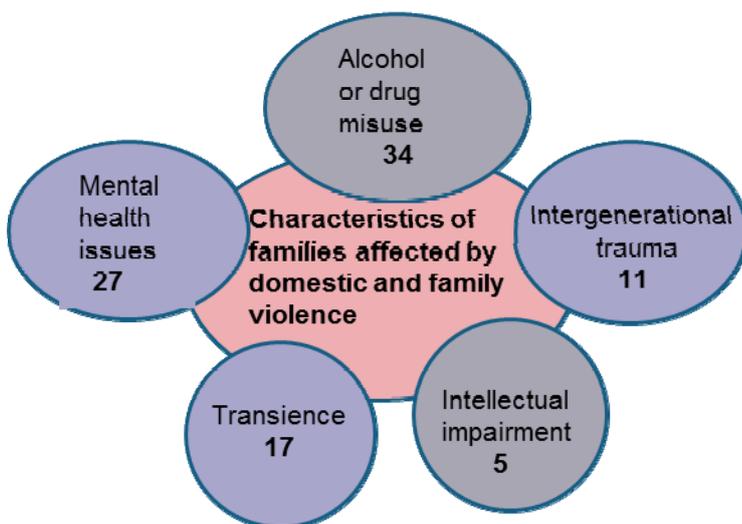


Figure 4. Characteristics of families affected by domestic and family violence from the 46 cases reviewed



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Of the 46 child death and serious injury cases that featured domestic and family violence, 34 cases (74 per cent) involved families that also experienced drug or alcohol misuse. Mental health issues were present in 27 cases (59 per cent), transience was present in 17 cases (37 per cent) and intergenerational trauma was present in 11 cases (24 per cent).

A history of child protection was also a common feature in families reviewed that were affected by domestic and family violence (*Figure 5*). Thirty-one of the 46 cases characterised by domestic and family violence also had a child protection history prior to the death or serious injury of a child or young person. In most of the cases, the child protection history related to someone as a parent, although in 11 of the 31 cases, the history related to someone when they were a child and also, later, while they were a parent.

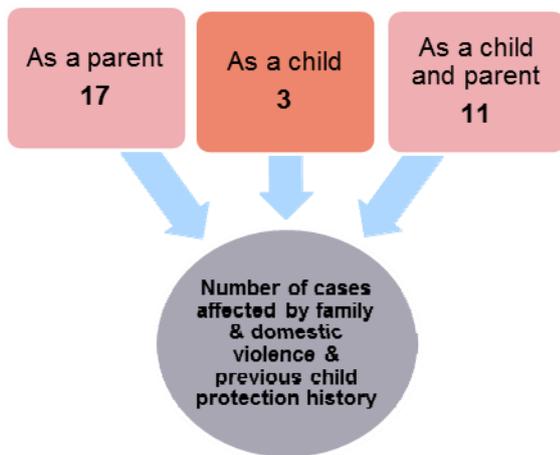


Figure 5. Cases affected by domestic and family violence and child protection history



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Domestic and family violence is suspected to be a cause of death or injury in seven of the cases reviewed for the 2015–16 period.¹¹ In one of these cases, involving death, a parent has been charged with inflicting fatal injuries. In two cases, a parent or care provider has been charged with offences relating to the infliction of an injury. In the remaining four cases (two involving death and two serious injury), domestic and family violence is suspected to be a cause; confirmation by the Coroner is pending.

Panel findings relating to domestic and family violence

Panels acknowledged the government's comprehensive agenda to eliminate domestic and family violence and the range of current departmental initiatives underway. The panels noted that a deeper understanding of the violence and its impact on children will contribute to better risk assessments and guide appropriate intervention strategies.

Understanding domestic and family violence

Panels referred to the significant amount of literature available on the impacts of violence on children — not only the risk of physical injury, but also the psychological trauma experienced by children living in a constant state of fear and anxiety. Such experiences carry a high risk of long-term developmental deficits and consequent implications for child protection. One panel identified research that likened a child's experience of serious forms of violence and abuse with living in a 'type of war zone'.¹²

Further, children are particularly vulnerable to cumulative harm in families with multiple and complex problems. In these families, the unremitting daily impact of multiple adverse circumstances and events has a profound and exponential impact on children, and diminishes their sense of safety and wellbeing.¹³

A number of panels noted that a mother and father residing separately cannot necessarily be relied upon to reduce the risk of further domestic violence. Post-separation is a time of heightened risk for a woman and her children in the context of ongoing domestic violence. The latest annual report by the Office of the State Coroner's Domestic and Family Violence Death Review Unit reported that 43 per cent of women killed by a male intimate partner in Queensland between 2006 and 2012 died during a period of actual or intended separation.¹⁴ The report advises, "Leaving a relationship, or just expressing an intention to get out, may increase the risk of harm for victims of domestic violence."¹⁵

¹¹ For the purposes of this report, a domestic and family violence death is defined as the deceased person was or had been in a relevant relationship with the perpetrator that involved domestic and family violence (section 91B *Coroners Act*). A relevant relationship is defined by section 13 of the *Domestic and Family Violence Protection Act 2012* and includes a family relationship or informal care relationship. A family relationship exists between two persons if one of them is or was the relative of the other; a relative of a person is someone who is ordinarily understood to be or to have been connected to the person by blood or marriage and may include (but not limited to): a child, step-child, step-parent, sibling, grandparent, cousin, and half-sibling.

¹² Rossman and Ho (2000) cited in Margolin, G. & Vickerman, K (2011). *Posttraumatic Stress in Children and Adolescents Exposed to Family Violence: Overview and Issues*. <http://psychnet.apa.org.ezproxy.library.uq.edu.au>

¹³ Bromfield, L. M., & Miller, R. (2007). *Specialist Practice Guide: Cumulative harm*. (PDF 795 KB) cited in "Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems". NSPC Issues No 33. (2010) *Child, Family and Community Australia*. <http://www.aifs.gov.au/nch/pubs/issues33/>

¹⁴ <http://www.abc.net.au/news/2015-07-14/45pc-of-qld-homicides-linked-to-domestic-violence-coroner-report/6618492>

¹⁵ Ibid



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Assessing risk

The panels identified a need for greater understanding of the dynamics and nature of the domestic violence in order to assess and intervene with families and better protect children. This includes understanding the nature of the motivations for the violence, and drawing from research and evidence about the details of risk in various situations. For example, the need for decisions about appropriate interventions to be informed by assessments of whether the violence is 'mutual combat' or whether the motivation for the violence is 'coercive control'.

The impact of violence on pregnant women and the risk to unborn children was also considered by a number of panels. Understanding risk during pregnancy requires an understanding of the nature and basis of the violence, and the relationship with the father. Where a father supports the pregnancy, the risk of physical violence towards the mother and child may *decrease*. But the controlling and coercive aspects of the violence may *increase*. This is further evidence of the importance of specialist domestic and family violence advice and a deeper understanding of domestic and family violence evidence and research.¹⁶ This will ensure that practice is evidence-based.

Assumptions and desensitisation

Panels also identified assumptions by Child Safety staff about the level of protection offered by a Domestic Violence Order (DVO).¹⁷ In 27 per cent of intimate partner homicide cases in Queensland between 2006 and 2012, a DVO between the offender and the deceased was in place at the time of the death.¹⁸

Desensitisation of Child Safety staff to the issue of domestic and family violence was another issue raised by panels. This was particularly evident in cases where serious violence was assessed as lower-end violence when compared with the numerous, high-level domestic violence incidents reported in the particular region. Panels highlighted the importance of reflection and ongoing professional supervision to identify and address common biases and desensitisation relating to domestic and family violence.

Support for Child Safety staff

Panels expressed the view that domestic and family violence is a specialised area and staff need easy access to the latest information, and professional guidance and advice. This includes access to research and emerging evidence about the nature of violence in intimate relationships. Panels acknowledged the positive steps taken by the department in addressing this issue.

¹⁶ The panel noted relevant research about the exposure to high levels of cortisol and other stress hormones during pregnancy, systems of the foetus and the prenatal care of the mother. For example findings show that domestic violence during pregnancy causes low birth weight in infants; preterm labour; unhealthy maternal behaviours; the infants' retina, optic nerve and thymus development are affected and there is decreased maternal attachment.

Quinlivan, JA (2000). "Study of adolescent pregnancy in western Australia", The Way Forward: Children, young people and domestic violence Conference Proceedings. Carlton Crest Hotel Melbourne, April 2000.

Quinlivan, JA & Evans, SF (2005). "Impact of domestic violence and drug abuse in pregnancy on maternal attachment and infant temperament in teenage mothers in the setting of best clinical practice." Archives of Women's Mental Health 8: 191 - 199.

Jasinski, JL (2004). "Pregnancy and domestic violence: A review of the literature". Trauma, violence and abuse, 5(1):47-67.

¹⁷ It is acknowledged that the correct legal term is 'Protection Order', however, it is noted that the term *Domestic Violence Order (DVO)* is the language commonly used and understood within the department. The department's practice papers include that "*The term Domestic Violence Order is used to collectively identify two types of orders:*" (namely Protection and Temporary Protection Orders).

¹⁸ <http://www.abc.net.au/news/2015-07-14/45pc-of-qld-homicides-linked-to-domestic-violence-coroner-report/6618492>



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Departmental response

The department considers domestic and family violence to be a critical issue and addressing it continues to be a high priority. The department has been progressing a range of actions and strategies to improve child protection practice where domestic and family violence is a factor.

The Queensland Government has accepted, and is implementing all recommendations in the report of the Special Taskforce on Domestic and Family Violence: *Not Now, Not Ever – Putting an End to Domestic and Family Violence in Queensland* (Taskforce report). This includes the commitment of an additional \$233 million to the prevention of and responses to domestic and family violence over the five years from 2015–16. Of that, funding totalling \$89.5 million over five years from 2015–16 has been provided to the department to address domestic and family violence.

The Minister's portfolio responsibilities for Communities, Women and Youth, Child Safety, and the Prevention of Domestic and Family Violence is enabling the department and partner agencies and sectors to advance more integrated responses.

The department is playing a key role delivering the government's response to the Taskforce report and the Government's new Queensland Domestic and Family Violence Strategy and associated action plan. The department is leading 30 recommendations and supporting implementation of a further 20. The reforms are expected to improve responses to the needs of children and families in contact with the child protection system where domestic and family violence is an issue.

Specific departmental responses include:

- Funding specialist Domestic and Family Violence positions in each of the 20 Family and Child Connect Services and in the Intensive Family Support services being roll-out statewide.
- Inclusion of representatives and experts from the Domestic and Family Violence sector on the department's Child and Family Reforms Stakeholder Advisory Group, and in Regional Child and Family Committees.
- Prioritisation of training to increase the knowledge and capability of staff and partners in the area of domestic and family violence. In 2015–16, this included:
 - five, four-day David Mandel *Safe and Together* training relating to domestic and family violence and child protection integration provided to 204 staff and partner participants
 - four, one-day *Safe and Together* model training provided to 114 Regional Intake Services staff and three partner agency staff
 - five two-day training sessions across the state by Wendy Bunston on the impact of domestic and family violence on infant brain development delivered to 141 carers, carer agencies and domestic and family violence workers.
- Development of a suite of online training resources as part of both CSO induction and advanced training. The foundational module will cover 'What is Domestic and Family Violence' and 'Engagement and Assessment', and the further training product will cover 'The impact of Domestic and Family Violence on Children', 'Working with People from Diverse Cultures', and 'Legislation and Support'.
- Development with Australia's CEO Challenge of the *Triple R Program – Recognise, Respond, Refer: Domestic Violence and the Workplace*, with access being provided to all departmental staff (including as part of CSO induction) and to non-government organisations.
- Strong collaboration between the department's Child Safety, Human Resources and Office for Women and Domestic Violence Reform teams to improve policies and practices and ensure continual enhancement of staff knowledge and skills.



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- Participation in the Australian National Research on Women’s Safety (ANROWS) ‘Patricia Project: Pathways and Research in Collaborative Inter-Agency working’, a cross-jurisdictional research initiative led by the University of Melbourne.
- Development of Domestic and Family Violence Integrated Response trials and High Risk Teams which will include dedicated Child Safety practitioners. Initially in three locations — Logan-Beenleigh, Mount Isa/Gulf and Cherbourg — panels of key government and non-government agencies will case manage high risk domestic and family violence cases. These will be expanded to five other locations across Queensland over the next three years.
- Involvement of the Office for Women and Domestic Violence Reform staff in the Child Death and Serious Injury SPRC.
- Casework consultation by the department’s North Coast Region with David Mandel, following on from the *Safe and Together* model training, on complex domestic and family violence and child protection cases.
- Commencement by the department of accreditation through White Ribbon Australia’s Workplace Accreditation Program.

Suicide

Characteristics of suicide involving young people

Sixteen cases reviewed in the 2015–16 reporting period involved a young person with a cause of death listed as suicide. These cases, involving nine males and seven females, were considered across three panels. Consistent with findings from the general population,¹⁹ suicide is the leading cause of death in young people aged 15–17 years of age.

As shown in *Figure 6*, 10 (63 per cent) of the young people who died by suicide in the reporting period were non Indigenous Australians or their cultural heritage was not noted, four (25 per cent) were Aboriginal, and two (13 per cent) were from other culturally and linguistically diverse backgrounds.

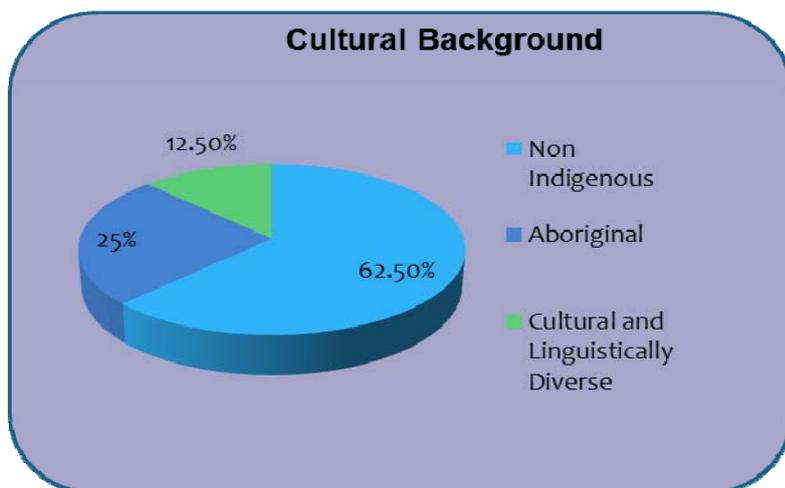


Figure 6. Cultural background of deaths by suicide

¹⁹Queensland Family and Child Commission (2015). Annual Report: Deaths of children and young people, Queensland, 2014–15. <http://www.qfcc.qld.gov.au/Documents/annual-report2015/Child%20Deaths%20Annual%20Report%20FINAL.pdf>



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The panels noted an increase in the number of deaths due to hanging in the general population and acknowledged this was reflected in the cases reviewed. Hanging is the hardest form of suicide to prevent due to the availability of paraphernalia to implement a decision to die by hanging and perceptions it is fast and lethal.²⁰

Suicide in both child and adult populations is acknowledged as a complex and challenging issue. In the cases considered by the panels, the life experience of multiple adverse circumstances and events was cumulative and destructive to a child and young person's sense of safety and wellbeing. The panels who considered this issue also noted that young people often die by suicide when they are at a complete point of separation from all support.²¹ Fifty per cent of the suicide cases involved young people in families affected by domestic and family violence.

There were some common characteristics of young people who died by suicide. Of the 16 young people whose cases were considered by the panels in the 2015–16 reporting period, 12 came from separated families.²² There was a common theme of disconnection with the young people experiencing challenges in both home and school settings. There were reports of seven (44 per cent) of the young people experiencing physical abuse in their homes and eight (50 per cent) experiencing emotional abuse in their homes. A large proportion (63 per cent) of the young people had issues with their schooling, namely being subject to bullying, or had significantly poor educational engagement. These figures demonstrate the number and complexity of the issues faced by young people who have suicidal ideation (acting on suicidal thoughts).

A large number of young people were in a carer role for younger siblings at the time of their death. Seven of the young people were the eldest of their sibling group, with one young person being an only child. Three were middle children, who took on the caring role in their family for younger siblings as their older siblings had left home or were part of another family group. Other complex family situations included unavailable parents, due to illness, drug and alcohol misuse, parental mental health conditions, parental criminal offending and incarceration, and transience or housing issues.

Panel findings

The panels acknowledged that the cases reviewed highlight the worst outcomes possible for young people and their families. The panels raised the need for training, skilled and reflective supervision and ongoing support and review, at key decision points and during case work.

Role of the department

The panels acknowledged that not all young people who experience suicidal ideation and self-harming behaviour are the responsibility of the child protection system. Rather, in cases where there are child protection concerns and a young person's situation has deteriorated enough for the department to be notified, the department is ideally placed to be the co-ordinating service to ensure holistic management and review of highly complex family situations. The panels considered there was a considerable need for inter-disciplinary case work for high risk adolescents, given the complexity of their experiences and their tumultuous stage of development.

²⁰ Factors influencing the decision to use hanging as a method of suicide: qualitative study
Lucy Biddle, Jenny Donovan, Amanda Owen-Smith, John Potokar, Damien Longson, Keith Hawton, Nav Kapur, David Gunnell, *The British Journal of Psychiatry* Sep 2010, 197 (4) 320-325.

²¹ Rossman and Ho (2000) cited in Margolin, G. & Vickerman, K (2011). *Posttraumatic Stress in Children and Adolescents Exposed to Family Violence: Overview and Issues*. <http://psychnet.apa.org.ezproxy.library.uq.edu.au>

²² In this context separated families refers to the child's mother and father no longer living together.



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Adolescent mental health

Just over half (nine out of 16 cases) of the young people who died by suicide had a diagnosed mental health condition. Panels acknowledged that in cases where the child protection issues are not the most significant issue the department may not be the best service to hold case responsibility for young people with mental health concerns. It was noted that young people with mental health considerations come to the notice of a range of services.

The panels were of the view that staff requires additional support to enable them to respond effectively. This is particularly the case when mental health considerations interconnect with trauma over their lifespan, including isolated events and cumulative, long term exposure to family situations, such as violence, abandonment, rejection and the impact of Aboriginal and Torres Strait Islander history.

Training and development

The panels asked the department to explore options to provide frontline staff with skills and knowledge, through training or access to specialists, consider screening processes at intake level and engage young people in assessment and intervention. Panels also noted the importance of using appropriate language and terms when referring to suicide to support help-seeking behaviours and reduce stigma attached to self-harm and suicide.²³

Engaging with young people

The characteristics of young people experiencing suicidal ideation demonstrate the complexity of the issues they face. Young people are often dealing with multiple complex issues at the same time, which impacts on their social functioning and emotional wellbeing. Panels were of the view that improved assessment skills of departmental staff would enable a more targeted and effective support plan to be put in place.

Departmental processes

The panels encouraged the department to include all services engaged with a family in SCAN meetings and considered that these services should be asked to contribute to case plans. These services include both government and non-government organisations. The panels considered this was particularly important when working with young people who are confused about their sexual identity or considering their gender identity.

Departmental response

The prevalence of suicidal ideation and attempts among young people generally is a continuing issue of significant public concern. Many young people known to the child protection system have experienced significant trauma, and are at higher risk of self-harm and suicidal ideation and attempts. The panels identified the need for continuing focus and work to build staff and provider capability and multi-agency responses in this area.

The department is working to more effectively engage young people who come into contact with the child protection system, including strengthening policies, procedures and responses to young people at risk of suicide and with suicidal ideation. The department is committed to embedding current research best practice into its responses to this very challenging and complex issue. The department recognises the critical importance of inter-agency approaches to quality service responses to children and families, and especially to vulnerable young people.

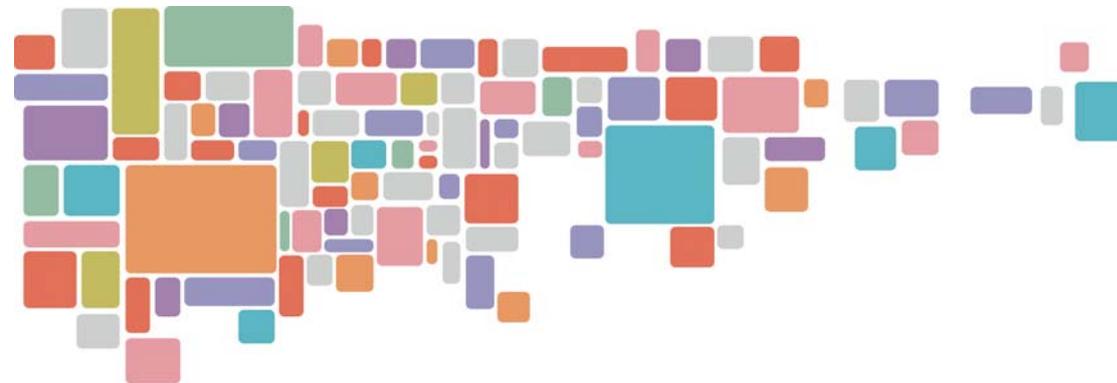
²³ Beaton, S. Forster, M. Maple, M. (2013) Suicide and language: Why we shouldn't use the 'C' word. InPsych February 2013, Vol35, Issue 1.



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The department's specific responses include:

- Extension of departmental funding for the specialist Evolve therapeutic mental health services provided by local Hospital and Health Services.
- Engagement with the Queensland Mental Health Commission and Queensland Health in the development of mental health and suicide prevention strategies and plans.
- Engagement with the Lady Cilento Hospital and State-wide Children's Hospital and Health Service in its implementation of the Platform 18 initiative to improve health care for children and young people in care.
- Development of the Hope and Healing Framework for residential care services in conjunction with PeakCare, to be implemented in 2016–17.
- Development of the Queensland Out-of-Home Care Outcomes Framework for implementation as part of the overhaul of Out-of-Home Care services to be advanced in 2016–17.
- Development of revamped arrangements for Comprehensive Health Assessments for children and young people coming into care, to commence in 2016–17.
- Review and roll-out of updated resources regarding adolescent mental health available to Child Safety staff. This includes the recent 'Working with Young People' Intensive Practice Module Series.
- Commitment to instigate a review in 2016-17 of SCAN teams.
- Facilitation of local inter-agency Complex Case Panels for vulnerable young people.
- Implementation of the *Strengthening Families Protecting Children Framework for Practice*, which emphasises holistic assessments and multi-agency responses.
- Engagement with CREATE, the consumer advocacy body for children and young people in care, as well as Community Visitors and Child Advocates, to enable the voices and experiences of children and young people to be better heard across the child protection system.
- Development and trialling of innovative ways of engaging with young people in care, including:
 - North Queensland, an adolescent team with a specific focus on working more effectively and creatively with young people in care.
 - North Coast, a mobile phone and tablet app (Kicbox), which allows young people to store and access information about their lives and better engage with their care team and CSO.



Appendix A:

External Assurance Review

Recommendations of the review of systems for conducting reviews of child death and serious injury

The table below lists the 26 recommendations of the review of systems for conducting reviews of child death and serious injury. All of the recommendations have been accepted by the department and an action plan implementing the responses has been developed and approved by the Minister. The majority of recommendations will be implemented by the end of 2016.

Recommendation 1	Amend the review dates for the Systems and Practice Review policy, procedure and practice documentation to one year to assess whether this documentation is providing appropriate guidance for the undertaking of departmental systems and practice reviews. Following this initial review, set the timeframe for routine three-year reviews unless legislation or practice change requires an earlier review date. [Section 4.2]
Recommendation 2	Monitor the requests for supplementary reviews by panels and if a common theme arises then a revision of the terms of reference for Systems and Practice Review types may be required. [Section 4.3]
Recommendation 3	Review the terms of reference of Systems and Practice Reviews and consider the benefits and risks of including other non-government organisations more formally in the review of child death and serious injury once the broader child and family welfare reforms are more fully implemented. [Section 4.4]
Recommendation 4	Review the analytical tools identified in Chapter 3 of this report to assess whether they could be useful in broadening the range of frameworks available to the Systems and Practice Review officers and SPRC in undertaking child death and serious injury reviews. Provide appropriate supports to ensure that relevant departmental staff are able to use selected analytical tools effectively. [Section 4.5]
Recommendation 5	Determine whether the Systems and Practice Review of child death or serious injury should focus on the practice of the department and other organisations at the case level, or also consider broader systems issues and improvements. Amend the terms of reference for the Systems and Practice Review process to reflect this determination. [Section 4.5]
Recommendation 6	As part of induction of panel members, ensure they are provided with information about the broader sector reform agenda and how the work of the Systems and Practice Review unit links to it. Provide regular updates on the reform agenda to allay panel members' anxiety that no action is being taken by the department on recurring themes they identify. [Section 4.5]
Recommendation 7	Determine and document the different roles of the Systems and Practice Review officers, SPRC and Child Death Case Review Panel (CDCRP) in reviewing child deaths and serious injuries to ensure duplication of effort is minimised and that each review type has a clear focus. [Section 4.5]



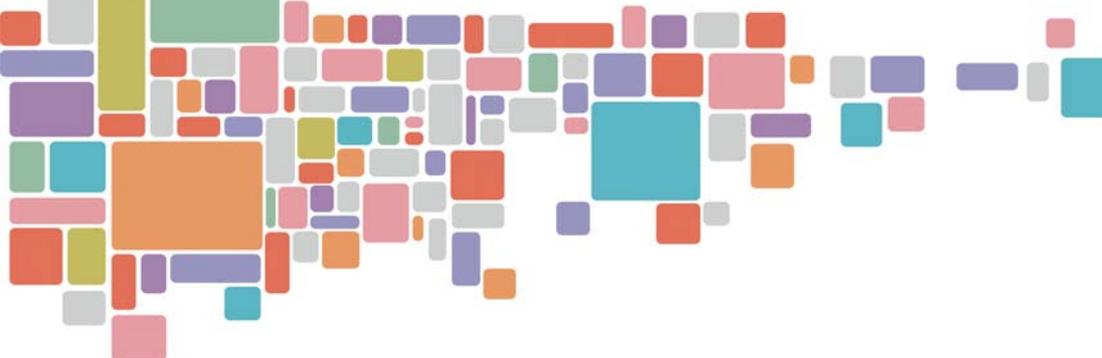
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Recommendation 8	Undertake capability development with Systems and Practice Review unit staff on using language appropriately to convey clear evaluations of decisions and practice without being seen to blame individual workers. [Section 4.5]
Recommendation 9	Undertake an annual self-assessment of the SPRC functioning to identify whether it is achieving its objectives and whether any improvements can be identified. This should be done at the individual and committee level. [Section 5.3]
Recommendation 10	Provide the six monthly SPRC reports to panel members so that they have information about the recommendations that the SPRC is working on and the resulting outcomes, as evidence of the department’s work to address issues raised by panels. [Section 5.4]
Recommendation 11	Consolidate the CDCRP chair arrangements to provide a clear, consistent decision-making and leadership structure for the panels. The recommended approach is to establish two panel leadership roles, Chair and Deputy Chair, each appointed on a 12-month rotating basis. Clarify the respective functions of these positions including: Exercising decision-making responsibility regarding the development of the CDCRP <ul style="list-style-type: none"> - Chairing all panels during the year - Leading the development of CDCRP practice - Providing support to panel members - In collaboration with the Secretariat, developing guiding documents to support panel processes - Reviewing each panel’s performance and conducting an annual review of the panels’ operations. [Section 6.1]
Recommendation 12	When undertaking reviews of each panel and its process include a question on how dissenting views are managed. This data should be collated and used to inform improvements, including reflecting on the independence of the panels. [Section 6.1]
Recommendation 13	Consider removing or revising Section 246DB of the Act to more accurately reflect the limitations of the panel’s ability to investigate the performance of individual departmental staff. [Section 6.1]
Recommendation 14	Develop clear panel member and chair role descriptions that define: <ul style="list-style-type: none"> - The purpose of the review - Responsibilities in relation to the review process - The role of the chair in conducting meetings and editing and finalising panel reports - The limits to information panels can expect to receive on ongoing matters relating to children and young people who have been seriously injured - The limits to information panels can expect to receive on welfare of families where a child or young person has died. [Section 6.2]
Recommendation 15	Develop operational guidance for the panels that includes information on: <ul style="list-style-type: none"> - What they are reviewing - How this is done - Findings and recommendations - Minute taking - Reports including feedback on draft panel reports - The processes through which the department will consider and potentially action recommendations. [Section 6.2]
Recommendation 16	Develop a set of principles that describe the process by which the Minister approves or does not approve panel members, individual panels and the make-up of these. [Section 6.2]



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Recommendation 17	Develop an induction program for all new panel members to support them with the information they need to perform their role. [Section 6.2]
Recommendation 18	When reviewing the Act as part of broader sector reform, consider removing the requirement for the Minister to approve each specific panel and its membership. [Section 6.2]
Recommendation 19	Establish an annual forum where chairs and panel members can meet together on a regular basis to share experience and develop consistent processes. [Section 6.2]
Recommendation 20	Ensure the role description for the chair clearly indicates the importance of meeting facilitation skills. Consider these skills as part of the selection criteria for appointment of the chair and develop mechanisms for chairs to continue to improve their facilitation skills. [Section 6.2]
Recommendation 21	Review the themes for the panels and reduce the overall number of themes. Schedule two or three panels each year that do not have a specific theme to accommodate the review of cases that due to their nature or because of time constraints do not readily fit into the overall pattern of panel themes. [Section 6.2]
Recommendation 22	Establish an annual calendar of panel meeting dates with assigned themes to facilitate planning. [Section 6.2]
Recommendation 23	Review the way that panels record findings and recommendations to ensure that information is concise and clear. Detailed commentary and minutes of discussions should be recorded for reference but not included in final reports. [Section 6.4]
Recommendation 24	Further develop CDCRP report writing templates and associated guidelines that support clear, concise presentation of panel findings and recommendations. [Section 6.4]
Recommendation 25	Implement an annual self-assessment process for the panel which invites feedback from everyone who has participated in a panel over the year. [Section 6.4]
Recommendation 26	Ensure comprehensive minutes are taken for all panel deliberations, including assessments of Systems and Practice Review findings and any information from individual panel members to be included in the final report. [Section 6.4]



Appendix B

Panel themes and composition

Panel 10	Theme: Serious Injury
External members:	Ms Beverley Fitzgerald (Chair) Ms Gwenn Murray Dr Anne Pattel-Gray
Other government agency:	Inspector George Marchesini
Departmental officer:	Professor Karen Nankervis
Meeting date:	23 June 2015
Date report delivered to Director-General:	23 July 2015
Panel 11	Theme: Limited departmental involvement
External members:	Ms Annette Sheffield (Chair) Ms Margie Kruger Mr Gregg Upkett
Other government agency:	Ms Natalie Parker
Departmental officer:	Ms Kathy Masters
Meeting date:	29 June 2015
Date report delivered to Director-General:	27 July 2015



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Panel 12	Theme: Complex Risk Factors External members: Dr Anne Pattel-Gray (Chair) Ms Gwenn Murray Mr Bryan Cook Other government agency: Inspector George Marchesini Departmental officer: Professor Karen Nankervis Meeting date: 9 September 2015 Date report delivered to Director-General: 25 September 2015
Panel 13	Theme: Suicide and Adolescent Issues External members: Ms Beverley Fitzgerald (Chair) Mr Clinton Shultz Dr Kairi Kolves Other government agency: Professor John Allan Departmental officer: Ms Nicola Jeffers Ms Kathy Masters Meeting date: 21 October 2015 Date report delivered to Director-General: 9 November 2015
Panel 14	Theme: Children Under 3 External members: Ms Gwenn Murray (Chair) Dr Anne Pattel-Gray Ms Raelene Ward Dr Deborah Walsh Other government agency: Mr Graham Kraak Departmental officer: Ms Barbara Shaw Meeting date: 5 November 2016 Date report delivered to Director-General: 30 November 2015



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Panel 15	Theme: Children in care External members: Ms Annette Sheffield (Chair) Mr Greg Upkett Associate Professor Kirstin Vallmuur Other government agency: Inspector George Marchesini Departmental officer: Ms Bernadette Harvey Meeting date: 13 November 2015 Date report delivered to Director-General: 10 December 2015
Panel 16	Theme: Suicide and Adolescence External members: Ms Beverley Fitzgerald (Chair) Mr Clinton Schultz Associate Professor Rosa Alati Dr James Scott Other government agency: Ms Jean Smith Departmental officer: Ms Nicola Jeffers Meeting date: 18 November 2015 Date report delivered to Director-General: 18 November 2015
Panel 17	Theme: Children under 2 External members: Professor Clare Tilbury (Chair) Professor Paul Colditz Dr Anne Pattel-Gray Other government agency: Mr Graham Kraak Departmental officer: Ms Nicola Jeffers Meeting date: 9 February 2016 Date report delivered to Director-General: 15 March 2016



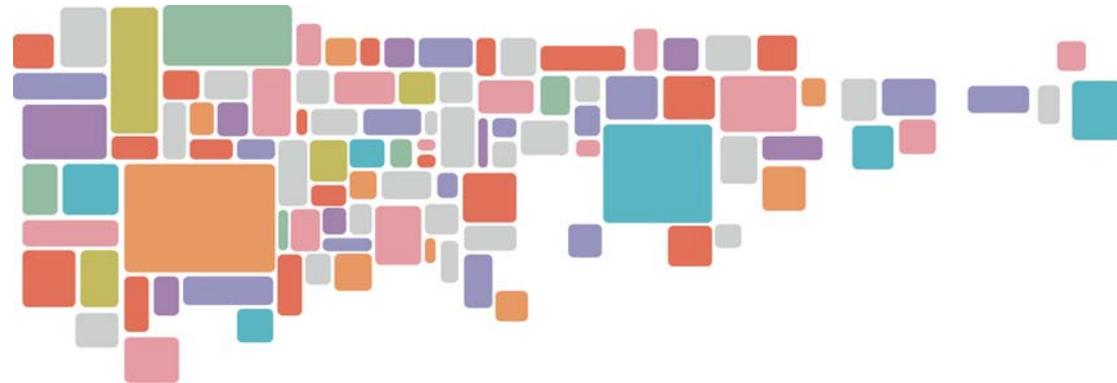
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Panel 18	Theme: Accidental
External members:	Mr Bryan Cook (Chair) Ms Susan Teerds Dr Anne Pattel-Gray Ms Laurel Downey
Other government agency:	Ms Natalie Parker
Departmental officer:	Ms Barbara Shaw
Meeting date:	1 March 2016
Date report delivered to Director-General:	6 April 2016
Panel 19	Theme: Adolescents
External members:	Gwenn Murray (Chair) Ms Raelene Ward Dr Kairi Kolves
Other government agency:	Ms Julie Kinross
Departmental officer:	Ms Bernadette Harvey
Meeting date:	14 April 2016
Date report delivered to Director-General:	19 May 2016
Panel 20	Theme: Disabilities
External members:	Mr Clinton Schultz (Chair) Associate Professor Mark Coulthard Dr Deborah Walsh
Other government agency:	Ms Jean Smith
Departmental officer:	Professor Karen Nankervis
Meeting date:	18 April 2016
Date report delivered to Director-General:	19 May 2016



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Panel 21	Theme: Children under 1 External members: Ms Margie Kruger (Chair) Ms Heather Douglas Professor Jeanine Young Mr Gregg Upkett Other government agency: Mr Graham Kraak Departmental officer: Ms Barbara Shaw Meeting date: 23 May 2016 Date report delivered to Director-General: 28 June 2016
Panel 22	Theme: Non-accidental or suspicious External members: Mr Bryan Cook (Chair) Ms Annette Sheffield Dr Anne Pattel-Gray Associate Professor Annabel Taylor Other government agency: Inspector George Marchesini Departmental officer: Ms Kathy Masters Meeting date: 13 May 2016 Date report delivered to Director-General: 29 June 2016



Appendix C

External Members

Associate Professor Rosa Alati

Has a distinguished research background in life-course epidemiology of drug and alcohol use problems. She is Professor at the School of Public Health & Centre for Youth Substance Abuse Research at the University of Queensland. In the last 10 years, she has worked collaboratively with national and international teams in the fields of maternal substance use, offspring outcomes and related aspects of developmental and life-course epidemiology, particularly in relation to psychosocial health and wellbeing. She also has a background in Indigenous health research, with a focus on alcohol and drug studies in urban and remote Aboriginal communities. Professor Alati identifies as from a culturally and linguistically diverse background.

Professor Paul Colditz

A practicing neonatologist with a Doctor of Philosophy in Medicine from the University of Oxford. He is the Foundation Professor of Perinatal Medicine at the University of Queensland (UQ) and for the past 20 years has been Director of the Perinatal Research Centre, and more recently, Deputy Director (Clinical) of UQ's Centre for Clinical Research. His research focuses on clinically important perinatal health problems and translation to clinical practice. It includes investigations relating to seizure identification and prevention, brain injury and neuroprotection, body composition and neural plasticity and pathways to improving neurodevelopmental outcomes. Professor Colditz is a board member of the SIDS and Kids Foundation (both national and Queensland).

Associate Professor Mark Coulthard

A practising paediatrician and intensive care specialist based at Royal Children's Hospital, Brisbane. Associate Professor Coulthard is also the Head, Academic Discipline of Paediatrics and Child Health at the University of Queensland.

Ms Heather Douglas

Professor and researcher at TC Beirne Law School, University of Queensland, she researches in the areas of criminal justice and domestic violence. She is particularly interested in the relationship between Indigenous people and the criminal law, and the way the criminal law impacts on, and constructs women. In 2014, she was awarded an Australian Research Council Future Fellowship to research the way in which women who have experienced domestic violence use the legal system to help them leave violence. She has also considered the criminal justice response to foetal alcohol spectrum disorders and to the drug, khat.



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Ms Laurel Downey

Chief Executive Officer of Catalyst Child and Family Services, a not-for-profit organisation that provides clinical and out-of-home care services to children and their families involved with child protection services in far north Queensland. Catalyst runs three therapeutic residential services for young people with complex to extreme emotional and behavioural difficulties. Ms Downey is completing a PhD program with the La Trobe University, School of Allied Health, Social Work and Social Policy. This research project is designed to take the first steps towards an evidence base for the Spiral to Recovery, a practice framework for therapeutic care of children and young people. Ms Downey is from a regional area.

Dr Kairi Kolves

A Principal Research Fellow and Lecturer at the Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University, she has been working in suicide research and prevention since 1998. Between 1999 and 2008, she worked at the Estonian-Swedish Mental Health and Suicidology Institute in Estonia and joined AISRAP team in 2008. She has been involved in different Australian, Estonian and international projects, and has published over 60 peer reviewed papers, several chapters and reports on suicide research and prevention. Dr Kolves identifies as from a culturally and linguistically diverse background.

Dr James Scott

A consultant psychiatrist at Royal Brisbane and Women's Hospital Early Psychosis Service and Associate Professor at the University of Queensland. He completed his PhD in 2009, with a focus on psychosis and epidemiology. He also holds a certificate in the subspecialty of child and adolescent psychiatry. Associate Professor Scott has worked extensively in child and youth mental health in community and inpatient settings while continuing clinical and epidemiological research.

Ms Rebecca Sherman

Operations Manager of the Domestic Violence Action Centre. She is a trained social worker and has a degree in psychology. Ms Sherman is a member of the Domestic and Family Violence Death Review Panel and was a member of the department's Domestic and Family Violence Strategy Implementation Advisory Group from 2010–2012.

Associate Professor Annabel Taylor

Former Director of Te Awatea Violence Research Centre at the University of Canterbury and is the Director of the Queensland Domestic and Family Violence Research Centre, Central Queensland University. Prior to this, Dr Taylor had an extensive research and academic background in partnering with community and government sectors to support research needs and interests aimed at reducing violence and child abuse.

Ms Elizabeth Taylor

An independent consultant specialising in developing services, programs and training in the area of domestic violence and sexual assault. Ms Taylor is a board member of Gold Coast Centre Against Sexual Violence, a founding member of the Domestic Violence Death Review Action Group, and a member of the Queensland Domestic and Family Violence Research Advisory Committee.



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Ms Susan Teerds

Chief Executive Officer of Kidsafe Queensland. Ms Teerds is on the Child Restraint, Education and Safe Travel Committee, Qld Council of Injury Prevention, the QCIP Consumer Product Injury Research Advisory Group, and is also an advisor for the collaborative researching the development of a sustainable prospective data collection system to identify cases and risk factors for low speed vehicle run-over incidents. Key focus areas for Kidsafe include Road Safety, Home Safety, School Safety, Playground Safety and Child Car Restraints for children with disability or medical conditions.

Associate Professor Kirsten Vallmuur

A Principal Research fellow with the Centre for Accident Research and Road Safety Queensland at Queensland University of Technology. Associate Professor Vallmuur was awarded her PhD in 2003 and has been focused throughout her academic life on Product safety, injury prevention, and wider accidental incidents, and has published a number of books and journal articles within this area.

Dr Deborah Walsh

A domestic and family violence specialist practitioner (social work) and researcher. She developed one of Australia's first risk assessment frameworks for use in family violence work and continues to provide training and consultancy to the health and welfare sector in Australia. Dr Walsh conducted a landmark Australian study on the level, extent and nature of violence against women during pregnancy. She is a Lecturer at the School of Nursing, Midwifery and Social Work, Faculty of Health and Behavioural Sciences at the University of Queensland.

Ms Raelene Ward (identifies as Aboriginal)

A registered nurse, holds a Masters in Health and is studying for her PhD. She is a Lecturer in Indigenous Nursing and an Aboriginal Researcher with the School of Health, Nursing and Midwifery at the University of Southern Queensland. She is a community representative on the Darling Downs-West Moreton Human Research Ethics Committee. Ms Ward is from a regional area.

Dr Nina Westera

A Research Fellow at Griffith Criminology Institute with a focus on investigations and policing. Dr Westera was conferred her PhD in 2012 and has a background in Psychology and criminal investigations.

Professor Jeanine Young

A Registered Nurse, Registered Midwife and qualified neonatal nurse. She completed her PhD in infant care practices and their relationship with risk factors for Sudden Infant Death Syndrome (SIDS). She has worked in Australia and the United Kingdom in neonatal intensive care, acute paediatrics and community child health. Professor Young has established a research program to investigate Queensland's relatively high infant mortality rate, with a particular focus on developing evidence-based strategies and educational resources to assist health professionals in delivering Safe Sleeping messages to parents with young infants and to address Close the Gap targets to reduce Aboriginal and Torres Strait Islander infant mortality. She chairs the SIDS and Kids National Scientific Advisory Committee, which works to ensure that safe sleeping public health recommendations are evidence-based.



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Ms Kathryn McMillan

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

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

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 in various roles, including social worker, policy advisor and senior advisor in child protection in the Court Services division.

Ms Annette Sheffield

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).

Professor Clare Tilbury

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.



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Ms Gwenn Murray

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 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 (identifies as Aboriginal)

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 to the influence the Catholic Church had over Aboriginal people.

Ms Beverley Fitzgerald

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 (identifies as Aboriginal)

A registered psychologist, 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 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 (identifies as Aboriginal)

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.



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Government members

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, Office for Women and Domestic Violence Reform
- Regional Director, North Coast Region
- Regional Director, Central Queensland Region
- Regional Director, South East Region.

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.
- Queensland Health
 - Director, Strategic Policy Priority Areas
 - Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch.
- Department of Education, Training and Employment
 - Executive Director, State Schools Operations.
- Queensland Police Service
 - Operations Manager, Child Safety and Sexual Crime Group, State Crime Command
 - Detective Senior Sergeant, Child Safety and Sexual Crime Group, State Crime Command.