31 October 2013

The Honourable Tracy Davis MP
Minister for Communities, Child Safety and Disability Services
Parliament House
George Street
BRISBANE  QLD  4000

Dear Ms Davis

I submit the annual report for the Child Death Case Review Committee (CDCRC) for the 2012–13 financial year.

The report is produced in accordance with section 141(1) of the Commission for Children and Young People and Child Guardian Act 2000 (Qld). It outlines the CDCRC’s roles, key activities and performance for 2012–13.

I draw your attention to section 141(3) of the Commission for Children and Young People and Child Guardian Act 2000, which requires you to table this report in Parliament within 14 sitting days of receipt.

Yours sincerely

Barry Salmon
Acting Chairperson
Child Death Case Review Committee
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Message from the Chairperson

During the 2012–13 reporting period, the Child Death Case Review Committee (the CDCRC) considered the deaths of 76 children and young people.

On behalf of the CDCRC, I would like to offer my condolences to the families, carers and friends of those children and young people whose deaths were considered by the CDCRC during the reporting period.

This is the ninth annual report of the CDCRC, an independent, multidisciplinary committee providing a second tier review of deaths of children, known to the Department of Communities, Child Safety and Disability Services (the Department) within three years of their death.

The child death case review jurisdiction emerged from the child protection system failures highlighted by the Queensland Ombudsman in its 2001 and 2003 investigations into the deaths of Brooke Brennan (aged 3 years) and baby “Kate” (aged 10 weeks). These investigations highlighted critical failings in both the government’s service delivery and the former Department’s child death review processes.

Since its inception in 2004, the CDCRC has reviewed the deaths of 532 children and young people. Over this time, the child death case review jurisdiction has consistently provided Queensland with a strong accountability framework ensuring rigorous and independent scrutiny is applied to all cases where the Department has had involvement with the child prior to their death. Transparency of the child death case review jurisdiction has been upheld by ensuring all cases are scrutinised by an independently appointed external committee with expertise in a range of areas including paediatrics, mental health, investigations and child protection. The review process acknowledges public interest and aims to ensure that the outcomes of the CDCRC’s work are available for all to access.

One of the key responsibilities of the CDCRC has been to identify if there were any instances where the Department’s actions and/or inactions may have been linked to the death of a child, and ensure that service system issues are able to be promptly addressed. The importance of the CDCRC’s role and responsibility is highlighted in this year’s annual report which refers to three cases in which the CDCRC identified a link between the Department’s actions and/or inactions and the death of a child. In response to these three cases, the CDCRC was able to make a number of recommendations and undertake appropriate referrals to strengthen future service delivery to other children in the child protection system.

In July 2012 the Queensland Government established the Queensland Child Protection Commission of Inquiry (the Commission of Inquiry) led by the Honourable Tim Carmody, QC to review aspects of the Queensland child protection system, and to chart a new road map for children protection for the next decade. The CDCRC made three detailed submissions to the Commission of Inquiry, sharing important learnings obtained over the past nine years about the child protection system, the child death case review jurisdiction, and serious service system issues highlighted in individual cases.

On 1 July 2013 the Commission of Inquiry released its report, Taking responsibility: A Roadmap for Queensland Child Protection. Included in the 121 recommendations made by the Commission of Inquiry, was a recommendation to disband the CDCRC and replace it with another body.
At the time of writing, the Government is considering its response to the recommendations of the Commission of Inquiry. In this Annual Report the CDCRC has highlighted the important learnings from its work so that this valuable source of information may be considered in any changes to either the CDCRC’s functions or the broader child protection system. Ultimately, the CDCRC is offering insights to ensure that children and young people in the child protection system have the best outcomes possible.

The 2012–13 reporting period saw the resignation of two valuable members of the CDCRC, the former Chairperson, Ms Elizabeth Fraser and member, Dr Neil Wigg. Ms Fraser served as the Commissioner for Children and Young People and Child Guardian from 2005 to 2013 and Dr Neil Wigg was the former Senior Director, Community Child Youth and Family Health Services (Central), Children’s Health Services, Brisbane and Associate Professor, Discipline of Paediatrics and Child Health, University of Queensland. Both Ms Fraser and Dr Wigg brought a wealth of experience and insight to the CDCRC, and I would like to thank them for their commitment to upholding the rights of children and young people in Queensland.

In addition, the terms of appointment of the remaining members of the CDCRC are due to expire in November 2013. I would like to take this opportunity to sincerely thank all the members of the CDCRC for their invaluable contribution over the past three years. I would also like to thank the secretariat team for the support they provide to assist members to complete their functions.

In conclusion and on behalf of the CDCRC, I would like to thank the Department and its staff for the cooperation and support they have given to the CDCRC’s review function throughout 2012–13. I trust the information in this report will continue to be useful to all those involved in protecting children and promoting their wellbeing in the same way previous processes have assisted to advance reforms.

Barry Salmon
Acting Chairperson
Child Death Case Review Committee
Executive Summary

Background
The Queensland child death case review jurisdiction consists of a two-tiered system for reviewing deaths of children known to the Department of Communities, Child Safety and Disability Services (the Department) in the three years prior to their death. The first tier is a review conducted by the Department about its involvement with the child or young person (the Department’s review). The Department’s review is then assessed by the CDCRC (the second tier) against a set of review criteria.

The CDCRC acts independently when performing its functions and is not under the control or direction of any other entity.

This system ensures that Queensland has a strong and independent child death case review jurisdiction. It provides the Queensland public and government with a strong accountability framework, ensuring that the Department conducts reviews of all child deaths where the child had involvement with the agency within the three years prior to their death, and rigorous and independent scrutiny is applied to all reviews.

Children and young people reviewed in 2012–13
In the reporting period, the CDCRC considered the Department’s reviews of the deaths of 76 Queensland children and young people.

Of the 76 children reviewed, 66% were male (50 children) and 34% were female (26 children).

Half of the children reviewed (50%, 38 children) were aged between birth and 4 years at the time of death. Twenty-three children (30%) reviewed by the CDCRC in 2012–13 were under 1 year of age. Eleven (14%) children were aged 5–9 years, eight young people (11%) were aged 10–14 years, and 19 (25%) were aged 15–17 years at the time of their death.

Of the 76 children and young people, 14 (26%) identified as Aboriginal, one (1%) identified as Torres Strait Islander and three (4%) identified as both Aboriginal and Torres Strait Islander.

Forty children and young people reviewed (53%) were identified as having a physical medical condition, intellectual impairment, developmental delay and/or a mental health condition.

Sixty children and young people (79%) were residing at home at the time of their death. Five children, all of whom were under the age of 1 year (7%) were residing in hospital at the time of their death. Nine children and young people (12%) were in out-of-home care at the time of their death. Two young people, both aged 15–17 years, were living independently.

Consistent with what has been seen in previous years, many of the families of the children and young people whose deaths were reviewed faced complex family and parental issues, such as substance misuse, domestic violence and high mobility of lifestyle (transience). The parents from these families often had mental health conditions, involvement in the criminal justice system and their own child protection histories.
Parental substance misuse was the most common family and parental issue occurring in 47 families (63%). Domestic violence was the second most common family and parental issues occurring in 46 families (61%). Parental criminal history was present in 44 families (59%) and parental mental health issues were identified in 35 families (47%).

The prevalence of multiple, co-existing family and parental issues, combined with the complex needs of the children, highlights the challenge faced by the child protection system in responding to complicated family situations and the need for an effective, coordinated multi-disciplinary response.

Eight young people reviewed had involvement with the youth justice system during their lifetime. One of the eight young people had spent time in youth detention.

**Cause of death for children reviewed in 2012–13 and associated risk factors**

In relation to nine deaths, the official cause of death was pending and could not be readily classified into a research category at the time of reporting.

Of the 76 deaths considered, 21 (28%) were due to diseases and/or morbid conditions.

Eleven children died as a result of sudden infant death syndrome (SIDS) and undetermined causes.

Transport incidents (13 deaths, 17%) and suicide (13 deaths, 17%) were the leading external causes of death.

Six children and young people drowned.

Two children were fatally assaulted.

One child died due to a non-intentional injury related cause.

**Child Death Case Review Committee findings**

The majority of departmental reviews were sufficiently comprehensive. In four reviews, the CDCRC found that the Department’s review was of a high quality. However, in four reviews, the CDCRC found that the Department’s review was insufficient.

In relation to 58 reviews, the Department engaged with external entities in conducting its reviews. In six reviews the CDCRC found the Department’s lack of engagement with some agencies in the review process resulted in missed learning opportunities impacting on future service delivery to children and young people.

The quality of the Department’s reviews remains variable, demonstrating value in ongoing external independent scrutiny of child deaths in Queensland.

In addition to endorsing 84 recommendations made by the Department, the CDCRC made a further 29 recommendations aimed at improving practice and policy within the Department.
In relation to the 18 Aboriginal and/or Torres Strait Islander children and young people whose deaths were reviewed, the CDCRC’s relevant Aboriginal and Torres Strait Islander representatives were present in all 18 reviews in accordance with legislative requirements.

In 15 reviews, the CDCRC referred 25 issues to other agencies for consideration of service delivery to children and young people.

In the reporting period, the CDCRC completed its consideration of all departmental reviews within the legislated timeframe.

**The Department’s service delivery**

In three reviews the CDCRC determined the actions and/or inactions of the child protection system were linked to the child’s death.

Two of the three children were fatally assaulted after the Department failed to identify and appropriately respond to the risks present in the home.

In relation to the other child, the CDCRC found the child protection system failed the child numerous times over their short life. Instead of being a mechanism to protect them, the system perpetuated further abuse and damage, to the point where the child’s behaviours escalated and the CDCRC concluded they were perceived by many service providers as being ‘the problem’.

In two further reviews, the CDCRC made a finding that while there was no direct link between the actions and/or inactions of the Department and the child’s death, there were significant deficiencies in service delivery that resulted in the child being harmed or being placed at risk of harm.

**Child death case review jurisdiction – Queensland Child Protection Commission of Inquiry**

The Queensland child death case review jurisdiction was established following the historical service system failures highlighted by the Queensland Ombudsman and the Crime and Misconduct Commission.

On 1 July 2012 the Queensland Government established the Commission of Inquiry led by the Honourable Tim Carmody, QC. On 1 July 2013 the Commission of Inquiry released its report making 121 recommendations, which, at the time of writing this report, are being considered by the Government.

The Commission of Inquiry recommends the Department establish a specialist investigation team and investigate cases where children in out-of-home care have died or sustained serious injury, overseen by a multi-disciplinary panel, which includes departmental officers, instead of the current CDCRC.

While the government is still considering the recommendations made by the Commission of Inquiry, the CDCRC is concerned the proposed changes to the child death case review process have the potential to impact on accountability and transparency.
In order to promote genuine accountability and transparency, the CDCRC considers it would be more appropriate that the panel or committee reviewing the deaths not include in its membership, officers of the department whose service delivery is being reviewed.

**Report Structure**

This report covering the 2012–13 reporting period is structured as follows:

**Chapter 1** provides an overview of the children whose deaths were reviewed by the CDCRC and outlines the level of involvement with Child Safety Services at the time of their death.

**Chapter 2** provides a summary of the causes of death and associated risk factors for the children whose deaths were reviewed by the CDCRC.

**Chapter 3** outlines the review process and the findings on the quality of the Department’s reviews and service delivery.

**Chapter 4** contains a discussion of reviews where the CDCRC determined actions and/or inactions of the child protection system were linked to the child’s death. In addition, it looks at reviews where the CDCRC determined there was no link between the Department’s service delivery and the death of the child, but where deficiencies in service delivery significantly adversely affected the child.

**Chapter 5** outlines some of the implications of the recommendations made by the Commission of Inquiry to abolish independent external oversight of child deaths in Queensland.
Chapter 1

Overview of children and young people reviewed in 2012–13

Key findings and messages

- In 2012–13 the CDCRC considered the Department’s reviews of the deaths of 76 Queensland children and young people.

- Of the 76 children reviewed:
  - fifty were male (66%) and 26 were female (34%)
  - half (50%, 38 children) were aged between birth and 4 years at the time of death
  - a quarter (25%, 19 children) were aged 15–17 years at the time of death
  - just over half (53%, 40 children) were identified as having a physical medical condition, intellectual impairment, developmental delay and/or a mental health condition
  - forty-seven children and young people (63%) were from families in which parental substance misuse was an issue, and
  - thirty-six children and young people (47%) were from families in which domestic violence co-existed with parental substance misuse.
In the 2012–13 reporting period, the CDCRC considered the deaths of 76 Queensland children and young people. The CDCRC reviewed these cases as the children and young people concerned were known to the child protection system within three years prior to their death.

This chapter provides an overview of the children and young people reviewed, their families, and their involvement with the child protection system.

Throughout this report, information about recommendations and actions undertaken by the CDCRC, in response to specific cohorts of children and service system issues, is included to highlight learnings and possible service delivery improvements. The CDCRC acknowledges that any observations made are based on the reviews of children who have died, and are not necessarily representative of issues across the whole child protection system.

**Characteristics of children and young people reviewed**

**Age and gender**

As shown by Table 1.1, half of the children reviewed by the CDCRC (50%, 38 children) were aged between birth and 4 years at the time of death. Twenty-three children (30%) were under 1 year of age.

Eleven (14%) children were aged 5–9 years, eight young people (11%) were aged 10–14 years, and 19 (25%) were aged 15–17 years at the time of their death.

Of the 76 children reviewed, 66% were male (50 children) and 34% were female (26 children).

<table>
<thead>
<tr>
<th>Age category</th>
<th>Female n</th>
<th>Male n</th>
<th>Total n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>11</td>
<td>12</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>1–4 years</td>
<td>2</td>
<td>13</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>5–9 years</td>
<td>5</td>
<td>6</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>10–14 years</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>15–17 years</td>
<td>6</td>
<td>13</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
<td><strong>50</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Aboriginal and/or Torres Strait Islander status**

Of the 76 children and young people, 14 (18%) identified as Aboriginal, one (1%) identified as Torres Strait Islander and three (4%) identified as both Aboriginal and Torres Strait Islander.

**Children with complex medical needs**

Forty children and young people reviewed (53%) were identified as having a physical medical condition, intellectual impairment, developmental delay and/or a mental health condition.

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1 The deaths of 76 children and young people were considered in 75 reviews as two siblings were considered in one review.
A number of children had co-morbid conditions where they identified with more than one complex medical need. These data highlight the challenges of the child protection system in providing appropriate service delivery to children and families with diverse social and medical needs.

Responding to these children and young people provides additional challenges for the Department, including the management of multi-agency service provision; identification of additional supports to provide respite; practical assistance and emotional support for families; and identification of appropriate placement options for children in out-of-home care.

**Geographical distribution**

As illustrated in Table 1.2, 35 children and young people reviewed (46%) resided in regional areas. Thirty-two (42%) resided in metropolitan areas, seven resided in remote areas, with the remaining two residing interstate at the time of their death.

<table>
<thead>
<tr>
<th>ARIA+ Classification</th>
<th>Female n</th>
<th>Male n</th>
<th>Total n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>12</td>
<td>23</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>11</td>
<td>21</td>
<td>32</td>
<td>42</td>
</tr>
<tr>
<td>Remote</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Interstate</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>50</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

**Living arrangements**

As shown in Table 1.3, 60 children and young people (79%) were residing at home at the time of their death. ‘Home’ for the purpose of this report means the usual family residence, and includes residing with the biological parent or parents, step-parents, partners of the biological mother or father, and extended family.

Five children (7%), all of whom were aged under 1 year were residing in hospital at the time of their death.

The CDCRC classifies the child’s residence as ‘hospital’ in cases where the child never left hospital after their birth or in cases where the child spent the majority of their life in hospital care due to complex and often terminal medical conditions. In these cases, the child or young person remained in hospital care until their death.

Nine children and young people (12%) were in out-of-home care at the time of their death. Five of these children and young people were living with foster carers and four young people were in residential facilities.

Two young people, both aged 15–17 years, were living independently. ‘Living independently’ refers to those young people who are not living with a parent or guardian and who are not under the custody or guardianship of the Chief Executive of the Department or subject to a child protection order.

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2 Accessibility/Remoteness Index of Australia
Table 1.3 Living arrangement category, 2012–13

<table>
<thead>
<tr>
<th>Residential status at time of death</th>
<th>Total n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>60</td>
<td>79</td>
</tr>
<tr>
<td>Out-of-home care</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Foster Care</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Residential Care</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Hospital</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Independent living</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Family and parental issues

Consistent with what has been seen in previous years, many of the families of the children and young people whose deaths were reviewed faced complex family and parental issues, such as substance misuse, domestic violence and high mobility of lifestyle (transience). The parents from these families often had mental health conditions, involvement in the criminal justice system and their own child protection histories.

The 76 children and young people whose deaths were reviewed in the reporting period came from 75 distinct families. Figure 1.1 shows the presence of these family issues in the 75 families.

Figure 1.1 Family and parental issues, 2012–13
Parental substance misuse was the most common family and parental issue occurring in 47 families (63%). Domestic violence was the second most common family and parental issues occurring in 46 families (61%). Parental criminal history was present in 44 families (59%) and parental mental health issues were identified in 35 families (47%).

A total of 32 families (43%) experienced housing and/or homelessness issues. Twenty-seven families (36%) had either one or both parents who had been involved with the child protection system.

Of the 20 families who were reluctant or refused to engage with support services, parental mental health issues were noted in 15 of those families (75%). Parental mental health issues were also present in more than half of the families (57%, 25 families) that had parental involvement in the criminal justice system.

Mental health issues and their co-existence with substance misuse were identified in 30 families (40%).

**Youth justice system**

Involvement in the youth justice system may range from being charged with a criminal offence by the Queensland Police Service to being detained in youth detention at some stage during the young person’s lifetime.

Eight young people reviewed had involvement with the youth justice system during their lifetime. One young person had spent time in youth detention.

Seven of these young people were aged 15–17 years at the time of their death, while one young person was aged 10–14 years when they died.

Five of the young people involved in the youth justice system were male and three were female.

**Involvement with the Department**

The trigger for a child death case review is any involvement by the Department with a child and their family within three years of the child’s death.

The following section examines the Department’s level of involvement with the child, prior to, and at the time of death.
Involvement at the time of death

Figure 1.2 illustrates the nature of the Department’s involvement with the children and young people at the time of their deaths.

Figure 1.2 Category of the Department’s involvement at time of death, 2012–13

‘Other intervention’ refers to cases where at the time of their death, the child was subject to ongoing intervention by the Department in a voluntary capacity; for example, Intervention with Parental Agreement and Support Service cases. Three children were subject to other interventions at the time of their death.

‘Under an order’ refers to cases where an order under the Child Protection Act 1999 had been granted to the Chief Executive of the Department in relation to the child or young person at the time of their death, including a short or long-term custody or guardianship order, or an assessment order. Ten children (13%) were under an order at the time of their death.

‘Assessment underway’ refers to those cases where the Department was in the process of assessing concerns received in relation to the child or their family. In relation to 18 children and young people (24%), assessments were underway at the time of their death.

‘No current involvement’ refers to those cases where the Department had no involvement with the child or their family at the time of their death. In the majority of cases (59%, 45 children), there was no current involvement of the Department with the children and young people or their families at the time of their death.

While these statistics have largely remained constant over the past five years, the number of children who have died while an assessment was underway has steadily increased during that time, from 15% (11 children) in 2008–09 to 24% (18 children) during the 2012–13 reporting period.
Involvement during the child’s lifetime

In addition to recording the involvement of the Department at the time of the child’s death, the CDCRC considers the extent of involvement with the Department during the child’s lifetime.

Figure 1.3 illustrates the nature of the Department’s involvement with the children and young people during their lifetime.

**Figure 1.3 Extent of departmental involvement, 2012–13**

To assist in analysing the level of involvement of the Department in each case, the CDCRC has categorised the level of involvement into four groups as outlined below.

‘Death incident’ refers to cases where the Department only became involved with the child in response to the incident which resulted in the death of the child. In such cases, it is common for the child to die within a few days of the incident occurring. Two children (3%) was known to the Department through the death incident.

‘Multiple concerns raised’ refers to cases where child protection concerns had been repeatedly raised in relation to the child, but where such concerns were assessed as not meeting the threshold for recording a Notification, or where a Notification was not substantiated. Twenty-five children and young people (33%) had repeated concerns raised that either did not meet the threshold for a Notification or were not substantiated when investigated.

‘One previous concern raised’ refers to cases where the Department had been notified about child protection concerns for the child on one occasion prior to the death of the child, and where the concerns either did not meet the threshold for a Notification or were not substantiated when investigated. Eighteen children and young people (24%) had one previous concern raised about them prior to their death.

‘History of service system involvement’ refers to cases where the child and their family had significant involvement with the child protection system, with at least one Notification having been substantiated. Thirty-one children and young people (41%) had a history of service system involvement.
Chapter 2
Overview of deaths in 2012–13

Key findings and messages

- Twenty-one children and young people reviewed died from diseases and morbid conditions. Deaths from diseases and morbid conditions were most common in children aged under 1 year (33%, 7 deaths).
- Transport incidents (17%, 13 deaths) and suicide (17%, 13 deaths) were the leading external causes of death.
- Eleven children died from sudden infant death syndrome and undetermined causes.
- Six children and young people died as a result of drowning.
- Two children were fatally assaulted.
- One child died due to a non-intentional injury-related cause.
The following causes of death were identified for the children and young people whose deaths were reviewed by the CDCRC:

- diseases and morbid conditions
- Sudden Infant Death Syndrome (SIDS) and undetermined causes
- external causes:
  - transport
  - suicide
  - drowning
  - fatal assault, and
  - other non-intentional injury-related deaths.

The data in this chapter regarding causes of death are sourced from the Queensland Child Death Register, which is maintained by the Commission for Children and Young People and Child Guardian (the Commission).

To assist with comparative research regarding the prevention of child deaths, the Queensland Child Death Register classifies cause-of-death data into categories according to the circumstances of each death, as agreed upon by the Australian and New Zealand Child Death Review and Prevention Group. Information about the Queensland Child Death Register classifications is presented in this chapter before the relevant analysis to aid understanding of findings and risk factors associated with specific causes of death.

In addition, this chapter details the data regarding risk factors relevant to deaths, which reflects the findings of the CDCRC in response to review criteria 2 and 4 (risk factors and recurring risk factors).

**Cause of death**

Table 2.1 provides an overview of the causes of death for the 76 children and young people reviewed by the CDCRC.

**Table 2.1 Cause of death by research category, 2012–13**

<table>
<thead>
<tr>
<th>Primary research category</th>
<th>Total n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown – pending test results</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Diseases and morbid conditions</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>SIDS and undetermined causes</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>External causes of death</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Transport</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Suicide</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Drowning</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Fatal assault</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other non-intentional injury-related</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Unknown – pending test results

There were nine deaths of children and young people reviewed by the CDCRC for which an official cause of death was pending and which could not be readily classified into a research category at the time of reporting.

Where a cause of death is pending, the CDCRC monitors the Queensland Child Death Register to establish the official cause of death. In cases where the CDCRC has already completed its review of the child, the review is reconsidered by the CDCRC once the cause of death has been determined to ensure that findings and recommendations remain accurate and appropriate.

Diseases and morbid conditions

Diseases and morbid conditions are those deaths for which the underlying cause is an infection, disease or other naturally occurring condition. Deaths from diseases and morbid conditions are often due to factors such as perinatal conditions and congenital malformations, deformations and chromosomal abnormalities.4

As illustrated in Figure 2.1, there were 21 children and young people (28%) who died from diseases and morbid conditions. Children in their first year of life are particularly vulnerable to diseases and morbid conditions.5

Figure 2.1 Deaths due to diseases and morbid conditions by age category, 2012–13

Sixteen males and five females died as a result of diseases and morbid conditions.

Of the 21 children who died from diseases and morbid conditions, six (29%) were of Aboriginal and/or Torres Strait Islander heritage.

Sudden Infant Death Syndrome and Undetermined

SIDS is defined as the sudden, unexpected death of an infant under one year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy and review of the circumstances of death and the clinical history. Each year, the deaths of a number of children over the age of one year are registered for whom a cause of death is unable to be determined. The circumstances of these deaths often resemble those of infants, but are precluded from a diagnosis of SIDS as they are over the age of one.

Nine children died as a result of SIDS and the cause of death for two children was undetermined. Of those 11 children, three were of Aboriginal and/or Torres Strait Islander heritage.

Of the nine children who died of SIDS, six were female, and three were male.

Of the two children whose cause of death was undetermined, one was female and one was male. One child who died as a result of an undetermined cause was aged <1 year and one child was aged 1–4 years.

Transport

Transport was one of the leading external causes of death accounting for 13 deaths (17% of the total number of deaths).

Age and gender breakdowns for transport fatalities are illustrated in Table 2.2.

Table 2.2 Transport deaths by age and gender category, 2012–13

<table>
<thead>
<tr>
<th>Age group</th>
<th>Female n</th>
<th>Male n</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–4 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5–9 years</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>10–14 years</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15–17 years</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>8</td>
<td>13</td>
</tr>
</tbody>
</table>

Of the 13 children and young people who died in transport incidents, nine died as a result of motor vehicle incidents. Six of the children and young people who died in motor vehicle incidents were passengers of the motor vehicle. Three young people were the driver of the motor vehicle at the time of the incidents.

In seven of the incidents, risk factors such as dangerous driving, inexperienced or unlicensed driving, speed, driving while fatigued or under the influence of a substance, late night driving and multiple peer passengers were identified as being relevant to death.

Four children and young people who died as a result of a transport incident were pedestrians. Two of the children were aged between 1–4 years, one child was aged 5–9 years and one young person was aged 15–17 years. Two of the children died as a result of low-speed vehicle run-overs.

**Suicide**

In the past, the substantial evidence required for suicide classifications often resulted in deaths that would ordinarily, in clinical or research situations, be categorised as suicides not meeting the threshold for a legal classification.

Consequently, in cases where a suicide was suspected but intent was unclear (that is, the deceased did not leave a suicide note and did not state their intent before death), the cases were often coded as accidents. This resulted in childhood and adolescent suicide being under-reported in official statistics, with a large proportion mistakenly recorded as accidental deaths.

The Commission has endeavoured to reduce the likelihood of suicides being undercounted by examining all cases where police have indicated that a death is a suspected suicide. In addition, to enable further categorisation of these deaths, the Commission has developed a suicide classification model (see Appendix 4). This model includes consideration of whether the method of death has a high likelihood of being a suicide (e.g. hanging). The suicide deaths reviewed by the CDCRC have been classified using this model.  

Suicide was another leading external cause of death for children and young people reviewed during the 2012–13 reporting period. Thirteen children and young people suicided.

Four young people who took their own lives were aged 10–14 years and nine were aged 15–17 years.

Four of the 13 children and young people who took their own lives identified as Aboriginal and/or Torres Strait Islander. Two of these were male and two were female.

Of the 13 suicide cases, eight were male and five were female.

**Risk factors**

This section examines the complex issues and risk factors, where known, that may have been associated with the 13 children and young people who suicided. The information used reflects, in part, the findings of the CDCRC in relation to review criterion 2 (see Appendix 2). The information is sourced from departmental reports and relevant documents provided to the CDCRC by the Department in accordance with the Child Protection Act 1999.

Table 2.4 shows the risk factors present for the children and young people who suicided. Many of the young people experienced multiple factors that placed them at a higher risk of suicidal behaviours.

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### Table 2.4 Significant factors identified in suicide deaths, 2012–13

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Known risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aboriginal and/or Torres Strait Islander</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Male</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Female</td>
<td>✓</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

³ ‘Low SES’ refers to children and young people who have been classified as residing in either a low or very low socio-economic region.
Drowning

Six children and young people drowned. All of the children and young people who drowned were male. Three of the children who drowned were aged 1–4 years, two were aged 5–9 years and one young person was aged 15–17 years.

Table 2.5 illustrates the different types of drowning related deaths by age category.

Three of the six drowning deaths occurred in private swimming pools and one in a public pool. Two drownings occurred in non-pool locations.

Table 2.5 Drowning deaths by age category, 2012–13

<table>
<thead>
<tr>
<th>Type of drowning</th>
<th>1–4 years</th>
<th>5–9 years</th>
<th>15–17 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swimming pool drownings</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Non-pool drownings</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Rural water hazard</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Static inland waterway</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

The CDCRC noted inadequate supervision was a risk factor in each of the five toddler and children drownings reviewed. That is, the children were not within the direct line of sight of an adult at the time of the incident.

A risk factor identified in one of the drownings that occurred in a private swimming pool was pool fencing that had a known defective gate latch.

Fatal assault

Fatal assault was the cause of death of two of the children.

Other non-intentional injury-related deaths

One child, aged 1–4 years, died as a result of an accidental injury.
Chapter 3
Child Death Case Review Committee findings in 2012–13

Key findings and messages

- All departmental reviews were completed within the legislated timeframe.

- The majority of departmental reviews were sufficiently comprehensive. In four cases, the CDCRC found that the Department’s review was of a high quality. However, in four cases, the CDCRC found that the Department’s review was insufficient.

- In relation to 58 cases, the Department engaged with external entities in conducting its reviews. In six cases the CDCRC found the Department’s lack of engagement with some agencies in the review process resulted in missed learning opportunities impacting on future service delivery to children and young people.

- The quality of the Department’s reviews remains variable and there is an ongoing need for external independent scrutiny.

- In addition to endorsing 84 recommendations made by the Department, the CDCRC made 29 recommendations aimed at improving practice and policy within the Department.

- The CDCRC’s relevant Aboriginal and Torres Strait Islander representatives were present when considering all 18 cases relating to Aboriginal and/or Torres Strait Islander children and young people in accordance with legislative requirements.

- In 15 cases the CDCRC referred issues to other agencies for consideration of service delivery to children and young people.

- In the reporting period, the CDCRC completed its consideration of all departmental reviews within the legislative timeframe.
During 2012–13 the CDCRC continued to play an important role in building public confidence that relevant departmental actions were independently reviewed to identify instances where child protection system failures may have been relevant to the deaths of children and young people known to the Department. The CDCRC collated its findings for every case and used this evidence to make recommendations aimed at strengthening service delivery across the Department.

The CDCRC consists of the Commissioner for Children and Young People and Child Guardian (the Commissioner) who is the Chairperson, the Assistant Commissioner and seven appointed members.

The members bring a wealth of multi-disciplinary expertise to the CDCRC. The 2010–2013 CDCRC comprises of specialists in the fields of mental health, paediatrics, youth justice and social work, as well as representatives from the Queensland Police Service and Aboriginal and Torres Strait Islander representatives (Appendix 1).

This chapter provides information about the CDCRC’s:

- review process
- findings on the quality of the Department’s reviews, and
- response to issues.

**Child Death Case Review Committee review process**

**Overview**

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

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

The focus of the Department’s review is identifying and responding to any shortcomings in the child protection system that may be implicated in the death.

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

- compliance with legislation and policies
- adequacy and appropriateness of the Department’s involvement with the child and the child family
- sufficiency of the Department’s involvement with other entities in the delivery of services to the child and the child’s family
- adequacy of legislative requirements and the Department’s policies relating to children, and
- recommendations relating to the above and strategies to put into effect the recommendations.\(^\text{10}\)

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\(^{10}\) *Section 246B(1) and (2) of the Child Protection Act 1999*
The CDCRC considers all of the Department’s reviews by assessing them against a set of review criteria (See Appendix 2) which consider:

- service system actions and/or inactions linked to the child’s death (discussed in Chapter 4)
- risk factors relevant to the child’s death (discussed in Chapter 2)
- service system issues identified as adversely affecting the child (discussed in Chapter 4)
- recurring risk factors and service system issues (discussed in Chapters 2 and 4), and
- the quality of the Department’s review (discussed in this chapter).

In 2012–13 the CDCRC considered the Department’s 75 reviews for 76 children and young people against its review criteria and a report of the CDCRC findings for each review was delivered to the Chief Executive of the Department.11 (Details of the children’s demographics and causes of death are detailed in Chapters 1 and 2).

**Timeliness**

Under the *Commission for Children and Young People and Child Guardian Act 2000*, the CDCRC must complete its assessment of the Department’s review within three months after receiving it.12

In the reporting period, the CDCRC completed all 75 reviews within the legislated timeframe.

**Cultural considerations**

Under the *Commission for Children and Young People and Child Guardian Act 2000*, when considering the death of an Aboriginal child, the CDCRC’s Aboriginal representative must be present. When considering the death of a Torres Strait Islander child, the CDCRC’s Torres Strait Islander member must be present.13

The respective Aboriginal and Torres Islander representatives of the CDCRC were present during the consideration of the Department’s reviews relating to the 18 Aboriginal and/or Torres Strait Islander children and young people.

**Meetings**

The CDCRC met 11 times during the 2012–13 period.

The CDCRC Secretariat prepares review briefs for each child to assist the CDCRC members’ discussions at each meeting. These review briefs are compiled by the Secretariat using all documents used by the Department when conducting its review, including:

- the Department’s review report
- the Department’s review plan
- ‘relevant documents’ consisting of:
  - the Department’s case material
  - Queensland Police Service Form 1
  - autopsy report
  - additional documents from external agencies that may be available (including Queensland Health, Queensland Police Service, Department of Education, Training and Employment and non-government service providers), and

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11 The deaths of two children were considered in the one review
12 Section 135 of the *Commission for Children and Young People and Child Guardian Act 2000*
13 Section 128(2) of the *Commission for Children and Young People and Child Guardian Act 2000*
• the departmental review team’s working documents for the purposes of conducting its review including:
  o hand-written notes taken during interviews
  o file and case notes
  o planning documents
  o draft versions of the Department’s review and review plan, and
  o emails.

The CDCRC is required by legislation to keep minutes of all its meetings. At each CDCRC meeting, draft minutes from the previous meeting are tabled and any necessary amendments are identified and incorporated. Once the minutes have been approved by the CDCRC members, the minutes are signed by the Chairperson. The final version of the minutes is published on the CDCRC website, subject to the deletion of information where publication may breach the CDCRC’s confidentiality or privacy obligations.

Reports
After the CDCRC considers the Department’s reviews, it produces a final report containing findings and recommendations. Two copies of this report are provided to the Chief Executive of the Department, with one copy to be forwarded to the Office of the State Coroner as required under section 246H of the *Child Protection Act 1999*.

Quality of the Department’s reviews

The Department’s review process
This section outlines the key factors considered by the CDCRC when considering the Department’s reviews including:
- timeliness of the Department’s reviews
- involving other service providers, and
- cultural considerations.

Timeliness
Under the *Child Protection Act 1999*, the Chief Executive of the Department must complete a review and provide a copy of the report, as well as any documents used in conducting the review, to the CDCRC within six months of the Chief Executive becoming aware of the child’s death.

During the reporting period, all of the Department’s 75 reviews and accompanying documents were provided to the CDCRC within the six-month timeframe.

Involving other service providers
When conducting its reviews, the Department may seek to engage with other government and non-government entities that were involved with the child or their family. Engagement may be conducted by way of request for written documents, informal interviews with individual officers or group discussions with officers of the external entity.

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14 Section 130 of the *Commission For Children and Young People and Child Guardian Act 2000*
15 Section 246D of the *Child Protection Act 1999*
In relation to 58 reviews, the Department engaged with external entities, including:

- Queensland Police Service
- Queensland Health
- Education Queensland
- Recognised Entities
- Youth Justice Services, and
- non-government service providers.

In six reviews the CDCRC found the Department should have engaged with other external entities to ensure a more comprehensive consideration of the issues.

In four of these six reviews the Department conducted a “limited review” due to the Department assessing there was no connection between departmental decision making or practice and the death of the child; limited potential for identifying and modifying decision making or practice issues, and limited educative value in conducting a more detailed review. In such cases the Department considered it was an unjustifiable use of resources to conduct a more detailed review.

In relation to three of the reviews, the CDCRC found the failure to engage with external entities adversely affected the quality of the review, as discussed below.

**Cultural consideration**

As noted above, 18 of the 76 children and young people whose deaths were reviewed in the reporting period were Aboriginal and/or Torres Strait Islander. In relation to 17 of the Department’s reviews concerning an Aboriginal and/or Torres Strait Islander child, the CDCRC identified that the Department appropriately employed its cultural consultants in the review process. In one case, the child’s status as Aboriginal and/or Torres Strait Islander was not known to the Department at the time of the child’s death and therefore a cultural consultant was not engaged.

**Quality of the Department’s reviews**

To assess the quality of each review, the CDCRC considers if significant service system issues or risk factors present in the case were identified, assessed and responded to by the Department, and that these service delivery areas were appropriately dealt with in the Department’s review.

In 2012–13 the majority of the Departments reviews (63 of the 75 reviews) were sufficiently comprehensive; however, the CDCRC found four of the Department’s reviews were insufficiently comprehensive and a further five reviews, while sufficient, overlooked some service system issues and an opportunity to engage other service providers that impacted on the quality of the reviews. In four reviews the CDCRC commended the Department for the high quality of its review.
In the four reviews the CDCRC considered to be of a high quality, the CDCRC observed the following aspects of the reviews were comprehensive, appropriate and of a high standard:

- the identification and analysis of the service system issues
- the identification of key learning areas
- follow-up actions and recommendations with an emphasis on facilitating staff professional development
- engagement with departmental officers and external agencies as part of the review process, and
- engagement with a cultural consultant (where relevant).

In the four reviews that the CDCRC found to be of insufficient quality, the CDCRC considered the reviews did not appropriately analyse information on a number of key service system issues present in the reviews that resulted in adverse outcomes for the children including:

- failing to identify risk of harm to a child (in all four of the reviews)
- inadequate information gathering to inform assessments (in two of the four reviews)
- insufficient quality of work and decision for case plans (in one of the four review), and
- not engaging with external agencies resulting in a missed opportunity to explore additional learning to inform future service delivery to children (in two of the four reviews).

In the five reviews that the CDCRC identified a number of oversights that impacted on the quality of the reviews, the CDCRC identified the following issues:

- lack of identification and analysis of service system issues (in three of the five reviews)
- not engaging with some external agencies resulting in a missed opportunity to explore additional learning to inform future service delivery to children (in one of the five reviews), and
- the recommendations and actions did not sufficiently address the service system failings evidenced in the case (in one of the five reviews).

These data demonstrate the quality of the Department’s reviews remains variable and the value of ongoing external independent scrutiny.

The Department’s recommendations and actions

Recommendations

The Department made 84 recommendations in its reviews, all of which were endorsed by the CDCRC. The recommendations have been categorised as follows:

- distribution of the Department’s review for learning
- referrals to other agencies
- localised action (departmental)
- training and professional development, and
- policy and research development.
Table 3.1 details the type and number of recommendations made in the Department’s reviews.

Table 3.1 Department’s review recommendations by type category, 2012–13

<table>
<thead>
<tr>
<th>Type of recommendation</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution of the Department’s review for learning</td>
<td>53</td>
</tr>
<tr>
<td>Referrals to other agencies</td>
<td>4</td>
</tr>
<tr>
<td>Localised action (departmental)</td>
<td>2</td>
</tr>
<tr>
<td>Training and professional development</td>
<td>1</td>
</tr>
<tr>
<td>Policy and research development</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>

**Actions arising from the Department’s reviews**

In addition to making recommendations, the Department took action in response to its reviews regarding the following areas of concern:

- review and/or development of policies, practice and procedures
- staffing and recruitment
- training and professional development
- monitoring of practice and increasing support to frontline staff
- managing workloads
- interagency communication, collaboration and relationship building, and
- professional supervision.

In one review the CDCRC found that the actions undertaken through the departmental review did not sufficiently address the failings evidenced in the case. The CDCRC identified that this case highlighted the child protection system’s lack of capacity to support children with very complex and extreme needs, resulting in those children being exposed to an unacceptable risk of ongoing and exacerbated harm.

**Child Death Case Review Committee response to issues**

**Recommendations**

As part of its critical assessment of the service provided by the Department as well as the quality of the Department’s review, the CDCRC may make recommendations which it considers necessary to improve service delivery to children and young people in Queensland. In the reporting period the CDCRC made 29 recommendations.

As illustrated in Table 3.2, eight recommendations requested policy development and research to improve service delivery areas with a further six recommendations aimed at providing training to staff members to improve practice in specific areas. Three recommendations requested further information from the Department be provided to the CDCRC in order to confirm practice issues were addressed.
Four recommendations requested that action be taken by the relevant Child Safety Service Centres including updating of records and disseminating learnings.

Five recommendations aimed to share the learnings of the case with external agencies.

Three recommendations were made in relation to disciplinary action.

**Table 3.2 CDCRC recommendations by type category, 2012–13**

<table>
<thead>
<tr>
<th>Type of recommendation</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and research development</td>
<td>8</td>
</tr>
<tr>
<td>Training and professional development</td>
<td>6</td>
</tr>
<tr>
<td>Share learnings with external agencies</td>
<td>5</td>
</tr>
<tr>
<td>Localised action (departmental)</td>
<td>4</td>
</tr>
<tr>
<td>Request for information</td>
<td>3</td>
</tr>
<tr>
<td>Disciplinary action</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

The CDCRC closely monitors the implementation of its recommendations and has determined that 16 recommendations made by the CDCRC in the reporting period have been implemented. The CDCRC is confident that the recommendations made and learnings identified in the reporting period will lead to improved service delivery to children and young people in Queensland.

**Referrals**

In addition to making formal recommendations under the *Commission for Children and Young People and Child Guardian Act 2000*, the CDCRC where appropriate:

- tests the willingness of other agencies to voluntarily participate in the review process
- makes referrals directly to the Child Safety Directors’ Network and/or individual line agencies for action, and monitors responses to those referrals
- requests the Commission to undertake specific areas of research (for example, relevant to particular classes of cases)
- refers issues to the Commission for monitoring and/or investigation, and
- refers any child protection concerns for the surviving siblings of the child to the Department for its consideration and action.
Outcomes of referrals to agencies other than the Department

In 15 cases the CDCRC referred 25 issues to other agencies for consideration of options to strengthen service delivery to children and young people. Efforts aimed at improving cross-agency collaboration highlight the complexity and multidisciplinary nature of implementing an effective child protection response.

In response to one case where the child died as a result of suicide, the CDCRC identified it was appropriate to refer aspects of the case to Queensland Health.

The letter to Queensland Health identified potential learning in the area of rural Child and Youth Mental Health Services, particularly in relation to follow up mental health services for children and young people who have expressed suicidal thoughts. Queensland Health undertook a review of mental health services in rural settings and identified a number of strategies to enhance the knowledge of relevant staff in assessing and treating children and adolescents with mental health concerns.

Another case involved the death of a significantly disabled child as a result of a complex medical condition. The family made the difficult decision to seek assistance from the child protection system as a last resort following scheduled disability respite being cancelled. The CDCRC referred this case to Disability Services for consideration of current policy positions around the support to significantly disabled children and their families to prevent those children from entering the child protection system. Disability Services advised that it supported the views of the CDCRC and had included this issue in a submission to the Queensland Child Protection Commission Inquiry highlighting that early intervention and support for families caring for a child with complex needs was needed before the family reaches a crisis point and enters the child protection system.

The CDCRC also referred a complaint to the Health Quality and Complaints Commission regarding the standard and appropriateness of health services provided to a child who died as a result of a cause yet to be determined. The Health Quality and Complaints Commission advised that the concerns raised by CDCRC would be included in a referral to the Office of the State Coroner following consultation with the Medical Board of Australia.

The CDCRC believes that the responses received from each agency highlight the value of the CDCRC continuing to make referrals to external agencies to encourage review of service delivery.
Chapter 4
The Department’s service delivery

Key findings and messages

- In relation to three deaths considered in 2012–13, the CDCRC identified a link between the actions and/or inactions of the child protection system and the deaths of the children.

- Two of the three children were fatally assaulted after the Department failed to identify and appropriately respond to the risks present in the home.

- In relation to the other child, the CDCRC found the child protection system failed the child numerous times over their short life. Instead of being a mechanism to protect them, the system perpetuated further abuse and damage, to the point where the child’s behaviours escalated and the CDCRC concluded they were perceived by many service providers as being ‘the problem’.

- Both the Department and the CDCRC have consistently identified cases where more intrusive action should have been taken at the Intake stage to adequately protect a child in response to allegations of harm.

- Therapeutic residential facilities require sufficient funding to support young people requiring long term placements as well as to provide ongoing therapeutic support by appropriately qualified personnel within the placement.
This chapter outlines cases where the CDCRC determined actions and/or inactions of the child protection system were linked to the child’s death.

In addition, it looks at cases where the CDCRC determined there was no link between the Department’s service delivery and the death of the child, but where deficiencies in service delivery significantly adversely affected the child.

This chapter also considers recommendations made by the Queensland Child Protection Commission of Inquiry (the Commission of Inquiry) that relate to some of the service system issues highlighted in the cases discussed. The purpose of the CDCRC’s examination of the Commission of Inquiry’s findings and recommendations is to highlight the important learnings from the CDCRC’s functions so that this valuable source of information may be considered in any changes to either the CDCRC’s functions or the broader child protection system.

**Actions and/or inactions linked to the death of children**

For three deaths considered in 2012–13, the CDCRC identified a link between the actions and/or inactions of the child protection system and the deaths of the children.

In two of the reviews, the children were fatally assaulted. The children were not related and died in separate incidents. Both were living in their respective homes and were allegedly fatally assaulted by a family member. In the third case, the child died in a transport accident. This child was under the guardianship of the Department and was living in out-of-home care. Details of each case are outlined below with a discussion of the relevant service system issues.
Fatal Assault cases – actions and/or inactions linked to the children’s death

Case study 1
The child came to the attention of the Department through a professional notifier reporting allegations of physical abuse of the child by a family member. The child was interviewed by the Department and the Queensland Police Service, during which they made disclosures of abuse. Despite this, the concerns were unsubstantiated on the basis that there was no evidence the child had suffered harm and that no child protection concerns were disclosed by the child.

Eighteen months later the Department received further concerns by a professional notifier in relation to the physical abuse of the child. During the investigation, the Department observed injuries sustained from the abuse, the child made disclosures of the abuse and the perpetrator admitted to abusing the child and further acknowledged they were likely to do it again. The child was removed from the home and placed in foster care. One week later the child was returned to the family home (at the request of the perpetrator).

One week after the child was returned to the perpetrator’s care, a professional notifier contacted the Department with concerns that the child had not been attending school. The Department recorded the information but took no action. The Department did not see the child again prior to the child’s death approximately one year later. Evidence indicated the child had been consistently abused during the year and was kept hidden from the community to prevent any further involvement by the Department.

The Department’s review of this case found that the following departmental decisions adversely affected the child:
- the assessment that the child was not in need of protection
- the decision to return the child to the care of the perpetrator of the abuse, and
- the screening decision to record a Child Concern Report upon receiving advice the child had been absent from school since returning to the perpetrator’s care.

The CDCRC found that the Department’s decisions resulted in the child being returned to, and remaining in, a harmful environment that was the cause of the child’s death. The CDCRC found that in making each of the above decisions, the Department failed to acknowledge the evidence of physical harm, the disclosures of the child, the perpetrator’s admissions (including advice that they may assault the child again), and the cumulative harm experienced by the child.

Overall, the CDCRC is of the opinion that:
- the Department knew about the significant child protection concerns present for the child
- the Department did not act adequately to ensure the safety of the child
- the significant level of risk associated with the child continued and escalated until the child’s death
- there was no reasonable explanation why the Department did not adequately protect the child, and
- the child may not have died if the Department had discharged its obligations.

Accordingly, the CDCRC found that the actions and inactions of the Department were linked to the child’s death.
Actions undertaken by the CDCRC
The CDCRC noted that while the Department’s review of this case identified all service delivery issues, it did not identify a link between the Department’s actions and inaction and the child’s death. In addition, the Department’s review did not consider individual officer accountability in relation to the very serious practice issues identified in this case.

The Department did not make any referrals to its Ethical Standards Unit or the Crime and Misconduct Commission (CMC) about individual officers’ conduct. Therefore the CDCRC actioned appropriate referrals regarding suspected official misconduct in accordance with the legislative obligation under section 38 of the *Crime and Misconduct Act 2001* (Qld).

In addition, the CDCRC referred the case to the Commission of Inquiry, Child Safety Directors’ Network and the Commissioner for Children and Young People and Child Guardian to ensure a greater understanding of the service delivery issues that were linked to the child’s death.

CDCRC Recommendations
The CDCRC made two recommendations to improve service delivery in the relevant Child Safety Service Centre and Regional Intake Service. The CDCRC is monitoring the Department’s implementation of the recommendations and this is ongoing.

Departmental update
The Department is continuing to work on implementing the CDCRC recommendations, including a comprehensive action plan developed to address the serious service system issues.

Case study 2
The Department had extensive involvement with the family prior to the child’s birth, particularly in relation to parental substance misuse, domestic violence as well as physical and sexual abuse and neglect of the child’s siblings. Some of the siblings were being looked after by other family members under an informal family arrangement. The Department first became aware of the child as an unborn child. Despite a significant history of involvement with the family, the Department did not record an Unborn Child Notification. After the child was born the Department received concerns from a professional notifier (as a mandatory reporter) who was concerned the child may have been neglected. Four days after receiving the information the Department recorded the information as a Child Concern Report. The same professional notifier recontacted the Department on the same day and raised further concerns about the child’s safety. Six days later the professional notifier again contacted the Department and raised further concerns with the Department. Based on the new information, the Department reassessed the information that had been received over the previous two weeks and recorded a Notification with a 10 day response priority timeframe. The investigation and assessment had not commenced when the child died after allegedly being assaulted by the parent.

The CDCRC found that the Department was aware of the risk factors present for the child given the parental history of substantiated and alleged physical abuse of other very young children, resulting in some children being removed from their care by family members. The CDCRC found that the failure to record an Unborn Child Notification when the Department became aware of the mother’s pregnancy, and the poor handling of the Intake event in the two weeks prior to the child’s death meant the child remained in an unsafe environment.
The CDCRC was of the opinion that despite knowing the risks present for the child, the Department did not act adequately to protect the child, resulting in them remaining in an unsafe environment that ultimately led to their death.

Overall, the CDCRC was of the opinion that:

- the Department knew about the significant child protection concerns
- the Department did not act adequately to ensure the safety of the child
- significant levels of risk associated with the child continued and escalated until the child’s death
- there is no reasonable excuse why the Department did not adequately protect the child
- the child may not have died if the Department had discharged its obligations.

Accordingly, the CDCRC was of the opinion that the inactions of the child protection system were linked to the child’s death.

The CDCRC found that the Department’s review of this case was of insufficient quality given it did not identify the key service system issue in relation to the failure to record the Unborn Child Notification.

**Actions undertaken by the CDCRC**

The CDCRC referred the case to another government agency to examine its involvement with the family. The other agency accepted the referral and conducted an investigation to obtain learnings to improve future service delivery.

**CDCRC recommendations**

The CDCRC made three recommendations. The first recommendation was to refer the case to the Department’s Ethical Standards Unit. The second recommendation was around providing practice and personal supports to the staff of the relevant Child Safety Service Centre and Regional Intake Service given their involvement in two of the reviews where the CDCRC found a link between the service delivery and a child’s death. The third recommendation was to distribute the CDCRC’s report to areas within the Department to improve future service delivery.

**Departmental update**

The Department has implemented two of the three recommendations, and the CDCRC continues to monitor the implementation of the other recommendation.

The Department is continuing to work on implementing the comprehensive action plan developed as a result of the recommendations made by the CDCRC.

In response to the relevant issues identified in the case, the region has implemented strategies to improve practice development within the relevant Regional Intake Service, specifically regarding risk assessment, decision making and general Intake practice.
Service system issues related to fatal assault cases

In relation to the fatal assault cases, the CDCRC was of the opinion that the children should have been removed from their parents’ care. In both cases the CDCRC noted the Department was aware of the risk of harm present, and the Department’s inadequate assessments resulted in the children remaining in unsafe environments that ultimately led to their death. In both cases the CDCRC found that poor service delivery by the Department was a risk factor relevant to the children’s deaths. The CDCRC noted that in both cases, the poor service delivery was provided by the same Child Safety Service Centre and Regional Intake Service. Accordingly, the CDCRC recommended the Department develop strategies to provide practice and professional support to the management and front-line staff of the relevant Child Safety Service Centre and Regional Intake Service who were involved in both cases.

Department’s inadequate response to allegations of abuse

In both fatal assault cases, the Department’s poor assessment of harm at the Intake phase resulted in each child remaining in an unsafe environment despite the Department being aware of the risk of physical harm to them. In both cases, the reports of harm came from professional notifiers, one being a mandatory reporter. In one case the reported harm was incorrectly screened by the Department and recorded as a Child Concern Report with no action taken. In the other case, incorrect decision making and delays at the Intake stage meant the child was fatally assaulted before the Department began its investigation into the allegations raised by the mandatory reporter.

In one of the cases, the Department received information that the child had not been attending school. Given the Department’s awareness of the previous abuse suffered by the child, the Department’s own review found this information should have raised serious concerns and therefore should have been recorded as a Notification and the child’s immediate safety investigated. The CDCRC agreed with this finding and found that the failure to record the information as a Notification and investigate the concerns was, in part, linked to the child’s death.

This is an example of a reported concern that may not seem serious in isolation, however, when considered in the context of the child and family’s child protection history, raises significant concerns about a child’s immediate safety and wellbeing.
Mandatory reporting describes the legislative requirement imposed on certain professionals to report suspected instances of child abuse and neglect to statutory bodies. Mandatory reporting legislation of various types exists in every jurisdiction in Australia and was introduced into Queensland in the 1970s when medical practitioners became mandatory reporters of child abuse in response to an increase in child protection notifications. Since that time mandatory reporting in Queensland has broadened to include other professionals and systematic mandatory public reporting as a result of three inquiries into institutional and systemic child abuse. These inquiries into child protection recommended the broadening of mandatory reporting to keep child protection in the foreground of the community’s consciousness; to reinforce the community’s moral responsibility to report suspected cases of child abuse and neglect and to create a culture which is more child-centred.

Commission of Inquiry – Recommendation 4.5
The Department of Communities, Child Safety and Disability Services establish a dual pathway with a community-based intake gateway that includes an out-posted Child Safety officer as an alternative to the existing Child Safety intake process.

Commission of Inquiry – Recommendation 4.6
That the Minister for Communities, Child Safety and Disability Services propose amendments to the Child Protection Act 1999 to:

- allow mandatory reporters to discharge their legal reporting obligations by referring a family to the community-based intake gateway, and afford them the same legal and confidentiality protections currently afforded to reporters
- provide that reporters only have protection from civil and criminal liability if in making their report they are acting not only honestly but also reasonably
- provide appropriate information-sharing and confidentiality provisions to support community-based intake.

The CDCRC has found that mandatory and professional reporters play a significant protective role in child protection as the main informants to the statutory system as a result of their professional contact with children. It is not the experience of the CDCRC that children are being notified to the Department unnecessarily. Rather, both the Department’s reviews and the CDCRC consistently identify cases where the Department should have taken action in response to the concerns raised at the Intake stage and by not doing so, the child protection risk continued and often escalated.

The Commission of Inquiry proposes “…a dual-reporting pathway that will allow reports to be made to either a community-based non-government broker or [to the Department]. Under this model, professionals who have legislative or policy obligations to report concerns about children will be able to discharge these obligations by reporting to either the non-government broker or to [the Department].

18 Queensland Child Protection Commission of Inquiry Taking Responsibility: A Roadmap for Queensland Child Protection p. 113
The CDCRC considers there are risks with requiring mandatory or professional notifiers to assess allegations of harm. In particular, the CDCRC notes that the notifier may be assessing concerns without knowing any of the child or family’s child protection history. As noted in case study 1, both the Department and the CDCRC found that the seemingly innocuous report that a child had not attended school was in fact highlighting potentially life threatening child protection concerns for the child, given previous abuse known to the child protection system.

The importance of Intake
In previous years the CDCRC has identified consistent shortcomings by the Department when assessing allegations of harm at the Intake phase. In 2010 the Department introduced the Regional Intake Service aimed at improving consistency and quality of Intake processes. The CDCRC has continued to monitor Intake since the inception of the Regional Intake Service. It should be noted the CDCRC’s monitoring is limited to the reviews which it considers.

In 2013 the CDCRC analysed all reviews it considered in the 2012 calendar year and identified those which had service system issues relevant to the Intake phase after July 2011. The analysis identified that Intake service system issues after July 2011 are generally the same as those identified by the CDCRC prior to the Regional Intake Services being implemented in 2010.

Both the Department and the CDCRC have consistently identified cases where more intrusive action should have been taken at the Intake stage to adequately protect a child in response to allegations of harm.

Intake is a critical step to ensure support is provided to a child who is experiencing significant harm or risk of harm. Given the importance of strong Intake processes in an effective child protection system, the CDCRC included this issue in one of its submission to the Commission of Inquiry. It is at this stage that the Department is required to gather as much information as possible to determine the appropriate response, ensuring children’s and young people’s risk factors are responded to appropriately and in a timely manner. Appropriate assessment of concerns at Intake is a vital step to ensure assessments are conducted to then enable support services to be provided where necessary. Without this step, children and young people may ‘slip through the gaps’ without risks to their safety being responded to or assessed.

The Commission of Inquiry has proposed significant changes to Intake processes in child protection. The Commission of Inquiry has recommended the Department establish a dual pathways option whereby allegations of significant harm will be received by the Department and any less serious concerns will be sent through to a community-based intake service which would then determine what support was required. Under the proposed dual pathways model, the notifier is responsible for assessing the level of harm to determine whether it should be reported to the Department or the community-based service.

19 A copy of the CDCRC’s submissions to the Queensland Child Protection Commission of Inquiry can be found at www.cdcrc.qld.gov.au
Commission of Inquiry – Recommendation 4.5

*That the Department of Communities, Child Safety and Disability Services establish a dual pathway with a community-based intake gateway that includes an out-posted Child Safety officer as an alternative to the existing Child Safety intake process.*

The CDCRC is of the opinion that any proposed changes to the Intake processes should ensure the following:

- a comprehensive record of the family’s child protection history is available to any officer (whether departmental or non-government) to ensure holistic assessment of concerns is undertaken
- officers (departmental or non-government) are adequately trained to assess risk of harm, including conducting holistic assessments of child protection history
- new information received about a child or their family should be recorded in such a way that it is available by officers (departmental and non-government) who may have to assess future concerns or information about the family
- a state-wide information system should be used across the government and non-government sector to ensure accurate records are kept for transient families to ensure emerging risk and cumulative harm are able to be accurately identified and responded to.

Complex therapeutic needs case – actions and inactions linked to the child’s death

**Case study 3**

The child faced significant challenges throughout their life. From the age of two years, the child experienced 14 different out-of-home care placements and was incarcerated at a youth detention centre on two occasions. Between the ages of nine years and the date of their death, the child was placed in residential care facilities.

The CDCRC noted that while the Department was the lead agency and had primary responsibility for the child, there were 60 agencies involved in supporting the child and it appears none of these agencies were able to assist the Department achieve positive outcomes for the child. More than 260 departmental and agency workers were involved in the child’s case during the period of the Department’s ongoing intervention, yet there were no ongoing, meaningful therapeutic or care relationships established and maintained.

The CDCRC concluded in its report that the service delivery provided by the Department and other service providers to the child reveals a system that could not adequately respond to the child’s needs. The child protection system failed the child numerous times over their short life. Instead of being a mechanism to protect them, the system perpetuated further abuse and damage, to the point where the child’s behaviours escalated and the CDCRC concluded they were perceived by many service providers as being ‘the problem’.

While the CDCRC identified serious failings with the child protection system, it identified strengths in some areas of the youth justice system’s service delivery to the child. In particular, the CDCRC noted the child appeared to respond well to the structure, stimulation, safety and security offered in the youth detention environment.

It was evident to the CDCRC that the child protection system was not aligned with the child’s needs and there needed to be another alternative, other than the model of residential care provided, to promote the rights, interest and wellbeing of the child.
Specifically, the CDCRC found that:

- the child’s community as well as the child protection system failed to address their needs
- the Department’s service delivery during the child’s lifetime did little to reduce their trauma and de-escalate their behaviours
- the child protection system provided a reactive and uncoordinated response that failed to meet the child’s developmental and therapeutic needs
- mental health services were not available to the child for long periods of time despite extreme diagnosed mental health issues
- education needs were not met
- the child entered the youth justice system (including two periods of detention) in part, because the Department, as guardian of the child, did not adequately address the child’s developmental and therapeutic needs, and
- the Department did not have placement options to address the child’s therapeutic and developmental needs.

The CDCRC found that while the Department’s review identified the majority of service system issues, it did not make recommendations or take action that enabled a timely response to the extreme failures of the child protection system evidenced in this case.

**CDCRC actions and recommendations**
The CDCRC undertook nine actions and made nine recommendations to improve service delivery by the whole of government to other children and young people in the child protection system.

**Departmental update**
The Department has undertaken considerable work in progressing the implementation of the recommendations. At the Child Safety Service Centre level, a number of changes to office procedures and practices have been implemented based on the findings and recommendations. A Priority Case Review Panel has been established to quality assure the intervention plans for high risk children and young people with complex needs referred by the region. At this stage, five of the nine recommendations have been implemented and the CDCRC continues to monitor the implementation of the remaining four.

The CDCRC considered this case was seminal in signalling the need for reform of intervention and placement options for children suffering trauma and mental health issues resulting from abuse and neglect. The child was diagnosed with significant mental health disorders resulting from the trauma and abuse, experienced both at home and in the Department’s care, which impacted on their emotions and behaviours. The foster carers and residential staff involved with the child did not appear to have an understanding of the child’s mental health issues and were not able to cope with their extremely challenging behaviours. There were limited therapeutic services provided to the child to address their complex mental health needs. This case highlighted the current lack of capacity of the child protection system to meet the needs of children with complex mental health and behavioural issues who require therapeutic residential care.
Given the significance of this case, the CDCRC made a submission to the Commission of Inquiry about its findings and provided it with a copy of the CDCRC report. The Commission of Inquiry report *Taking Responsibility: A Roadmap for Queensland Child Protection* (the Commission of Inquiry Report) refers to a number of issues raised by the CDCRC, around the lack of therapeutic residential services available to children and young people in Queensland. Specifically it reported that of the 109 residential care facilities in Queensland, only four are therapeutic facilities. As noted by the Commission of Inquiry, children in residential care facilities often have complex needs requiring a comprehensive therapeutic response rather than simply responding to behaviour.

The CDCRC supports the Commission of Inquiry’s view that residential facilities in Queensland require a therapeutic framework with thorough understanding of trauma and attachment. Given that some children require long term placements at residential facilities, the CDCRC notes the importance of such facilities being sufficiently funded to enable ongoing therapeutic support by appropriately qualified personnel within the placement throughout the child’s stay.21

**Therapeutic residential facilities require sufficient funding to support young people requiring long term placements as well as ongoing therapeutic support provided by appropriately qualified personnel within the placement.**

**Commission of Inquiry – Recommendation 8.9**

If and when the Queensland Government’s finances permit, the Department of Communities, Child Safety and Disability Services develop a model for providing therapeutic secure care as a last resort for children who present a significant risk of serious harm to themselves or others. The model should include, as a minimum, the requirement that the department apply for an order from the Supreme Court to compel a child to be admitted to the service.

The Commission of Inquiry defines secure care as “...a placement option delivered through purpose-built facilities that provide for the containment of children and young people. Secure-care models are designed to restrain and protect children in circumstances where they pose an immediate and serious risk to themselves or another person.”22

The CDCRC notes the Commission of Inquiry’s statements that secure care should only be considered when all other options have been exhausted and have failed. The CDCRC considers that without well established and well-funded therapeutic residential care facilities readily available throughout the state, it is possible some children may end up in secure care due to the failure of the child protection system to provide consistent therapeutic support in response to their needs. The CDCRC cautions that if this were to occur, detaining a child in secure care may be tantamount to punishing the child for having been a victim of abuse that was not adequately responded to by government.

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Other cases highlighting significant service system issues

In addition to the three cases discussed in this chapter, in two cases considered, the CDCRC made a finding that while there was no direct link between the actions and/or inactions of the Department and the child’s death, there were serious deficiencies in service delivery that resulted in the child being harmed or being placed at risk of harm.

The key child protection concerns for both cases included exposure to domestic violence and parental substance misuse. Both children had been victims of emotional abuse and had suspected or diagnosed mental health issues. These cases are examples of the complexity of families and carers requiring child protection support and the challenges that confront frontline staff on a day-to-day basis.

**Case study 4**

The child was displaying complex and challenging behaviours as a result of the physical and emotional harm they were exposed to at a very young age.

On two occasions the Department successfully advocated for the child to have a mental health assessment. On the second occasion they were subsequently placed in a therapeutic facility that focused on assisting the child to heal from past trauma and abuse and also address their complex and extreme behaviours. The child was returned to the previous foster carers and shortly after, the carers and the child moved interstate, though the child continued to be under the custody of the Department.

The CDCRC found that while the child was interstate, the Department did not appear to provide sufficient support to the child and the carers despite having an ongoing legal obligation. The Department and CDCRC’s reviews identified the following service system issues had adversely affected the child:

- not having contact with the child for 11 months, despite being under the custody of the Department
- a lack of capacity to generate reports to monitor home visits
- not including the child or external agencies in recent case planning, and
- not transferring case work to an interstate government agency.

The CDCRC was of the opinion that these service system issues resulted in the child’s educational, behavioural, social, medical and therapeutic needs being unmet for a lengthy period of time and resulted in a significant decline in the child’s behaviours. This also meant that the child’s carers were not being adequately supported in managing the child’s complex behaviours.

The CDCRC found that the actions and/or inactions of the Department were not directly linked to the child’s death. However, the CDCRC considered the inaction of the Department once the child and the carers relocated interstate resulted in the child’s needs not being adequately met and the carers not being provided with appropriate supports to assist the child.

**CDCRC recommendation**

The CDCRC made a recommendation for the Department to consider strategies to improve the monitoring of children in out-of-home care.

The CDCRC will work with the Department on the implementation of this recommendation.
Case study 5

During the child’s lifetime the Department recorded multiple child protection concerns about the child’s emotional distress, ongoing parental conflict, self-harming and displaying escalating negative behaviours.

The child experienced multiple, long-term stressful life events including: physical abuse; ongoing psychological distress; unstable living arrangements; school transience from an early age; and possible exposure to domestic violence. The child was reported to display aggressive behaviours from the age of six which escalated to violent and self-harming behaviours over time. It appeared that the child also had suspected mental health issues. The Department had no involvement with the child at the time of their death.

The Department and CDCRC’s reviews identified the following service system issues had resulted in adverse outcomes for the child:

- failing to respond to the child’s self-harming
- inappropriately identifying a parent as a protective factor despite evidence that the parent was exposing the child to further abuse
- inappropriate assessment of evidence at Intake that the child had not been harmed and was not at risk of further harm
- failing to obtain further information at Intake to facilitate a more comprehensive assessment of risk of harm to the child
- failing to consider the family’s child protection history at Intake to ensure an holistic assessment of the risk of harm.

As a result of service system deficiencies, the CDCRC found that the Department missed opportunities to intervene and protect the child from a harmful environment, and to provide the child with appropriate support services to address their complex, violent and self-harming behaviours.

The CDCRC found that no actions and/or inactions of the child protection system were linked to the child’s death. However, the CDCRC considered that there should have been a detailed assessment by the Department about any mental health services the child was receiving and consideration of the role ongoing family conflict played in the child’s violent and self-harming behaviours.

Action undertaken by the CDCRC

The CDCRC referred de-identified case information to another agency to promote ongoing practice improvement of service delivery to children with complex needs.
Chapter 5

Child death case review jurisdiction – Queensland Child Protection Commission of Inquiry

Key findings and messages

- The Queensland child death case review jurisdiction was established following the historical service system failures highlighted by the Queensland Ombudsman and the Crime and Misconduct Commission.

- On 1 July 2012 the Queensland Government established the Commission of Inquiry led by the Honourable Tim Carmody, QC.

- The CDCRC made three submissions to the Commission of Inquiry.

- On 1 July 2013 the Commission of Inquiry released its report making 121 recommendations, which, at the time of writing this report, are being considered by the Government.

- The Commission of Inquiry recommends the Department establish a specialist investigation team and investigate cases where children in out-of-home care have died or sustained serious injury, overseen by a multi-disciplinary panel, which includes departmental officers, instead of the current CDCRC.

- In order to promote genuine accountability and transparency, the CDCRC considers it would be more appropriate that the panel or committee reviewing the deaths not include in its membership, officers of the department whose service delivery is being reviewed.
## History of Queensland’s child death jurisdiction

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>Prior to 2002</td>
<td>Child death reviews are internal reviews conducted by the Department</td>
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<tr>
<td>2002–2003</td>
<td>Queensland Ombudsman conducts major investigations into the deaths of Brooke Brennan and Baby “Kate”, finding:</td>
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<td></td>
<td>• the Department’s service delivery failed these children</td>
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<td></td>
<td>• the Department’s child death review processes failed because they</td>
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<td></td>
<td>either endorsed major service delivery failings or did not ensure</td>
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<td></td>
<td>recommendations were actioned to prevent future deaths.</td>
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<tr>
<td>2004</td>
<td>Crime and Misconduct Report <em>Protecting Children: an Inquiry into the abuse of children in foster care</em> reinforced the findings of the Queensland Ombudsman, specifically:</td>
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</table>
|            | “Departmental decisions and actions relating to such children need to be independently examined to promote internal accountability and enhance future decision making, so that the lives of other children may in future be improved or even saved.”  

23 Crime and Misconduct Commission report *Protecting Children: An Inquiry into the abuse of children in foster care* p. 163

| 2004       | Establishment of the CDCRC – independent and external oversight to review departmental reviews. |
| 2004–2013  | CDCRC examines the deaths of 532 children and young people.                                      |
|            | • Identified departmental reviews that were of inadequate quality.                               |
|            | • Between 2008 and 2013 the CDCRC identified five cases where the actions and/or inactions of the child protection system were linked to the child’s death. |
| 2013       | The Queensland Child Protection Commission of Inquiry recommends the Department establish a specialist investigation team and investigate cases where children in out-of-home care have died or sustained serious injury, overseen by a multi-disciplinary panel, which includes departmental officers, instead of the current CDCRC. |

## Background

On 1 July 2012 the Queensland Government established the Commission of Inquiry led by the Honourable Tim Carmody, QC. The Commission of Inquiry was established to review progress of outcomes related to the Commission of Inquiry into Abuse of Children in Queensland Institutions (the Forde Inquiry) and the Crime and Misconduct Commission Inquiry and to chart a new road map for child protection for the next decade.
On 1 July 2013 the Commission of Inquiry released its report making 121 recommendations, which, at the time of writing this report, are being considered by the Government. As discussed in Chapter 4, the purpose of the CDCRC’s consideration of the Commission of Inquiry’s findings and recommendations is to highlight the important learnings from the CDCRC’s functions so that this valuable source of information may be considered in any changes to either the CDCRC’s functions or the broader child protection system.

Child Death Case Review Committee submissions

The CDCRC made three submissions to the Commission of Inquiry. The first submission made in September 2012 noted that while the capacity of the Department to conduct child death reviews has increased since 2004, the CDCRC findings demonstrate that the quality of the Department’s reviews remains variable and the value of ongoing external independent scrutiny. The submission included a number of confidential case studies to provide evidence of the issues identified by the CDCRC.

The CDCRC’s second submission was provided to the Commission of Inquiry in November 2012. The submission related to a specific case in which the CDCRC found the actions and inactions of the Department were linked to the child’s death because the Department knowingly returned the child to, and allowed them to remain in, a harmful environment. Further information about the case is outlined in case study 1 in Chapter 4 of this report.

The CDCRC’s final submission to the Commission of Inquiry was provided in January 2013. The submission related to a further case in which the CDCRC found the actions and inactions of the child protection system were linked to the child’s death. The CDCRC was of the opinion the child protection system failed the child numerous times over the child’s short life. Instead of being a mechanism to protect the child, the system perpetuated further abuse and damage, to the point where the child’s behaviours escalated and the CDCRC concluded the child was perceived by many service providers as being ‘the problem’. The CDCRC considered the case was seminal in signalling the need for reform for placement options for children suffering trauma and mental health issues resulting from abuse and neglect. This case is discussed in more detailed in Chapter 4 of this report (case study 3).

Proposed recommendations relevant to the jurisdiction

Commission of Inquiry – Recommendation 12.11

That the Department of Communities, Child Safety and Disability Services:

- establish a specialist investigation team to investigate cases where children in care have died or sustained serious injuries (and other cases requested by the Minister for Communities, Child Safety and Disability Services)
- set the timeframe for such a child ‘being known’ to the Department at one year,
- provide for reports of investigations to be reviewed by a multidisciplinary independent panel appointed for two years.
The Commission of Inquiry report proposes “…that the Department establish an external review panel that oversees the reports of the investigation team instead of the current Child Death Case Review Committee. This approach has the benefit of independence and multidisciplinary expertise while reducing duplication and allowing staff the opportunity to hear deliberations and gain insight directly from experts. The review panel may also be asked to give an independent view on other contentious issues that arise, where the department may have, or be seen to have, a conflict of interest. To ensure independence the committee should consist of:

- a minimum of three external child protection specialists
- a member of the Child Protection Senior Officers group, on rotation
- a maximum of three departmental officers separate from the work unit associated with the case
- at least one Aboriginal or Torres Strait Islander.

Importance of independent oversight

The CDCRC is of the opinion that a panel made up, in part, of internal departmental officers cannot be regarded as an external or independent oversight mechanism. That is, the Commission of Inquiry proposed changes to the child death case review jurisdiction effectively abolishes any independent or external oversight of child deaths in Queensland.

In addition, the CDCRC notes that recommended changes to Intake processes (discussed in Chapter 4 of this report) will also mean a large number of children who potentially should be known to the child protection system, will no longer be known. Therefore, in the tragic event that one of those children were to die, they would fall outside of the child death review jurisdiction, meaning any potential adverse role of the Department or other agency may go undetected, learnings would not be obtained and the opportunity to prevent future deaths would be lost. The CDCRC’s suggests its concerns about children falling outside the child death case review jurisdiction require careful consideration.

The CDCRC holds serious concerns about the Commission of Inquiry’s proposal to significantly change Queensland’s child protection system while simultaneously removing the external independent oversight mechanism. In particular, the CDCRC is concerned the proposed changes to the child death review process may adversely affect future service delivery, and consequently the safety of Queensland’s most vulnerable children and young people.

While the CDCRC considers it important the Department has opportunity to critically reflect on its own practice, there is a public interest in the child death case review jurisdiction remaining independent.

In order to promote genuine accountability and transparency, the CDCRC considers it would be more appropriate that the panel or committee reviewing the deaths not include in its membership, officers of the department whose service delivery is being reviewed.

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Appendix 1

CDCRC members in 2012–13

In November 2010, the Premier of Queensland approved the appointment of the current members of the third CDCRC. Under section 124 of the Commission for Children and Young People and Child Guardian Act 2000, members are appointed for three years.

Current membership of the CDCRC comprises:

**Mr Barry Salmon**
Acting Commissioner (Acting Chairperson)
Commission for Children and Young People and Child Guardian  
*DipTeaching, BA, BEd, MEdSt, FAIM*

Barry began his career as a primary school teacher and has over 25 years’ experience in supporting young people, teachers and administrators in Queensland schools. He has worked in a range of policy and managerial positions with Education Queensland. Before joining the Commission, Barry was Assistant Director of the Queensland School Curriculum Council, managing the Preschool to Year 10 (P–10) curriculum development program for state, Catholic and independent schools in Queensland.

In 2001, Barry was appointed Executive Director of the Commission, with responsibility for the employment screening, Community Visitors and complaints functions. He was appointed to the new role of Assistant Commissioner, with responsibility for the Commission’s Child Guardian functions, in February 2005.

Barry is committed to the view that strengthening children and young people’s primary relationships will improve their wellbeing.

**Ms Moira Bligh**

Ms Bligh has worked extensively in policy and community engagement with a particular interest in Indigenous issues. Ms Bligh has held Management, Principal Project Officer and Program Coordinator positions within the Community and Personal Histories section and the Social Development Policy units of the Department of Aboriginal and Torres Strait Islander Policy and Development.

During her time working in government, Ms Bligh has been responsible for providing high level strategic advice to the Director-General on whole-of-government Indigenous Policy and Government Champion work. This has included: evaluating the department’s reconciliation strategy, implementation of the Office of Fair Trading’s ‘Indigenous Fair Go’ strategy, and developing and implementing a vision for the Department’s Indigenous Service Delivery.
Ms Bligh has received a number of awards for her work, including for outstanding service to the Department of Aboriginal and Torres Strait Islander Policy and Development and outstanding achievement in the field of Indigenous reconciliation.

Ms Bligh is currently the Director, Binambi-Barambah Aboriginal Corporation Ltd and President of the Noonga Reconciliation Group.

Dr Yvonne Darlington
Dr Darlington’s professional background is in social work, with extensive experience in the fields of mental health and family dispute resolution.

She holds a part-time position as a Senior Lecturer in the School of Social Work and Human Services at the University of Queensland and also provides research consultancy services in the field of child and family welfare.

She has completed major research projects on interagency collaboration between child protection and mental health services and on the involvement of parents in child protection decision-making.

Mr Cameron Harsley
Detective Superintendent, Queensland Police Service

Detective Superintendent Harsley is the Director of Child Safety for the Queensland Police Service. He also manages and leads the Child Safety and Sexual Crime Group in providing statewide, national and international responses to child protection related investigations and is responsible for overviewing all reportable child death investigations conducted by the Queensland Police Service.

Detective Superintendent Harsley has over 20 years’ policing experience, working predominantly in a variety of operational roles including as a general criminal and specialist child abuse investigator and as a police Suspected Child Abuse and Neglect (SCAN) Team representative. Since January 2006, he has performed a variety of management roles within the Child Safety and Sexual Crime Group and has been heavily involved in the implementation of child protection reforms from a whole-of-government and Queensland Police Service perspective since 2004.

Detective Superintendent Harsley worked within the former Department of Child Safety during the reform (Protecting Children) period and has also worked within the Commission for Children and Young People and Child Guardian on projects.
Professor Graham Martin OAM
Professor Martin is the Director of Child and Adolescent Psychiatry at the University of Queensland, and Clinical Director, Royal Children’s Hospital Health Service District Child and Youth Mental Health Services.

He is a clinician, researcher, writer and commentator, with 35 years of clinical experience underpinning development of preventive programs in mental illness, and programs for promotion of mental health in families, communities, schools, the defence force cadets and other systems.

Professor Martin has been dedicated to suicide prevention since 1987, and is a member of the International Association for Suicide Prevention and the International Association for Suicide Research. He is currently National Advisor on Suicide Prevention to the Australian Government and Director, Centre for Suicide Prevention Studies in Young People at UQ. In 2004, Professor Martin became a Life Member of Suicide Prevention Australia (SPA) and in 2008 was awarded the SPA ‘Lifetime Contribution to Suicide Prevention Research’ award. He received a Medal of the Order of Australia in 2006.

A major focus of Professor Martin’s work is the area of self-injury in young people. His team has recently completed the largest ever, national survey of self-injury for the Department of Health and Ageing (The Australian National Epidemiological Survey of Self-Injury). Professor Martin is also the Editor in Chief for the online journal AMH (Advances in Mental Health).

Mr Charles Passi
Mr Passi resides on Thursday Island, in the region of the Torres Strait.

Mr Passi has extensive experience in the government and non-government sectors. He has held various management, project, training and research positions in organisations associated with Aboriginal and Torres Strait Islander people.

Mr Passi is actively involved in matters relating to Torres Strait Islander women and children and has affiliations with a number of organizations that represent these interests including:
- Board Member Aboriginal and Torres Strait Islander Healing Foundation Ltd
- Member of Indigenous Reference Group for the Centre for Family and Domestic Violence Research Queensland
- Member of Thursday Island Community Justice Group
- Member of Lena Passi Women’s Shelter Inc.
- Member of Mura Kosker Sorority Inc., and
- Member of Kaziw Asesered Le Inc.

Mr Passi has also worked as an Office Manager and Court Support Worker for the Kaziw Asesered Le Association Inc., Thursday Island.

Mr Passi is currently working as an Area Supervisor with the Bureau of Statistics.
Professor Anna Stewart
Professor Stewart is professor in the School of Criminology and Criminal Justice, Griffith University. She is a Member of the Australian Psychological Society’s College of Forensic Psychologists.

After graduating with her PhD from University of Queensland in 1994, Professor Stewart started work in the School of Criminology and Criminal Justice at Griffith University. Her research interests include: examining the links between child protection, youth justice and the adult criminal justice system; system responses to youth offending and domestic violence; management of risk; diversionary responses; and system modelling. She is currently working on a project examining the links between mental health and offending.

A focus of Professor Stewart’s work is building the relevant partnerships to strengthen the integration of key research findings into legislative policy and practice development.

Former CDCRC members
In addition, the following former members resigned during the reporting period:

Ms Elizabeth Fraser (Chairperson)
Commissioner for Children and Young People and Child Guardian
BA, BSocWk, GradDip in Multicultural Studies, CertTeaching

Elizabeth has worked at all levels of government and has lived and worked in a number of countries, both in direct service delivery roles and in the management of policy development and implementation. She has also been responsible for leading large-scale organisational change and coordinating, overseeing and evaluating major policy and program reforms.

After graduating from the University of Queensland, Elizabeth worked for 19 years as a social worker in child health and welfare in Canberra, interspersed with short breaks to look after children and travel overseas, teaching English as a foreign language in Hong Kong, Sweden and Nigeria. She subsequently worked in the Australian Government’s overseas aid program, managing a number of policy and funding reforms.

In 1992, Elizabeth returned to Brisbane, where she started work with the Queensland Government public service, initially to undertake a program review of the Office of Rural Communities. Upon its completion, she held a range of policy and program management positions, including General Manager, Corporate and Executive Services, in the former Department of Innovation and Information Economy, Sport and Recreation Queensland. She also held the position of Executive Director, Social Policy in the Department of the Premier and Cabinet.

Elizabeth has a long-standing commitment to improving government service delivery, particularly for children and young people, and is committed to working closely with key stakeholders to achieve effective policy and program outcomes.
Dr Neil Wigg
Dr Wigg is the Senior Director, Community Child Youth and Family Health Services (Central), Children's Health Services, Brisbane and Associate Professor, Discipline of Paediatrics and Child Health, University of Queensland.

Dr Wigg is a graduate of the University of Tasmania Medical School, and undertook his paediatric training in New Zealand and the USA. He specialised in the care of children and young people with developmental disorders and has practised in that field for 30 years. He has also taken a special interest in child public health, with involvement in state and national child health policy development. He was awarded a Masters of Policy and Administration in 1992 (Flinders University).

Dr Wigg has worked in child health service management since the mid-1980s in South Australia and Queensland.

For over a decade, he was on the national executive of the College of Paediatrics, and then the Division of Paediatrics and Child Health, The Royal Australasian College of Physicians. Dr Wigg is a past-President of the Paediatrics and Child Health Division, Royal Australasian College of Physicians. Currently he serves on the Executive Committee of the International Paediatric Association, and on the Board of the Asia Pacific Paediatric Association. He is the Congress President for the International Congress of Paediatrics to be held in Melbourne in 2013.
Appendix 2

Review criteria

Commission for Children and Young People and Child Guardian Act 2000

Section 133

Review Criteria for Child Death Case Review Committee

14 November 2008

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

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

## Abbreviations and dictionary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia Plus (ARIA+). An index of remoteness derived from measures of road distance between populated localities and service centres. These road distance measures are then used to generate a remoteness score for any location in Australia. The 2001 update uses population figures and spatial boundaries from the Australian Bureau of Statistics 2001 Census of Population and Housing.</td>
</tr>
<tr>
<td>Autopsy</td>
<td>Also ‘post-mortem’. A detailed physical examination of a person’s body after death. An autopsy provides detailed information about the person’s health and gives an understanding of the various factors that may have contributed to their death.</td>
</tr>
<tr>
<td>CDCRC</td>
<td>Child Death Case Review Committee</td>
</tr>
<tr>
<td>Case planning</td>
<td>Case planning is a participative process of planning strategies to address a child’s protection and care needs and promote a child’s well-being. It is made up of a cycle of assessment, planning, implementation and review.</td>
</tr>
<tr>
<td>Child/young person</td>
<td>A person aged 0–17 years</td>
</tr>
<tr>
<td>The child</td>
<td>The child whose involvement with the Department was the subject of the child death case review.</td>
</tr>
<tr>
<td>Child and Youth Mental Health Services (CYMHS)</td>
<td>Child and Youth Mental Health Services (CYMHS) is an agency within Queensland Health which offers specialised mental health services for families with children and young people who are, or are at risk of, experiencing severe and complex mental health problems.</td>
</tr>
<tr>
<td>Child concern report</td>
<td>A child concern report is a record of child protection information received by the Department that has been ‘screened out’ and does not meet the threshold for a Notification.</td>
</tr>
<tr>
<td>Child death case review</td>
<td>The entire process for reviewing the Department’s involvement with a child who has died, as provided for by Chapter 7A of the Child Protection Act 1999 and Chapter 6, Part 1 of the Commission for Children and Young People and Child Guardian Act 2000.</td>
</tr>
<tr>
<td><strong>Child Protection Order</strong></td>
<td>A child protection order is an order made by the Children’s Court under the <em>Child Protection Act 1999</em>, when a child is considered in need of protection.</td>
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<tr>
<td><strong>Child Safety Directors’ Network</strong></td>
<td>The Child Safety Directors’ Network supports the Queensland Government’s child protection system across the continuum from prevention and early intervention to statutory intervention and ensures that child protection is a whole-of-government responsibility. The CSDN operates at the strategic whole-of-system level and leads the coordination, communication and strategic planning in the child protection system in Queensland to promote the safety and wellbeing of children and to find solutions to complex child protection issues. The CSDN is chaired by the Deputy Director-General, Department of Communities, Child Safety and Disability Services and its members represent 10 government agencies that have been identified as having a key role in the delivery of child protection services.</td>
</tr>
<tr>
<td><strong>Child protection system</strong></td>
<td>The child protection system consists of whole-of-government and non-government services provided to children and young people and their families with suspected or actual child protection concerns.</td>
</tr>
<tr>
<td><strong>Child Safety Officer</strong></td>
<td>A child safety officer is an authorised officer under the <em>Child Protection Act 1999</em>, who is responsible for delivering statutory child protection services, such as investigating and assessing allegations of suspected child abuse and neglect, and intervening to ensure the safety and well-being of children subject to ongoing intervention, in accordance with legislation, policies and procedures.</td>
</tr>
<tr>
<td><strong>The Commission</strong></td>
<td>The Commission for Children and Young People and Child Guardian</td>
</tr>
<tr>
<td><strong>The Commissioner</strong></td>
<td>The Commissioner for Children and Young People and Child Guardian</td>
</tr>
<tr>
<td><strong>The Commission of Inquiry</strong></td>
<td>The Queensland Child Protection Commission of Inquiry</td>
</tr>
<tr>
<td><strong>Cumulative harm</strong></td>
<td>Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.(^\text{25})</td>
</tr>
</tbody>
</table>

\(^{25}\) Victorian Government Department of Human Services, ‘Cumulative harm: a conceptual overview’, March 2007, page 1
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Death incident</td>
<td>The incident causing the death</td>
</tr>
<tr>
<td>The Department</td>
<td>The Department of Communities, Child Safety and Disability Services and also, where applicable, the Former Department of Child Safety and the former Department of Families</td>
</tr>
<tr>
<td>The Department’s review</td>
<td>Also referred to as the ‘original review’. The Department’s review is carried out by the Department pursuant to section 246A of the Child Protection Act 1999.</td>
</tr>
<tr>
<td>Disability Services</td>
<td>The Department of Communities, Child Safety and Disabilities Services and also, where applicable, the Former Disabilities Services Queensland</td>
</tr>
<tr>
<td>External causes</td>
<td>Pertaining to environmental events and circumstances that cause injury, such as motor vehicle accidents, drowning and poisoning</td>
</tr>
<tr>
<td>Fatal assault</td>
<td>The death of a child or young person from acts of violence perpetrated by another person, even when the perpetrator may not have intended the outcome. This includes cases where the death is a result of an assault even if the death occurred sometime later.</td>
</tr>
<tr>
<td>Foster carer</td>
<td>Any individual, or two or more individuals approved by the Department to care for a child subject to the Department’s intervention and an out-of-home care placement (irrespective of type of placement).</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Refers to children identified as Aboriginal and/or Torres Strait Islander</td>
</tr>
<tr>
<td>Intake</td>
<td>Intake is the first phase of the child protection continuum, and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child, or when a request for departmental assistance is made.</td>
</tr>
<tr>
<td>Investigation and Assessment</td>
<td>Investigation and assessment is the second phase of the child protection continuum. It is the Department’s response to all notifications, to determine the safety and protective needs of a child under the Child Protection Act 1999, section 14, where there are allegations of harm or risk of harm to a child.</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Refers to the Queensland child death case review jurisdiction, which consists of a two-tiered system for reviewing deaths of children known to the child protection system in the three years prior to their death. The first tier is a review conducted by the Department about its involvement with the child (the Department’s review). The Department’s review is then assessed by the CDCRC (the second tier) against a set of review criteria.</td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td>Neglect and negligent treatment are jointly defined as the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres – health, education, emotional development, nutrition, shelter and safe living conditions – in the context of resources reasonably available to the family or caretakers; it is treatment that causes or has a high probability of causing harm to the child’s health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible (World Health Organisation, 1999).</td>
</tr>
<tr>
<td><strong>Notification</strong></td>
<td>Information received about a child who may be harmed or at risk of harm which requires an investigation and assessment response. A Notification is also recorded on an unborn child when there is reasonable suspicion that they will be at risk of harm after they are born.</td>
</tr>
<tr>
<td><strong>Notifier</strong></td>
<td>A notifier is a person who informs the Department about alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, irrespective of how the information is recorded or responded to by the Department.</td>
</tr>
</tbody>
</table>
| **Ongoing intervention** | Ongoing intervention is the third phase of the child protection continuum. It occurs when it is necessary for the Department to provide support and assistance to the family to reduce risk to a child, or to the extent necessary to ensure that the child’s protection and care needs are met. There are three types of ongoing intervention, including:  
- a support service case  
- intervention with parental agreement  
- intervention with a child protection order. |
| **Original review** | The Department’s review |
| **Out-of-home care** | Out-of-home care refers to placements of children, subject to statutory child protection intervention, with individuals and services approved or licensed under the *Child Protection Act 1999*. Out-of-home care includes placements with:  
- a licensed care service, or  
- an approved carer |
<p>| <strong>Perinatal conditions</strong> | Perinatal conditions are diseases and conditions that originated during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. These include maternal conditions that affect the newborn, such as complications of labour and delivery, disorders relating to foetal growth, length and gestation and birth weight, as well as disorders specific to the perinatal period such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Report of Death to a Coroner (Form 1)</td>
<td>A form completed by the Queensland Police Service in accordance with section 7 of the <em>Coroners Act 2003 – Duty to Report Deaths</em>.</td>
</tr>
<tr>
<td>Pool and Non-pool drowning</td>
<td>Pool drowning deaths are defined as drowning deaths which occurred in private and public swimming pools. Non-pool drowning deaths are defined as drowning deaths which occurred in non-pool locations including dams, bathtubs and the beach.</td>
</tr>
<tr>
<td>Queensland Child Death Register</td>
<td>Register of all deaths of children and young people in Queensland.</td>
</tr>
<tr>
<td>Queensland Child Protection Commission of Inquiry</td>
<td>The Queensland Child Protection Commission of Inquiry, led by the Honourable Tim Carmody QC, was established on 1 July 2012 by the Queensland Government to review Queensland’s child protection system.</td>
</tr>
<tr>
<td>Recognised Entity</td>
<td>It is a requirement under the <em>Child Protection Act 1999</em> that when making a significant decision about an Aboriginal or Torres Strait Islander child, the Recognised Entity for the child must be given the opportunity to participate in the decision-making process.</td>
</tr>
<tr>
<td>Reporting period</td>
<td>1 July 2012 to 30 June 2013.</td>
</tr>
<tr>
<td>Research category</td>
<td>Category used by the Commission for Children and Young People and Child Guardian to classify external causes of death according to their circumstances.</td>
</tr>
<tr>
<td>Reviewed</td>
<td>Refers to when the CDCRC has provided its final report to the Department about its review of the Department’s review.</td>
</tr>
<tr>
<td>Service system</td>
<td>The child protection system.</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden infant death syndrome.</td>
</tr>
<tr>
<td>Support Service Case</td>
<td>A type of ongoing intervention that can only be used when it is determined that a child is not in need of protection, based on an agreement by the parents, pregnant woman or young person to work with the department.</td>
</tr>
<tr>
<td>Suicide</td>
<td>A self-inflicted injury that is accompanied by the intention of the individual to die as a result of the action taken.</td>
</tr>
</tbody>
</table>
| Suspected suicide                                                   | Where no coronial findings are available, but other factors and information raise suicide as a possible cause of death. Relevant evidence and factors include QPS opinions, previous statements of intent by the deceased, the presence
of a suicide note, witnesses to the event, prior suicide attempts or any precipitating factors.

| Unborn Child Notification | If the information received by the Department indicates that an unborn child may be at risk of harm after they are born and will not have a parent able and willing to protect them from harm, an unborn child notification will be recorded and an investigation and assessment will be conducted. |
| Undetermined | Cause of death certified 'undetermined' refers to a death in which available information is insufficient to classify the death into one of the specific causes of natural or unnatural death. If an extensive investigation and autopsy cannot clarify the circumstances, the death is placed in this category. Sudden unexpected deaths of infants are certified as undetermined when insufficient findings are present to support a particular diagnosis but when sufficient abnormal features in the history or at the scene, examination, autopsy or laboratory workshop were found that were not typical of sudden infant death syndrome.²⁶ |
| Unknown/pending (cause of death) | Includes the following causes of death: ‘Autopsy Notice given – cause of death not yet determined’, ‘Not yet determined pending test results’ and ‘Not yet established, tests required.’ |
| Youth Justice Services | Department of Justice and Attorney General which is responsible for supervising young people involved in the Youth Justice system. |

Appendix 4

Suicide classification model

The Commission’s suicide classification model is used to classify all cases of suspected suicide into one of three levels of certainty. In classifying these deaths, the Commission considers a number of factors, including whether intent was stated previously, the presence of a suicide note, witnesses to the event, previous suicide attempts and any significant precipitating factors or life stressors.

Information used to classify suicide certainty is based on data available to the Commission at the time of reporting. Information is gathered from numerous records, including the Police Report of Death to a Coroner (Form 1), autopsy and coronial findings, toxicology reports, child protection system records and, for finalised cases, police briefs of evidence to the coroner (which can include witness statements, supplementary Form 1s, additional police reports and suicide notes).

Levels of classification are as follows:

- **Confirmed:** The available information refers to at least one significant factor that constitutes a virtually certain level of suicide classification, or coronial investigations have found that the death was a suicide.

- **Probable:** The available information is not sufficient for a judgement of confirmed, but is more consistent with death by suicide than by any other means. Risk factors for suicide have been identified and/or the method and circumstances surrounding the death are such that intent may be inferred.

- **Possible/undetermined:** The police have indicated (on the Form 1) that the case is a suspected suicide or the Commission has identified the possibility of a suicide but, because of a lack of information on the circumstances of the death, there is a substantial possibility that the death may be the result of another cause, or is of undetermined intent.

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27 The Commission’s classification model is an amended version of the Australian Institute of Suicide Research and Prevention’s (AISRAP) suicide classification flow chart.
Any child death

Examination of Form 1 – Summary of incident

Has the circumstances in the Form 1 completed by police indicate the death is likely to be a possible suicide?

No, it is not possibly a suicide (e.g. heart attack)

Did the method of death have a high likelihood of being a suicide (e.g. hanging, self-inflicted gunshot wound, carbon monoxide) and there were no mitigating circumstances that may indicate that the death was possibly a death by illness, accident or homicide?

ANY / OR

Any history of mental health issues?

ANY / OR

Any significant stress (e.g. relationship breakdown, death of a loved one)?

ANY / OR

Did the deceased make an obvious effort to die (complex plan, etc.)?

ANY / OR

Any prior suicidal behaviour or attempts?

ANY / OR

Any witness to the actual suicide event (e.g. saw deceased jump from building)?

CLASSIFICATION = HIGHEST PROBABILITY ACHIEVED