A systems review of individual agency findings following the death of a child

Queensland
Family & Child
Commission

Queensland
Government

Acknowledgements

The Queensland Family and Child Commission (QFCC) acknowledges the sad death of Mason Jet Lee.

We acknowledge too the grief and loss experienced by those close to Mason, and by those who worked with him and his family before his death.

We also recognise how deeply affected the broader Queensland community has been by this tragedy.

The QFCC thanks government and non-government agencies from across Australia for their willingness to provide information that assisted in the preparation of this report.

Protecting children, both in Australia and internationally, is a complex responsibility. To do it well requires a collaborative effort from all jurisdictions and an acknowledgement that everyone is responsible for keeping our children safe.

At the time of writing, criminal proceedings in relation to Mason's death were being heard by the Queensland Court System. The QFCC is mindful of seeking justice for Mason and will not disclose specific case details about him or his family that are relevant to the criminal proceedings.

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March 2017

In memory of Mason Jet Lee

Birth: *16 August 2014*
Death: *11 June 2016*

'The challenge of ending child abuse is the challenge of breaking the link between adults' problems and children's pain.'

UNICEF, A league table of child maltreatment deaths in rich nations, September 2003

Foreword

On 11 June 2016, Queensland woke to reports of the death of a toddler in Caboolture. Mason Jet Lee was 21 months old.

How he died is a matter for the coroner and the police to answer. The question many people in the community asked themselves was what could have been done to keep him safe? They also asked what changes needed to be made to protect other vulnerable children and prevent their deaths?

In 2015–16, more than 45 children and young people known to child safety died. Some attended school, some had been in contact with health services, while others were receiving support from a non-government organisation. Very young children and babies may not have been in touch with any services on a regular basis, but in most cases, there were potentially many eyes on the children before they died and missed opportunities to check on their safety.

In July 2016, the Premier asked me to oversee the reviews being undertaken by the Department of Communities, Child Safety and Disability Services and by the child death case review panel, and the investigation conducted by Queensland Health about the services provided to Mason Jet Lee before his death. This report focuses on the results of this. All information was received by the Queensland Family and Child Commission by 17 January 2017.

I would like to acknowledge the work undertaken by the departments in completing their reviews. I recognise that reviewing the circumstances of a death of a young child is difficult and sad work with many hard questions to answer.

The role of the Queensland Family and Child Commission in writing this report was to examine current systems for reviewing the deaths of vulnerable children and make recommendations for change to create a contemporary and up-to-date child death review system.

This change must identify better child death prevention strategies to be put in place across all agencies providing services to children. This change must demonstrate that we have not only learned from the circumstances surrounding the deaths of vulnerable children, but have also applied the lessons in a sustainable way.

To a concerned community looking for action, reviews may not seem the right way to respond to this tragedy, but they are important starting points. They are about getting the right people together with the right information in order to identify what has not worked. They are about identifying areas of strength to make the most of, and areas where changes must occur in order to deliver the best possible services to children and their family.

It is not the role of the Queensland Family and Child Commission to make recommendations about the actions or responses of individual officers.

We have been advised that we are unable to release the reviews or publish the findings before the police and the coroner have completed their investigations. The reviews themselves were timely and thorough, but as a whole, did not provide a child death review system to deliver the outcomes and guidance needed to make the system changes to protect our vulnerable children. We need to go beyond what we currently do and beyond the recommendations of the 2013 Queensland Child Protection Commission of Inquiry.

Child Safety Services has the statutory responsibility for child protection, but many agencies provide services to children and have a duty of care to keep children safe. To prevent the deaths of our most at risk children, Queensland needs a contemporary child death review system linking all of these agencies, regardless of their different models of service delivery and cultures.

The system must be nimble and comprehensive and must provide recommendations to all agencies for preventative action.

The Queensland Family and Child Commission's analysis of the reviews undertaken by the departments has highlighted a number of areas for improvement in policy, organisation, workforce and collaboration.

Without a committed focus on these fundamental structures supporting service delivery we cannot expect transformational change to children's safety.

By policy, I mean the overall management, not only of processes and services, but also of the current changes in the child protection system. Staff and clients are at risk of being overwhelmed by reforms to child protection, domestic and family violence and other policy and practice changes. While these changes are important and necessary, they need to happen in a stable, organised way, so that Child Safety Services can maintain an unwavering focus on core business.

Policies must support these changes, measure them effectively and enforce them with legislation.

Organisationally, resources must be in place to make sure services are delivered appropriately to children and families. Without well-targeted resources, agencies will struggle to do what needs to be done.

Organisational culture and climate also play a part. Stressed organisations cannot deliver good service and staff can become demoralised when, despite their best efforts (and some of their efforts are very good), a child is seriously injured or dies. The leaders of organisations need to manage this.

This links to workforce—the practitioners. Their sense of vocation, along with their practical skills and knowledge can make a huge difference. They need to be clear on what is expected of them and on what they are allowed to do. In delivering their important services, they need high quality clinical supervision and professional education.

Collaboration refers to the need for the different agencies associated with child safety and child protection to not only work together, but also to recognise that their joint efforts will deliver better results. No one agency can do what needs to be done, and every agency can learn from the lessons of others. Only in this way will they continue to improve the services they provide to our children.

As Emeritus Professor Dorothy Scott says, it takes a combined effort of the community and of health, police, child safety and education services to protect a vulnerable child.

I do not believe the child protection system in Queensland is broken. Nor is it a perfect system. It has become clear that there are pockets of risk and there are pockets of excellence. It is important to identify these. Child Safety Services should continue its work of auditing practice, culture and service delivery in every Child Safety Service Centre.

At a bigger picture level, the Queensland Family and Child Commission has commissioned research into the causes of deaths of all children in Queensland. From this research, preventative measures will emerge which Queensland can use to shape future policy and to respond to risk factors associated with child deaths.

It can be easy to become despondent about this situation, particularly when we consider what has happened to other children in the past (like Brooke Brennan and Baby Kate, whose cases are discussed in Appendix B of this report) and the recommendations that were made after their deaths. However, despondency is not helpful, and uninformed recriminations are counterproductive. Clearly, we have not yet learned all the lessons we need to learn. We need to make the recommendations of reviews stick. We need to create real system improvement.

I firmly believe the implementation of the recommendation of this review will lead to a stronger child protection system in Queensland.

We must remain vigilant. Every person, every community and every organisation has a role in protecting our children. In memory of Mason, I ask that we all do everything we can to keep Queensland's children more than safe.

Cheryl Vardon

Principal Commissioner

Queensland **Family and Child** Commission

30 March 2017

Executive summary

High quality child protection and child health services are two of the most important functions governments deliver. Their aim is to protect and care for some of the most vulnerable members of our community, often at a time when their own families are unwilling or unable to look after them. Those services must be responsive and effective so the community can be confident government is doing its best to protect children and support them and their families.

Queensland's child protection system has been in a state of reform for a number of years. Many of these reforms have been started because of high profile instances of child death or serious harm or abuse. These events cause widespread community concern about the quality of services government is providing. Reviews are undertaken to identify lessons learned and changes needed, with the intention to prevent similar events in the future.

In July 2016, Annastacia Palaszczuk, Premier of Queensland and Minister for the Arts asked the Queensland Family and Child Commission (QFCC) to oversee three reviews into the death of 21-month old Mason Jet Lee. This meant working with both the Department of Communities, Child Safety and Disability Services (Child Safety Services) and Queensland Health to make sure their reviews were timely and thorough and that they will deliver outcomes to improve the child protection system and child health services.

We worked with both agencies as they planned and completed their reviews. They provided us with their final review reports for analysis. This report examines each of those reviews and, more broadly, ways in which the child protection system and child health services can better protect our most vulnerable children in the future.

One of the QFCC's functions is to provide oversight of the child protection system. This report focuses on system level issues arising from the agencies' child death reviews. The QFCC does not investigate the circumstances of individual children or their families.

Because the Queensland Police Service has charged a number of people with criminal offences over Mason's death, it is important this review does not prejudice those proceedings. For this reason, it does not include any information about the circumstances leading up to Mason's death, or how he died. It focuses on government service delivery to Mason and his family, not the actions or inactions of the other people in his life.

The Office of the State Coroner is ultimately responsible for determining the identity of deceased persons, when and where they died, how they died and their medical cause of death. Once all the criminal proceedings are finalised, the investigating coroner may decide to hold an inquest into Mason's death, and make recommendations to prevent similar deaths. Until then, the government is determined to identify whether it needs to make changes to the child protection system to strengthen its response to children in Mason's situation in the future.

Mason Jet Lee

Mason Jet Lee was born in August 2014 in a suburb north of Brisbane. Tragically, he died in June 2016 three months before his second birthday. This is a time when he should have been a happy, lively toddler, playing with his toys, laughing, learning and growing.

In the days and weeks following his death, there was an understandably high level of media and public interest in what happened to him. Several media reports commented on the nature and extent of Mason's injuries at the time of his death.

A number of people were charged with manslaughter, child cruelty and failing to provide Mason with medical attention.

The Child Safety Minister confirmed that Mason was known to the child protection system when he died. He also received health care in public hospitals.

Agencies providing services to children have an opportunity to critically review and reflect on the services delivered if those children later die. It is also important that an independent body considers the child's safety and whether the child protection system as a whole did the best it could to protect and care for the child.

The QFCC assessed three reviews of the services provided to Mason before his death:

- Child Safety Services' internal review, known as a systems and practice review, with examination by a Systems and Practice Review Committee
- an external review of the systems and practice review by an independent child death case review panel
- Queensland Health's health service investigation.

The QFCC's assessment of the three reviews of service delivery to Mason identified some opportunities to strengthen the child protection system. It also highlighted some gaps in the current child death review system.

Despite the child death case review panel process being subjected to a number of reforms since 1999, Queensland does not yet have a contemporary best practice child death review model.

Recommendation

That the Queensland Government considers a revised external and independent model for reviewing the deaths of children 'known to the child protection system' (s. 246A (2)(a–d) of the Child Protection Act 1999).

This model will be designed by the Queensland Family and Child Commission and an expert advisory group in consultation with the directors-general from the 'nominated agencies' (s. 159k (a)(i-iv) of the Child Protection Act 1999) and other key stakeholders, and be endorsed by the Interdepartmental Coordination Committee.

A report will be provided to the Premier three months following the announcement with a framework for a contemporary child death review process for Queensland.

Amendments will be required to the Child Protection Act 1999 to transfer responsibility for the child death case review panel to an independent government agency.

The review of the Child Protection Act 1999 will also provide an opportunity to reconsider the functions of the child death case review panel, including the determination of accountability, in consultation with the nominated agencies.

As part of designing a contemporary model for child death case review, best practice benchmarks and experiences of other Australian jurisdictions, as identified by the Queensland Family and Child Commission, must be considered.

This includes the following:

- *extending the scope of powers and the authority of the child death case review panel in the new independent agency*
- *reconsidering legislative timeframes, including the receipt of information from other agencies*
- *reporting to government and public audiences on outcomes of child death reviews*
- *extending the scope to include other government and non-government organisations in the model*
- *extending the panels' power to make recommendations and require agencies to take action*

- *reconvening as necessary to consider new information, regarding the death of a child, to support systemic changes*
- *reconsidering selection, appointment of members and period of membership, and ongoing support, guidance and strong governance to the panel members*
- *providing appropriate resourcing for secretariat, panel operation and agency reviews*

Legislation will be required to compel nominated agencies who have provided service delivery to the child to undertake an internal review.

Each nominated agency may be required to:

- *establish an internal process for reviewing their involvement with children known to the child protection system who have died. These reviews should promote learning and analysis of internal decision making, consideration of systems issues, and collaboration with other agencies*
- *initiate this process whenever it has been determined that a child known to the child protection system and the agency dies*
- *provide the agency responsible for child death case review panels with the terms of reference for the internal reviews, and a copy of the internal review reports, including any findings and recommendations*
- *report regularly to the agency on progress in implementing any recommendations.*

The revised model should also consider giving the child death case review panel members the additional capacity to undertake own-motion reviews (based on their own expertise and observations of what is needed). This would enable the panel to identify trends in all child deaths in Queensland and complete a review into service delivery to prevent future deaths.

Contents

Chapter 1

The Queensland Family and Child Commission Review

The Premier's request

On 11 July 2016, the Premier of Queensland, the Honourable Annastacia Palaszczuk, asked the Queensland Family and Child Commission (QFCC) to oversee the internal and external reviews of the Department of Communities, Child Safety and Disability Services (Child Safety Services) and the investigation conducted by Queensland Health into the death of Mason Jet Lee. A copy of this letter is provided at Attachment A.

The Premier asked the QFCC to:

- consider Child Safety Services' internal and external reviews and Queensland Health's investigation to make sure they were undertaken with speed and in a thorough manner
- exercise oversight functions to ensure all reviews are able to deliver the outcomes and guidance needed to make the systems changes required.

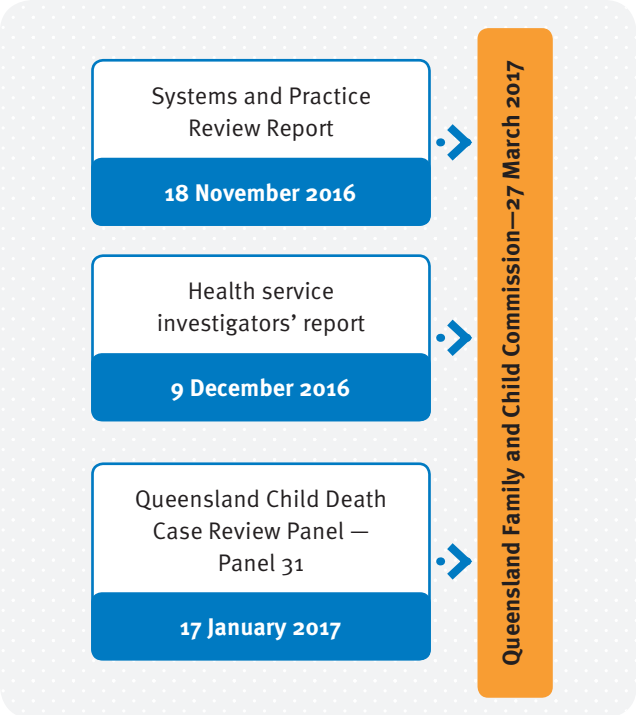
Terms of reference

The QFCC developed the following terms of reference to guide the review:

- Review the legislation, governance frameworks and methodologies for agency reviews to ensure they are thorough, effective and impartial.
- Review the application of internal and external agency review processes for Mason to ensure the review is prioritised.
- Review the information, findings and recommendations of individual agencies to provide oversight and identify trends and opportunities for whole-of-system recommendations, particularly those related to information sharing.

The QFCC provided the terms of reference to the Premier, and to the directors-general of Child Safety Services and Queensland Health on 18 August 2016. Copies of these letters are provided at Attachment B.

The QFCC received the individual agency reports required to prepare this review on the dates shown below.



Authority to access information

The QFCC conducted this review under Part 3 of the *Family and Child Commission Act 2014* (the Act).

The Principal Commissioner, QFCC delegated to reviewers the authority to access any information to support the review. The QFCC requested information from other government agencies under s. 27 of the Act.

The QFCC review approach

The QFCC worked collaboratively with Child Safety Services and Queensland Health to share information. The QFCC also worked with the directors-general of both departments throughout the review process and during the preparation of this report.

In addition, the QFCC consulted with other Queensland Government agencies, including the Office of the State Coroner, and agencies in other Australian states and territories.

This broad consultation allowed us to consider potential areas of reform in Queensland based on other contemporary models and experiences.

Out of scope

Under the Act, it is not a function of the QFCC to investigate the circumstances of a particular child, young person or family. As a result, this report does not comment on matters to do with individuals.

This report also does not address the ongoing criminal investigation being led by the Queensland Police Service, or any investigations by the coroner in relation to Mason.

This report does not focus on how Mason died. It also does not duplicate any agency's ethical standards or disciplinary processes. It focuses on system level issues arising from the two Child Safety Services reviews and Queensland Health's investigation. Only a coroner can investigate how Mason died and the medical cause of death. These proceedings are underway.

Provision of interim assessments during the course of the review

The QFCC provided the Premier with two confidential updates based on the QFCC's interim assessments of the Queensland child death review functions. These reports were as follows:

Interim assessment of agency reviews into the circumstances surrounding the death of Mason Jet Lee, provided on 16 September 2016. This report gave an overview of the mandated requirements for child death reviews of Child Safety Services and Queensland Health, and identified key dates for reporting. Both agencies were provided with an opportunity to review the content and provide feedback.

Interim assessment of agency reviews into the circumstances surrounding the death of Mason Jet Lee (second update), provided on 19 December 2016. This report contained an update on the agency reviews completed to date and identified early themes for systemic reform and further considerations. This information was not provided to either Child Safety Services or Queensland Health for their review or comment.

Procedural fairness

This report contains comments that may be considered adverse to the agencies involved in this process.

It is not the QFCC's intention to comment on the individual actions of those employed within either Child Safety Services or Queensland Health. Each department has been consulted prior to the release of this report and advised of the QFCC's findings.

Quotes, comments and findings

In this report, the QFCC has provided findings, included some comments necessary for understanding, and quoted some authorities on the subject of child protection. These appear in boxes coloured blue, orange and green, respectively.

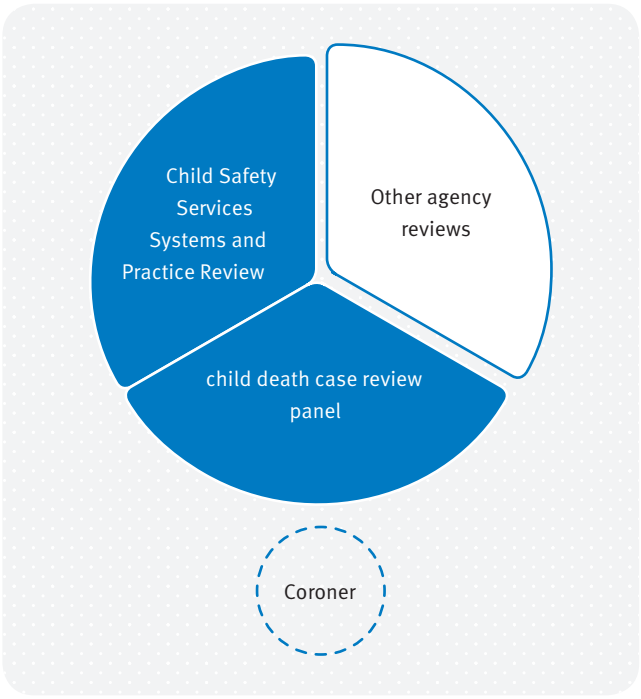
QFCC findings

Quotes

QFCC comments

Chapter 2

The child death review process in Queensland



Child death teams attempt to understand cases of preventable death, rather than assign blame, and to uncover ways that child welfare systems (eg child protection, public health, juvenile justice) can be improved to prevent future deaths or injuries.[1]

Background

In Queensland, many different agencies (and non-government organisations) provide services to children and young people in the child protection system. The government agencies include:

- Department of Communities, Child Safety and Disability Services—child protection services (through Child Safety Services)
- Queensland Health—public health and mental health services
- Department of Education and Training—education, vocational training services and care services
- Department of Justice and Attorney-General—youth justice services, the Office of the Public Guardian, court services and advocacy and support for children in out-of-home care
- Queensland Police Service—investigation of criminal offences against or involving children.

Currently, only the Department of Communities, Child Safety and Disability Services (Child Safety Services) has a statutory obligation to review its own involvement with children who have died. Many other government agencies have legislation, policies and procedures allowing them to review their service delivery for children who have died, but it is not mandatory for them to do so. This is not ideal.

Under the *Coroners Act 2003*, anyone who becomes aware of a 'reportable death' must report it to the coroner or the Queensland Police Service. Failure to do so is a criminal offence. The coroner has authority and power to conduct investigations (and inquests where appropriate) into the deaths of persons in Queensland. All Queensland Government agencies cooperate and participate in these investigations when required.

Reportable deaths are deaths where:

- the person's identity is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a 'cause of death' certificate hasn't been issued and isn't likely to be
- the death was related to health care
- the death occurred in care, custody or as a result of police operations.

1 Hochstadt, N 2006, 'Child Death Review Teams: A Vital Component of Child Protection', *Child Welfare*, vol. LXXXV, iss. 4, pp. 653–670, p. 659.

Further information regarding other agencies' child death review mechanisms can be found in Appendix A.

The review and investigation processes carried out by Child Safety Services and the Department of Health are introduced in the following paragraphs. They are examined in more detail later in the chapter.

Child protection services

The *Child Protection Act 1999* establishes a two-tier system for reviewing Child Safety Services' involvement with children and young people who have died:

- Tier one is an internal review, known as a systems and practice review—with examination by the Child Safety Services Systems and Practice Review Committee
- Tier two is an external review of the systems and practice review by a child death case review panel.

These are explained in more detail later in this chapter.

The purposes of both reviews are to:

- bring about ongoing learning and improvement in departmental service provision
- identify departmental accountability.

Health services

Queensland Health includes the Department of Health and 16 hospital and health services, which are statutory bodies governed by hospital and health boards. The Department of Health is responsible for the overall management of the public health system in Queensland—including monitoring of performance, strategy and planning. Individual hospital and health services provide public health services—including child health services.

Queensland Health does not currently have any legislative or policy requirement to review its own involvement with public hospital and health service patients who have died. However, depending on the circumstances in which the death occurred, there are two options available for an internal review of those deaths. Neither is mandatory.

The chief executive of Queensland Health or of a hospital and health service may commission:

- a health service investigation under Part 9 of the *Hospital and Health Boards Act 2011*
- a root cause analysis under Part 6 of the *Hospital and Health Boards Act 2011*.

The chief executive can also request a clinical review, which includes an assessment of whether a health service provided to a person was in accordance with recognised clinical standards.

These are explained in more detail later in this chapter.

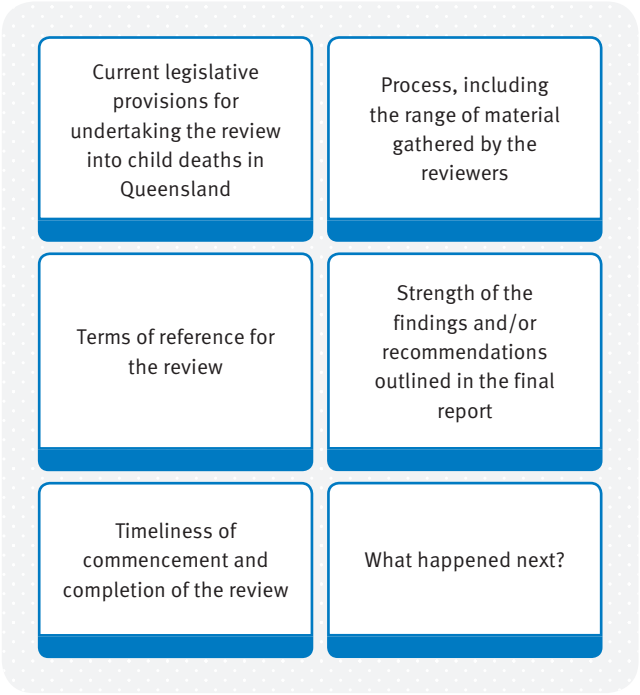
Analysis of the reviews and investigation

Child death case reviews allow staff and stakeholders to intensely examine what has happened and make the necessary changes to practices and systems. The objective is to make sure that, as much as possible, no child dies in the same circumstances in future.

The Queensland Family and Child Commission (QFCC) review focuses on identifying system improvements for the child death case review process.

The QFCC framework

The QFCC used the following framework in analysing each of the two reviews and the investigation.



Key findings

Child Safety Services

The terms 'the department' and 'Child Safety Services' are used interchangeably throughout this chapter depending on the nature of discussion or reference source.

Tier one—systems and practice review

Current legislative provisions for undertaking the review into child deaths in Queensland

Section 246A of the *Child Protection Act 1999* (the Act), requires the chief executive of the Department of Communities, Child Safety and Disability Services to review the department's involvement with a child, where the child was known to the department one year before the child's death.

Given that Mason Jet Lee was known to Child Safety Services at the time of his death, the department was legally required to review its actions.[2]

Terms of reference for the review

The department must decide the extent of, and terms of reference for the review.[3] The Act outlines that the department may consider:

- the nature of the department's involvement with the child and its relevance to the cause of death
- whether the department's involvement with the child and family complied with legislation and policies
- the adequacy and appropriateness of the department's involvement with the child and family
- the sufficiency of the department's involvement with other entities involved
- the adequacy of legislation and policies relating to the child
- making recommendations and suggesting strategies to put them into effect.

2 *Child Protection Act 1999*, s. 246A.

3 *Child Protection Act 1999*, s. 246B.

While legislation only requires the department to review their involvement with a child 'where the child was known to the department in the year prior to their death'[4], the department's terms of reference for a child death review process stipulates a **two-year review period.**[5]

The terms of reference for the systems and practice review were:

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

Child Safety Services uses these terms of reference for all its systems and practice reviews. While the terms of reference are broad and not specific to Mason's case, the resultant review plan sufficiently considered the practice, actions taken, and rationales for the actions.

4 Department of Communities, Child Safety and Disability Services, '10.19: Systems and Practice Reviews following the serious physical injury or death of a child', *Child Safety Practice Manual*, https://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-19-systems-practice-reviews-following-serious-physical-injury-or-death-child, accessed 10 March 2017.

5 Department of Communities, Child Safety and Disability Services, *Queensland Child death case review panels Annual Report 2014–15*, https://www.communities.qld.gov.au/resources/childsafety/child-protection/child-death-case-review-panel-annual-report.pdf, accessed 10 March 2017, p. 16.

The Child Safety Practice Manual notes that the department conducts three types of review: detailed, limited and brief. The associated procedure sets out the terms of reference for these reviews:

- Detailed and limited reviews
  - review the department's service delivery in the two years prior to the child's injury or death with a focus on ensuring continuous improvement of service delivery, public accountability and improved outcomes for children
  - for Aboriginal and Torres Strait Islander children, consider whether practice decisions enabled the child to receive services in a culturally appropriate manner. A cultural consultant will provide advice regarding culturally appropriate practice throughout the review process.
- Brief reviews summarise the department's service delivery to the child in the two years prior to the child's death or serious physical injury.

The department conducts a **detailed review** when:

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

It conducts a **limited review** when using resources to conduct a detailed review is not justified and:

- there is limited potential for identifying and modifying decision-making or practice issues, or
- there is limited educative value in conducting a more detailed review.

It conducts a **brief review** when there is no probable link between departmental decisions or practice and the injury or death of the child, and in the last year any of the following applied:

- the child was only listed as an 'other child' in all events
- the child had a client profile recorded but it was not linked to any events
- the child was only known to the department in relation to Intake Enquiries
- involvement with the family primarily occurred under the *Adoption Act 2009* but placement of the child may have occurred under the [*Child Protection*] Act
- the only involvement was limited to one Child Concern Report
- the only action taken by the department resulted from the incident leading to the child's death or serious physical injury.[6]

The QFCC supported the decision of the department to conduct a detailed review. The department applied sufficient scrutiny according to the circumstances of Mason's death.

Timeliness of commencement and completion of the review

Mason died on 11 June 2016. Child Safety Services completed its systems and practice review on 18 November 2016, less than six months later.

This review was finalised within the legislative timeframe.

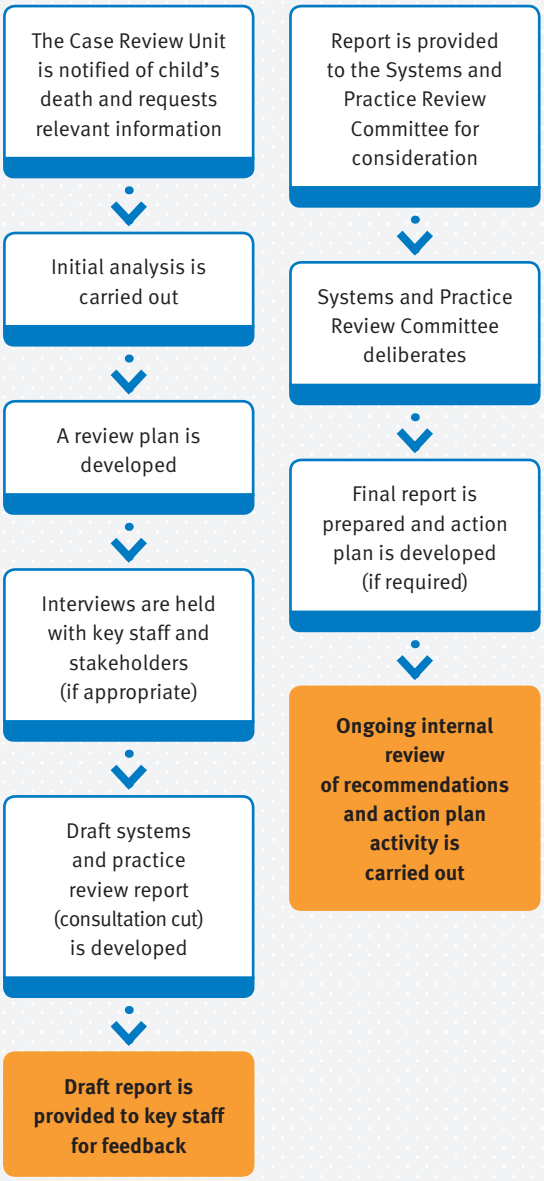
Process, including the range of materials gathered by the reviewers

The QFCC concludes that the department operates an established and thorough internal child death review process. This process was suitably prioritised for the review of Mason's case.

6 Department of Communities, Child Safety and Disability Services, '10.19: Systems and Practice Reviews following the serious physical injury or death of a child', *Child Safety Practice Manual*, https://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-19-systems-practice-reviews-following-serious-physical-injury-or-death-child/key-steps/2-decide-type-review, accessed 10 March 2017.

The systems and practice review process occurs in two phases, as shown in Figure 1:

Figure 1



Case Review Unit—request for information

In accordance with departmental policy, the Case Review Unit (review team) was notified of Mason's death on 15 June 2016 through an internal critical incident report. On receipt of this report, the review team began to review the department's involvement with Mason and his family.

Case Review Unit—initial analysis

The review team completed an initial analysis of actions, decision-making points, notable events and preliminary practice considerations (chronology) related to the department's service delivery to Mason and his family. This initial analysis assists the review team to determine what further information or discussion is required to guide the review process.

The following documents were prepared by the review team to inform the systems and practice review considerations:

- *de-identified chronologies*—information sourced directly from case files and including key information or actions undertaken by Child Safety Service staff and other professionals
- *systems and practice review*—child death review plan (the review plan)—information outlining Child Safety Services' process for undertaking the review.

Together, these documents provide a detailed and comprehensive background and timeline of Mason's life and outline the extent of Child Safety Services' actions in relation to Mason and his family.

> The chronologies provided a comprehensive narrative of the varying involvements the department had with Mason and his family. It included key details and information relating to the decision-making of Child Safety Services staff, including subsequent outcomes, and provided a strong foundation for considering systems and practice issues.

Case Review Unit—review plan

The review plan, which was provided to the QFCC for review and comment, included more specific details to support the review process. Specifically, the plan provided:

- an initial analysis of the practice under review, including preliminary considerations by the review team relating to initial concerns and areas for further consideration
- recommendations regarding the systems and practice review terms of reference and methodology.

On 29 September 2016, the QFCC provided feedback to the department regarding the review plan, requesting a small number of additional considerations, including further exploration of the engagement and correspondence with Queensland Health.

The review plan was thorough and outlined the required steps to inform further review discussions.

Interviews with key staff and stakeholders

In accordance with the review methodology, the review team sought additional case-specific and contextual information from departmental staff. The review team held discussions with:

- departmental staff and other professionals involved in the delivery of services to Mason or his family
- departmental staff and other professionals in line management roles or those who could provide relevant contextual information about the period under review.[7]

Departmental records indicate 32 individuals were interviewed as part of the review process.[8]

The review team was unable to hold discussions with all relevant staff as some were not available at the time of interview or were no longer employees of the department.

Case Review Unit—draft Systems and Practice Review Report and natural justice

On conclusion of the initial investigations, the review team drafted a *Systems and Practice Review Report* (the review report) for the Systems and Practice Review Committee.

The review report included an overview of key practice decisions affecting the department's service delivery to Mason.

In the interests of natural justice, the review report (consultation cut) was provided to the departmental staff who participated in the discussions for their review and comment.

The review team also consulted staff to seek feedback on the review report and to share the learnings from it.[9]

The review team provided a comprehensive analysis of practice issues identified in the review plan to support the deliberations of the Systems and Practice Review Committee. The investigations and the preparation of materials appeared to be thorough and timely.

Child Safety Services' Systems and Practice Review Committee

Child Safety Services' Systems and Practice Review Committee (the committee) oversees all systems and practice reviews. The committee considers all reviews before they are finalised and is responsible for making findings and recommendations in the final reports.

The committee's terms of reference are to consider:

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

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

7 Queensland Government, *Detailed Systems and Practice Review Report*, 206, CONFIDENTIAL, p. 15.

8 Queensland Government, *Detailed Systems and Practice Review Report*, 206, CONFIDENTIAL, pp. 12–13.

9 Queensland Government, *Detailed Systems and Practice Review Report*, 206, CONFIDENTIAL, pp. 16–17.

The committee met on 9 November 2016 and considered the review report and the identified learnings. Mason was the only child discussed at the meeting.

The committee was made up of:

- Executive Director, Practice Leadership Unit
- Manager, Practice Leadership Unit
- Director, Child Protection Service System Redesign, Child Protection and Adoption Design and Commissioning
- Manager, Violence Against Women Prevention Commissioning
- Manager, Clinical Innovation and Governance, Disability Services
- Director, Case Review Unit
- Manager, Case Review Unit
- Principal Review Officer, Case Review Unit
- Manager, Workforce Capability, Child Safety Training
- Regional Director, South West Region
- Regional Director, North Coast Region
- Regional Director, Brisbane Region
- Director, Placement and Service Support, North Coast Region.

The QFCC was invited to attend the Systems and Practice Review Committee as an observer.

The QFCC observed that the committee's discussions were appropriately focused on the draft review report findings.

After the meeting, the QFCC queried why the committee did not critically reflect on a number of practice issues identified in the draft report. The committee advised that all of its members had read the report and considered the practice issues to be thoroughly addressed in it and confirmed by the committee. They also advised that their focus was on the identified gaps in the report and on analysing and discussing the findings.

Final report and action plan

Following the committee meeting, the Case Review Unit prepared the *Mason Lee—Systems and Practice Review Action Plan* (the action plan) and circulated it to relevant staff.

The action plan included:

- an overview of the actions identified in the internal review process
- a detailed status update relevant to each identified action
- the assignment of a responsible officer to each action
- proposed action completion dates.

A de-identified copy of the review report was also provided to:

- all staff who participated in the review process
- the Executive Director, Child and Family Practice and Service Improvement—to inform practice leadership as appropriate
- the Director, Organisation and Workforce Development—to be considered in learning and development as required
- the Executive Director, Child and Family Reform Projects—to inform relevant program development and the Child and Family Reform Agenda.[10]

A full copy of the review report was provided to the departmental delegate to determine whether the referral of individual staff to the Ethical Standards Unit was required.

The final *Systems and Practice Review Report*, which included the deliberations and findings of the committee, was provided to the QFCC on 18 November 2016.

The department must provide its final review report to the external child death case review panel within six months of the date of a child's death or serious physical injury. It met this requirement.

10 Queensland Government, *Detailed Systems and Practice Review Report*, 206, CONFIDENTIAL.

When the review team is notified of a child's death, it is required (by policy and procedure) to immediately request information from the relevant regional director and Child Safety Service Centre or Regional Intake Service.

The material requested, in all instances, includes:

- all paper files, including intake records, hand written case notes and case plans
- Suspected Child Abuse and Neglect team minutes and files
- Information Coordination Meeting records
- relevant Child Safety Services' emails
- any accessible records kept within data management and record keeping systems managed by the department, including historical records
- any files held at regional office level, including Ministerial and executive correspondence
- archived files
- court files
- carer files
- supervision files.

In addition, the *Child Protection Act 1999* s. 246C allows Child Safety Services to request information from other entities about the child, providing the information is relevant to the child's protection or wellbeing while the child was alive.[11]

The review team requested, and was provided with, additional information from the Office of the State Coroner, the Queensland Police Service, Queensland Health and service providers from the non-government sector.

The QFCC notes that the department requested information from other agencies; however, the information was limited to what the review team and the committee knew to ask for. In the absence of access to other agencies' records and the mandate for those agencies to provide them, the review team and committee may not be aware of additional information to support their report. It is at the agencies' discretion as to what information is provided if not explicitly requested.

Strength of the findings and/or recommendations outlined in the final report

On receipt of the draft *Systems and Practice Review Report*, and following discussion, the Systems and Practice Review Committee made a number of key findings and recommendations.

The QFCC believes the findings and recommendations as they relate to the service delivered to Mason were appropriate.

Given there are criminal proceedings and a coronial matter pending, the QFCC is unable to provide details of the findings and recommendations as they relate to Mason. The following information is from observations at the meeting and further discussion with departmental representatives regarding the process of child death reviews.

Further finding for the department's consideration—individual accountability

In reviewing Mason's case, the Systems and Practice Review Committee considered that it did not have sufficient information to be able to decide whether it needed to recommend action for individual accountability. The committee forwarded the concerns to the delegate to determine whether a referral to the Ethical Standards Unit was required.

This is despite its terms of reference specifically including:

- accountability of officers involved in the case
- whether any practice issues amount to misconduct and require referral to the Ethical Standards Unit.

The committee has the ability to determine the individual accountability of employees. Accordingly, it should be provided with enough relevant information to do so.

11 *Child Protection Act 1999*, s. 246C.

What happened next?

As mentioned before, the department developed the *Mason Lee—Systems and Practice Review Action Plan* (the action plan) following the Systems and Practice Review Committee meeting. The action plan identified the recommendations made by the committee and assigned timeframes and a responsible officer to each of these.

A total of 13 actions were identified following the meeting, with the department advising that seven have been completed and the remaining six are underway, with anticipated completion by June 2017. Actions were identified for the region, the state and central office.

The QFCC noted that the department has reported progress on the actions outlined in the action plan. The QFCC also noted that while a number of findings and recommendations were made specifically about the particular region's service delivery, a number of these have been expanded statewide and the scope increased.

The department reports that it will continue to take necessary action to strengthen practice and operational management in Child Safety Service Centres.

The QFCC supports driving improvements to practice and quality of child protection operations, processes and systems. A dedicated focus on support, supervision, critical thinking and analysis in case related decision-making is required across the state.

Tier two—child death case review panel

Current legislative provisions for undertaking a review into child deaths in Queensland

For each tier one systems and practice review, the Minister for Child Safety must establish a child death case review panel or nominate an existing panel to independently review the department's involvement with the case, including reviewing the systems and practice review report and other relevant documents. (A panel may review one or more systems and practice review reports at once.)

The purpose of the independent review, as outlined in the *Child Protection Act 1999 s. 245,* is to facilitate ongoing learning and improvement in the provision of services and promote accountability by the department.

The *Child Protection Act 1999*, Chapter 7A, Part 2 outlines the requirements for child death case review panels. These provisions were amended and included in the *Child Protection Act 1999* as a result of the repeal of the *Commission for Children, Young People and Child Guardian Act 2000* in 2014. The statutory requirement for parliamentary tabling of annual reports was also abolished at this time.

On 15 September 2016, the Minister for Child Safety appointed six representatives to child death case review panel 31 (the panel). As required, the minister appointed representatives in line with the following professional experience and qualifying criteria:

- *at least three persons who are not public service employees and who the Minister is satisfied have specialist knowledge and experience in child protection issues:*
  - a Professor of Child and Family Research at a Queensland university, who has 30 years of experience as a social work practitioner, researcher, and educator
  - a lecturer in Indigenous Nursing, who is also an Aboriginal researcher at a Queensland university, and a community representative on a Human Research Ethics Committee
  - an independent consultant who specialises in developing services, programs and training in relation to domestic violence and sexual assault and who is a board member of the Domestic Violence Death Review Action Group and Research Advisory Committee
  - a practising neonatologist who is also currently the Foundation Professor of Perinatal Medicine at a Queensland university and who has 20 years of experience in perinatal and clinical research

- *at least one, and no more than three, public service officers employed in the department*
  - a Child Safety Services representative from the Office for Women and Domestic Violence Reform
- *at least one public service officer (senior executive or senior officer level), from a department other than the department responsible for administering the Child Protection Act 1999*
  - a senior representative from the Child Safety and Sexual Crime Group, State Crime Command in the Queensland Police Service.

Panel 31 was specifically convened to review Mason's case.

Terms of reference for the review

Each review panel must decide the extent and terms of reference for its review, consistent with s. 246DB of the *Child Protection Act 1999*. These may include:

- a matter within the original (tier one) review's terms of reference
- ways of improving the department's practices
- ways of improving the relationship between the department and other entities
- whether disciplinary action should be taken against a departmental employee.

The panel endorsed the following terms of reference:

1. Do the learnings and key issues (and any recommendations or actions to improve service delivery) identified in the department's review require the panel to make additional findings or take further action?
2. Is there any further policy or practice improvement that may assist officers in achieving better outcomes for children?
3. Are there any opportunities to improve relationships between the department and other entities with functions involving children or families?
   - Did the case and/or issue require inter-agency service delivery?
   - Were the coordination efforts appropriate?
   - Were there alternative options?
   - Is action recommended in relation to the child protection system as a whole?
4. Is any action required in response to the conduct of any public service employee of the department?

The QFCC notes that the panel adopted the terms of reference to ensure a targeted discussion regarding actions recommended in relation to the child protection system as a whole, and actions required in response to the conduct of any public service employee. The terms of reference were sufficient to direct discussion and to determine appropriate findings and recommendations.

Timeliness of commencement and completion of the review

The Minister for Child Safety appointed the panel on 15 September 2016.

Child Safety Services provided the panel with its final systems and practice review report on 18 November 2016. The panel convened on 5 December 2016.

The panel provided its final report to Child Safety Services on 17 January 2017, well within its six month timeframe.

Process, including the range of material gathered by the reviewers

The process

The QFCC believes that the child death case review panel's process, while meeting its legislative requirements, was constrained by its inability to access information from other agencies to inform its findings and recommendations.

The process for undertaking a child death case review panel is represented in Figure 2:

Figure 2

The process involved each panel member reading Child Safety Services' *Systems and Practice Review Report* and a detailed case chronology that contained excerpts from case records, and which covered all of the department's involvement with the subject child and the child's family. The panel did not review all the original records considered by the systems and practice review or transcripts of discussions with relevant officers. The only case-related materials assessed were the chronologies, timelines and the *Systems and Practice Review Report*.

The *Child Protection Act 1999* does not require panels to make recommendations to the department or require the department to monitor and report on action taken in response to panels' reports.

The department provides the panel's final report and its response to the Minister for Child Safety.

When a panel reviews a reportable death of a child, the department must also provide a copy to the Office of the State Coroner.

The material

In addition to the final *Systems and Practice Review Report* and the case chronology, Panel members were provided with information to inform their discussion, including:

- a research article relating to findings from United Kingdom death reviews (this was circulated by the Chair)
- practice papers and information available to Child Safety Services' staff
- a Circles of Safety and Support booklet (information on risk factors)
- medical articles
- the *Mason Lee—Systems and Practice Review Action Plan*.

The child death case review panel did not have the benefit of considering any other agency's internal review report, which is unfortunate. Queensland Health provided services to Mason before his death and was undertaking a review, but it was not required to provide its health service investigation report to the panel.

In Mason's case, other government agencies had minimal involvement with him prior to his death. However, there is benefit in the child death case review panel having access to comprehensive, timely in-house reviews conducted by each agency involved. This would reflect the government's position that child protection is everyone's responsibility.

Strength of the findings and/or recommendations outlined in the final report

The panel noted that the *Systems and Practice Review Report* was comprehensive, and that it critically analysed the information gathered to capture the complexity of the case and the many practice issues identified.

The panel noted that problems in this case were repeatedly found in child death inquiries in other jurisdictions.

The QFCC was invited to attend the child death case review panel as an observer.

Given that there are criminal proceedings and a coronial investigation scheduled, the QFCC is unable to provide details of the findings and recommendations as they relate to Mason.

The QFCC observed that the panel made a number of general comments and recommendations regarding the department's service delivery to Mason. The findings and the proposed recommendations were the outcome of robust and considered discussion by the panel. The meeting lasted a number of hours, and the commitment of those in attendance was demonstrated through the insight and responses provided.

Further observation—individual accountability

The child death case review panel's terms of reference (4) required it to consider the individual accountability of public service employees. The *Child Protection Act 1999* s. 245(3)(b) states that one of the purposes of the review is to 'promote the accountability of the department'.

The panel found that there was insufficient information available to determine that further action was required in relation to any individual worker.

However, the panel is able to ask for further information under the *Child Protection Act 1999 s. 246DA* to allow it to conduct further review into matters such as whether disciplinary action should be taken against an individual of Child Safety Services.

Regardless, the department is best placed to consider what disciplinary action (if any) is required and what the legislative and policy impacts are.

While practitioners must be held accountable when malpractice is proven, this is a matter for employer-led disciplinary processes and must not be confused with acknowledging the mistakes that inevitably arise because of the inherent uncertainty in child protection work.[12]

Caution needs to occur to make sure that malpractice is not confused with a lack of practice knowledge and application. This is a determination for the employer to make.

12 Munro, E 2011, *The Munro review of child protection: part 1— a systems analysis*, https://www.gov.uk/government/publications/munro-review-of-child-protection-part-1-a-systems-analysis, accessed 10 March 2017, p. 39.

What happened next?

The child death case review panel made a number of findings for the consideration of Child Safety Services. Child Safety Services endorsed the findings and made sure appropriate actions were detailed in the *Mason Lee—Systems and Practice Review Action Plan*.

Child Safety Services' implementation of actions in response to the internal and external review recommendations will be overseen by the agency's Performance and Reform Committee and reported regularly to the director-general and the Minister for Child Safety. The agency will also brief the Interdepartmental Coordination Committee on key findings and actions.

Queensland Health's investigation

Current legislative provisions for undertaking a review into child deaths in Queensland

Queensland Health does not currently have any legislative or policy requirement to review its own involvement with public hospital and health service patients who have died. However, depending on the circumstances in which the death occurred, there are two non-mandatory options available for reviewing those deaths.

As mentioned earlier in this report, the chief executive of Queensland Health or of a hospital and health service may commission:

- a health service investigation under Part 9 of the *Hospital and Health Boards Act 2011*
- a root cause analysis under Part 6 of the *Hospital and Health Boards Act 2011*.

Before July 2014, the former Health Quality and Complaints Commission's *Review of hospital-related deaths standard* required a review of all hospital-related deaths, including where deaths occurred:

- in public hospitals, licensed private hospitals or day hospitals
- in public or private emergency departments, pre-admission clinics and outpatient clinics
- within 30 days of a patient being discharged or attending a hospital for clinical care.

The standard required a review of all deaths:

- by a clinical team—within two weeks of the death
- by an independent peer reviewer and/or mortality review committee—within eight weeks of the death in circumstances where
  - there was a concern or complaint about the deceased person's care, or
  - a root cause analysis was commissioned, or
  - multiple clinical units were involved in the deceased person's care
- externally—by the coroner, Queensland Police Service, Health Quality and Complaints Commission or other relevant entity.

The chief executive may request a clinical review, which includes an assessment of whether a health service provided to a person was in accordance with recognised clinical standards.

Health service investigations

Chief executives of Queensland Health may appoint health service investigators to investigate and report on the management, administration or delivery of public sector health services.

Chief executives give investigators an instrument of appointment. This sets out the scope of the investigation and any conditions of the appointment and limits on the investigators' powers. It also outlines the specific services the investigators must review, and any relevant timeframes.

Investigators have broad powers to conduct their investigations. These include access to health service facilities and the power to request information from Queensland Health employees. There are penalties for giving false and misleading information or obstructing an investigator.

Investigators must prepare a report on their investigation. In doing so, they have to consider any report previously provided by a clinical reviewer. The investigators' report may include recommendations on ways to improve the administration, management or delivery of public sector health services.

Division 3 of the *Hospital and Health Boards Act 2011* sets out the provisions for 'Clinical reviews'. Section 124 sets out the functions of a clinical reviewer. This includes conducting a review and providing expert clinical advice to:

- the chief executive or a health service chief executive
- a person or entity whose role includes maintaining and improving the safety and quality of public sector health services
- a health service investigator.

After considering the investigation report, a chief executive may issue a direction to a hospital and health service. It must comply with this.

Root cause analysis

A root cause analysis is a quality improvement technique used to assess and respond to reportable events that happen while a health service facility is providing a health service. It identifies:

- factors contributing to the reportable event
- remedial measures that could be implemented to prevent recurrence of a similar event.

A root cause analysis does not include:

- investigating the professional competence of a person
- finding out who is to blame for the reportable event.

'Reportable events' only include deaths occurring while the health service is being provided.

Chief executives of Queensland Health may appoint a root cause analysis team to review a reportable event. The *Hospital and Health Boards Act 2011* includes the following principles to guide root cause analysis:

- reporting and acknowledging errors is encouraged if people do not fear blame or reprisal
- people involved in providing health services should be accountable for their actions
- the focus should be on identifying and improving the policies, procedures or practices about the health service that contributed to the event, rather than on the conduct of individuals
- participation should be voluntary
- benefits will be maximised
  - in an environment oriented towards learning from analysing the event
  - if the root cause analysis is timely
- teamwork, good communication and information sharing should be fostered.

Queensland Health chose to conduct a health services investigation. The QFCC endorsed this choice.

Terms of reference for the investigation

The terms of reference required the investigators to investigate and report on matters relating to the management, administration and delivery of public sector health services provided to Mason Jet Lee by Queensland Health.

The terms of reference were to:

a) review the patient records for Mason and any documents, including reports, file notes and telephone records, whether held on Mason's patient record or not, created or received by staff at the Caboolture Hospital and the Lady Cilento Children's Hospital in relation to Mason

b) review the decisions and actions taken by Queensland Health staff at both the Caboolture Hospital and the Lady Cilento Children's Hospital

c) develop a sequence of key events and significant clinical decision-making points relevant to the clinical management of Mason, and of communications between staff of the Caboolture Hospital and the Lady Cilento Children's Hospital in relation to Mason

d) review the admission, examination, assessment, diagnosis, treatment, discharge, post-discharge follow-up and overall management of Mason

e) review the effectiveness of liaison between relevant hospital and health services regarding the assessment, care and treatment of Mason, including any post-discharge care and follow-up arrangements

f) review the effectiveness of communications and liaison between Queensland Health and other government agencies (in particular, Child Safety Services) or other relevant organisations in respect of Mason

g) review the interactions between persons involved in Mason's family life and staff at the Caboolture Hospital and the Lady Cilento Children's Hospital and the impact those interactions had, or ought reasonably have had, on the care, discharge and post-discharge follow-up arrangements for Mason, including, to the extent considered necessary by the health service investigators

   - review the patient records of any member of the immediate family of Mason
   - review any documents, including reports, file notes, telephone records and communications with external agencies, whether held on patient files or otherwise, created or received by staff at the Caboolture Hospital and the Lady Cilento Children's Hospital
   - obtain information relating to such interactions

h) review the compliance or non-compliance with policies and procedures (both statewide and local) applying in relation to the care and treatment of the patient, including those relating to child protection and child safety

i) consider whether the content and level of compliance with existing legislation, policies and/or procedures had any impact on the standard and quality of care provided to Mason.

The terms of reference also required that the investigators make findings about:

a) the adequacy of the management, administration or delivery of the public sector health services to Mason, including the adequacy of relevant training practices of Queensland Health, the Caboolture Hospital and the Lady Cilento Children's Hospital and whether such was reflective of reasonable practice

b) the compliance or otherwise with relevant legislation, policy or process

c) whether the standard of care for Mason met the required standard of competent professional practice, and if it did not, the respects in which it fell below that standard

d) any other relevant matter identified during the course of the investigation.

The Director-General, Queensland Health provided the investigators with appropriate powers under the terms of reference, in line with legislation, to both request information and to interview employees of Queensland Health as appropriate.

Timeliness of commencement and completion of the investigation

In September 2016, the director-general appointed three investigators to investigate the delivery of public sector health services provided to Mason. They were appointed in line with Part 9 of the *Hospital and Health Boards Act 2011*.

The investigators appointed were a health consultant with a wealth of experience in health service reviews and policy, a professor of paediatrics and child health and a director of paediatrics.

The QFCC notes and recognises the diverse experience and expertise of the investigators.

The health service investigators finalised their report in December 2016. Queensland Health provided a copy to the QFCC in confidence on 9 December 2016.

Queensland Health undertook a timely investigation. The investigation report was detailed and addressed the terms of reference.

Process, including the range of material gathered by the reviewers

The process

The process for undertaking the health service investigation is represented in Figure 3:

Figure 3

Queensland Health provided the health service investigators with a brief of documents upon appointment. Further information was requested by the investigators throughout the course of the investigation.

Interviews were undertaken with relevant staff in person or via the telephone. The interviews were recorded and transcribed, and interviewees were offered a copy of the recording if they wanted one.

Investigators also offered interviewees an opportunity to respond if there were any adverse comments.

The material

Information reviewed included:

- legislation, policies, procedures and guidelines relevant to
  - reporting and responding to child abuse and neglect suspicions
  - information sharing in child protection
  - care and treatment orders for a child
- clinical records
- the Suspected Child Abuse and Neglect team's electronic files
- instruments of delegations
- correspondence with external agencies including the QFCC and Child Safety Services
- child protection training resources.

The investigators also interviewed individuals they considered may be able to provide information relevant to matters within the terms of reference.

Strength of the findings and/or recommendations outlined in the final report

The Department of Health (Queensland) health service investigators made a number of findings in their final report. In accordance with the terms of reference, they made no recommendations.

The QFCC believes the findings in relation to Queensland Health's service delivery to Mason were appropriate.

Further finding for Queensland Health's consideration:

Children's Health Queensland is a specialist statewide hospital and health service dedicated to caring for children and young people from across Queensland and Northern New South Wales. It delivers a full range of clinical services, tertiary level care and health promotion programs.

The QFCC suggests that any internal reviews undertaken by Queensland Health regarding service delivery to children draws on the expertise of Children's Health Queensland.

What happened next?

The health service investigation report identified some areas for improvement.

As a result of these findings, Queensland Health provided a copy of the health service investigation report to relevant hospital and health services to inform practices and processes. Extracts of the report were also provided to Child Safety Services to assist in understanding agency interactions from a health perspective. A copy of the report is to be provided to the coroner.

Queensland Health is also using the health service investigation report to inform the development of statewide policies, guidelines and procedures in respect of child safety.

The QFCC conclusions from the analysis of the reviews

The reviews and the investigation conducted were satisfactory and complied with the agencies' terms of reference and legislative requirements.

The individual agency reports provided an analysis of agency actions and made adequate findings and recommendations.

The QFCC does not believe that this is enough.

Individual agency reports undertaken in isolation do not allow for a systemic analysis in considering the prevention of child deaths.

The different agency responses and frameworks impact on the development of a coherent and whole-of-government review process and the embedding of a shared culture to protect children and ensure their safety.

The reviews and the investigations were thorough, robust and timely, but undertaken independently and in isolation from each other. The current systems do not encourage verification of key points of agency interaction and service delivery.

There is an opportunity to strengthen and streamline these processes.

Government has a commitment in place to improve systems to keep children safe and well. All government agencies need to reflect this commitment.

When a child dies, agencies must respond collectively. They must recognise that no single agency can deliver what is needed, or influence the entire child protection system. They also need to genuinely believe they can deliver improved joint services. Real change will take commitment from all agencies and their staff, with systems in place to support this.

Accordingly, the government needs to invest in systems that promote the fact that child protection and children's safety is everybody's business. This should include:

- mandatory internal reviews by the agencies who have contact with a child who has died
- timely and required sharing of information between agencies
- recommendations from child death case review panels on amendments to legislation, policy and practice at a whole-of-system level
- whole-of-system commitment to acting on those recommendations, with expanded accountability for the implementation of any recommendations.

At present, those agencies that conduct internal reviews after the death of a child do not routinely share their findings with other agencies. None of the agencies make recommendations for whole-of-system improvements. This means opportunities for learning and change are being wasted.

The internal reviews of all involved agencies must be provided to the child death case review panel. This will give the panel more complete information on which to base its recommendations.

Government needs to be open and honest about deficiencies and failures to children and their families. This is not easy, but it offers the chance to treat failures (and successes) as opportunities to improve. It also offers opportunities to, as far as possible, prevent the deaths of other children.

Chapter 3

The past, present and future of Queensland's child death case review system

Just as a health system is more than hospitals, a system for the protection for children is more than a statutory child protection service.[13]

Media reports about Mason Jet Lee's death showed there is still a long way to go before it is recognised that protecting children is everybody's business.

Child abuse and child deaths have widespread impact on Queensland communities. This issue was rarely discussed in this past, but is now often front page news. The public is increasingly reluctant to allow government to address these issues behind closed doors. They want to see transparent and rigorous review processes, and they want to see action. They don't just see 'Accountability' as an action brought against an individual or agency. They now expect to see inquiries and whole-of-system changes.

When a child is in need of protection, Child Safety Services is responsible for delivering services to provide care and protection. However, most children also receive services such as education, health, allied health, mental health, child care services and non-government support services.

As child protection reflects the public health model of service delivery, emphasis is placed on involving other professionals, families and the wider community in providing protection. The public heath approach does not remove the responsibility of government to provide statutory child protection responses, but it does demand commitment from all parties to focus on, and evaluate the way they interact with children.[14]

Government is expected to protect children and to be answerable for child deaths where statutory services are involved. Systems must therefore be established that provide for accountability and responsiveness and for the prevention (as much as possible) of child deaths.

National Framework for Protecting Australia's Children

The National Framework for Protecting Australia's Children (the framework) provides a long-term strategy for the protection and wellbeing of children in Australia. It promotes a cultural shift from child protection being the sole responsibility of statutory child protection agencies to being a whole-of-community responsibility. The framework is underpinned by the message 'protecting children is everyone's business'. It represents an unprecedented level of collaboration between Australian, state and territory governments and non-government organisations, and places responsibility on governments to increase responsiveness to child protection matters.[15]

Several of the findings made throughout this report highlight the strengths and robustness of elements of the current child death case review process. Queensland continues to provide a strong internal case review model, allowing Child Safety Services to critically reflect on and improve its systems and practices. However, neither the internal case review model nor the current child death case review panel model considers or identifies improvements from a whole-of-system perspective. This encourages the view of child protection as the sole responsibility of Child Safety Services and limits information sharing.

13 Commonwealth of Australia 2009, *Protecting Children is Everyone's Business—National Framework for Protecting Australia's Children 2009–2020*, pp. 7–9.

14 Commonwealth of Australia 2009, *Protecting Children is Everyone's Business—National Framework for Protecting Australia's Children 2009–2020*, pp. 7–9.

15 Babington, B 2011, *National Framework for Protecting Australia's Children, Perspectives on progress and challenges*, Australian Institute of Family Studies.

History of reform

Section 159A of the *Child Protection Act 1999* expressly states that service providers are to

appropriately and effectively meet the protection and care needs of children and promote their wellbeing. They are to do this by coordinating the delivery of services to children and families by exchanging relevant information, while protecting the confidentiality of the information.

Over the last fifteen years, Queensland's approach to child death case reviews has been subject to three major reforms. Throughout each reform, the need for independence in child death case review processes has been apparent. See Appendix B for further details on child protection reform in Queensland.

In 2002 and 2003, the Queensland Ombudsman conducted investigations into the deaths of two children known to the Department of Families—Brooke Brennan and Baby Kate.

Each investigation recommended establishing external oversight of child death reviews. This involved an entity external to the department being responsible for:

- monitoring and reviewing child death investigation processes
- appointing members to conduct reviews
- directing whether a child death review be conducted
- making recommendations to agencies with child protection responsibilities about policies and procedures to prevent or reduce child deaths.

In January 2004, the then Crime and Misconduct Commission released its report *Protecting Children: an inquiry into the abuse of children in foster care*. The report echoed the need for an independent review mechanism to scrutinise the circumstances following the death of any child known to child protection services.

In August 2004, the former Commission for Children and Young People and Child Guardian established the independent Child Death Case Review Committee. The committee's role was to oversee Child Safety Services' internal child death reviews and make recommendations to improve service delivery to children and young people.

In July 2013, the Queensland Child Protection Commission of Inquiry released its report *Taking Responsibility: a roadmap for Queensland Child Protection*. The report included a recommendation to establish an external review panel to oversee the reports of the investigation team instead of the Child Death Case Review Committee. The report stressed the benefit of independence and multidisciplinary expertise in child death review processes. It also recommended a two-tier process review system.

In 2014, the Queensland Government introduced legislation to abolish the Commission for Children and Young People and Child Guardian and to amend and transfer the relevant provisions into the *Child Protection Act 1999*.

The decision was made to introduce the child death case review panels, with members appointed by the Minister for Child Safety.

In July 2014, the new child death review processes recommended by the Queensland Child Protection Commission of Inquiry commenced. This included the current two-tier system for reviewing departmental involvement with children and young people who have died or suffered serious physical injury.

Review of current model

In 2015, the Minister for Child Safety tasked the Department of Communities, Child Safety and Disability Services to engage Quality Innovation Performance Consulting (QIPC) to review the model following its first year of operation. During this period, 23 panel members and 7 different chairs were involved in 11 panels.

QIPC found the model had several significant strengths including that:

- everyone involved was passionate and committed to improving outcomes for children
- systems and practice reviews were guided by clear documentation and effective practices
- there were good working relationships between the external child death case review panels and the secretariat
- the grouping of cases into themes allowed panels to have high levels of expertise in those areas
- the diversity of panel members brought a broad range of experience and perspectives.

However, QIPC also reported that as all panel members were new to the role, they did not know each other. A number of panel members, while experts in their field, had limited knowledge of the child protection system. This led to panel reports of varying quality, limiting their usefulness for Child Safety Services.[16]

QIPC also highlighted some challenges and areas for improvement and made recommendations to address them.[17] Many of these challenges are reflected in Child Safety Services' reviews of their service delivery to Mason Jet Lee. Child Safety Services is now implementing those recommendations.

QIPC found that, in terms of the governance and operations of the panel:

- the *Child Protection Act 1999* gives the Minister for Child Safety authority to appoint panel members and establish panels but does not give the Minister any powers to direct a panel's performance or the way it conducts its business. Although this may have been intended to reinforce the independence of the panels, in the absence of any direction by the Minister there is currently no identified person or structure responsible for overseeing the operation of panels or leading their practice
- governance of the panels was problematic in the first year of operations—panel members and secretariat staff identified a need for guiding documentation, but without clear decision-making authority for the panel, it was (and is) difficult to see how these materials can be developed
- communication between the panels and Child Safety Services had also been problematic—no feedback had been provided to panels and they were unclear what action had been taken as a result of their reports and findings.[18]

QIPC found that, in terms of the roles and review methodology:

- the child death review system had dual purposes—learning/improvement and departmental accountability. This created process tensions between the compliance focus and the goal of fostering systems and practice improvements
- panel members had mixed understandings about their role and the role of systems and practice reviews.
- some members felt that in order to meet their accountability requirements they needed to review each individual case, while others took the view that they were providing independent oversight of the department's report as a whole
- it was difficult for panels to determine if any disciplinary action was required in relation to individuals—they were not given enough information to make these decisions.

16 Quality Innovation Performance Consulting 2015, *Review of systems for conducting reviews of child deaths and serious injuries.*

17 Quality Innovation Performance Consulting 2015, *Review of systems for conducting reviews of child deaths and serious injuries.*

18 Quality Innovation Performance Consulting 2015, *Review of systems for conducting reviews of child deaths and serious injuries.*

These findings are still relevant now.

QIPC found that, in terms of reporting:

- it was unclear who was responsible for writing and signing off panel reports
- in most cases, the secretariat drafted the reports, with feedback from panel chairs and members.

Individual accountability

QIPC also found that there were difficulties with panels' legislated role in determining if any disciplinary action was required in relation to public servants involved in child deaths or serious injury. This seems to have been a prompt for panel members to delve deeply into specific cases and focus on the decision-by-decision analysis.

However, in many cases, to properly make these determinations, panel members would need access to detailed information about:

- the circumstances in which the staff member's conduct occurred
- the performance and management of individual staff over time.

The exception may be clear cases of gross misconduct. However, it is unlikely that such cases would not already have been effectively actioned by the department.

The *Child Protection Act 1999* is clear that one of the purposes of both the systems and practice review and the child death case review panel is to promote *departmental* accountability. The current model calls for *individual* accountability.

In Mason's case, both the Child Safety Services' Systems and Practice Review Committee and the Child Death Case Review Panel found that there was not enough information to be able to determine whether further action was required in relation to any individual worker. In the absence of this information, this issue was appropriately referred to the delegate for action.

The QFCC agrees with QIPC that panels do not have enough information to determine individual accountability or enough resources to pursue these questions effectively despite it being in the terms of reference.

In designing the new model, there should be consideration of legislative amendments to remove this requirement. Decisions on accountability are the responsibility of the employer and coroner.

Feedback from the panels

Some chairs indicated that they did not have sufficient time to review the reports and were not happy with the quality of the end product. Panel members advised the Queensland Family and Child Commission (QFCC) that the department had not been clear or consistent in telling the panel the purpose of 'reviewing the review'. It was reported that some panels believed they needed to analyse and make a finding on each decision and other panels preferred a more broad-brush approach. The department said it leaves it up to the panel to determine the format of each meeting.

Despite the recommendation from the Queensland Child Protection Commission of Inquiry, findings from the QIPC report and existing review mechanisms, there remains arrangements that lack, at a systems level, sufficient agency linkages, timeliness, transparency and accountability.

Government needs to invest in review models that allow for a full and robust process of accountability for whole-of-system responses. There needs to be an opportunity for an independent body to review each of the relevant agencies' service delivery and their intersection points with other agencies in delivering services to children—to make sure that the system did the best it could to protect and care for the child.

Processes must be put in place to allow for:

- timely and comprehensive reviews by individual agencies involved in child protection
- cultural change that keeps children at the centre of business and thinking
- an independent child death review model with a mandate to
  - request and receive information in accordance with legislation
  - consider findings thoughtfully
  - make recommendations for whole-of-system improvements.

Having an independent body overseeing the reviews ensures recommendations are not subjected to influence by any one agency.

The way forward

The purpose of QFCC's review process was to ensure that all reviews and reports are able to deliver the outcomes and guidance needed to make system changes to protect our vulnerable children. They are not.

The opportunity to make significant whole-of-system changes, reflecting that child protection and children's safety is a shared responsibility, is being missed.

Research

There is limited research on child death review processes in Australia. In 2010, the University of New South Wales Law Journal published an article, *Legislation and child death review processes in Australia: Understanding our failure to prevent child death*.[19] The authors provided an overview of child death review practices in Australia at that time.

They found that to be effective and lead to accurate identification of causes of unexpected child deaths:

- a formal, multidisciplinary child death review team should be established. A multidisciplinary approach provides a range of perspectives to identify social, medical, economic, familial and agency factors. This is useful when considering the involvement of other agencies as well as the child protection authority
- the team should be independent—independence is essential so that the findings and recommendations are not influenced in favour of the government whose services are being reviewed
- the child death review team should be legislatively based—this is important to protect its independence
- preferably, the team should be located externally to the department responsible for child protection and attached to an office that is independent of government
- the team should have a broad scope of review when considering child deaths—it should have the capacity to evaluate the role of agencies or services involved (in addition to the child protection authority)
- the team should have a public reporting process. This is seen to contribute to the level of independence of the review body, as when findings and recommendations are made public, government is more accountable for acting on the issues identified.

Building the case for reform

The QFCC identified many positive features of Queensland's child death case review model, including that:

- Child Safety Services' internal review processes are comprehensive and effective at an agency level
- child death case review panels are established under legislation and members are from a variety of disciplines
- both Tier one and Tier two reviews include serious injuries and not just deaths
- both are empowered to consider learning and system improvements as well as departmental accountability issues—although in practice this has proven problematic.

19 Newton, R, Frederick, J, Wilson, E, Dibben, M and Goddard, C 2010, *Legislation and child death review processes in Australia: Understanding our failure to prevent child death*, University of New South Wales Law Journal, p. 987 (http://www.unswlawjournal.unsw.edu.au/sites/default/files/44_newton_et_al_2010.pdf).

However, in considering the best practice benchmarks identified by the University of New South Wales Law Journal[20], it is clear that the Queensland system has some additional deficiencies to those previously identified in the analysis. These include the following:

- Child death case review panels are not truly independent of Child Safety Services—they share the governance and administrative support.
- Panels are not sufficiently broad in scope—they only consider the final report of Child Safety Services' systems and practice review despite a lot of other information being available.
- Child death case review panels' requests for information from other agencies are undertaken via the secretariat in Child Safety Services. This could call into question the independence of the panel. Panels can only make findings or recommendations about other agencies (such as Queensland Health) in relation to their interface with Child Safety Services. Recommendations cannot be made directly to an agency.
- Panels cannot monitor and report on the implementation of their recommendations.
- Panels have no public reporting process outside of the annual report.
- Panels are not able to undertake own-motion reviews (ones they decide to do themselves) of systemic issues arising from individual child death reviews.
- Other agencies with involvement with children known to the child protection system are not compelled to undertake a review.

The QFCC consulted with a range of agencies across Australia that are responsible for independent child death review committees or panels in order to identify additional best practice for consideration in Queensland. Further information regarding this consultation can be found in Appendix C.

Key findings from this consultation include:

- There is strong correlation between independence, a broader scope of reviews, proactive analysis and parliamentary-tabled reporting processes; and transparency, accountability and systems change.
- Some agencies have noted successful systemic change within the medical, safety and wellbeing functions. This success seems to correlate with the ability of the external review panel to conduct own-motion and serious injury reviews.
- Successful statewide preventive strategies have resulted from using the evidence and learnings derived from collaborative child death review processes.
- Effective monitoring of recommendations from individual case reviews requires transparency and escalation when action is not taken.

Queensland's current child death case review process has provisions to review and consider serious injuries to children known to Child Safety Services. Whilst not in scope of the QFCC's review, this best practice initiative should continue.

20 Newton, R, Frederick, J, Wilson, E, Dibben, M and Goddard, C 2010, *Legislation and child death review processes in Australia: Understanding our failure to prevent child death*, University of New South Wales Law Journal, p. 987 (http://www.unswlawjournal.unsw.edu.au/sites/default/files/44_newton_et_al_2010.pdf).

The new model

Queensland's child death case review system has withstood 15 years of reform; however, the underlying principles, while consistent with national review processes, do not provide for a contemporary model of review—Queensland can do better.

Queensland requires a child death case review model that is independent and can make recommendations across government regarding service delivery for children who are known to the child protection system.

The system should reflect independence, shared commitment and culture around timeliness, transparency and accountability.

This means it must:

- continue to evolve
- be monitored and evaluated frequently
- lead to ongoing learnings
- be capable of having its scope expanded as necessary. For example, future consideration should be given to involving non-government agencies or other government agencies as part of the review process.

This is not only echoed in national frameworks and reform, but is also the growing expectation of the Queensland public.

Based on our observations of the review and investigation processes, the QFCC has resolved that some changes need to occur—to legislation, to the location of the child death case review panels, and to the expectations placed on agencies other than Child Safety Services.

This will mean significant changes to agencies that have not been compelled to undertake internal reviews and share their findings in the past.

It will, however, reinforce that every agency and every person is responsible for the safety and protection of children.

Recommendation

That the Queensland Government considers a revised external and independent model for reviewing the deaths of children 'known to the child protection system' (s. 246A (2)(a–d) of the Child Protection Act 1999).

This model will be designed by the Queensland Family and Child Commission and an expert advisory group in consultation with the directors-general from the 'nominated agencies' (s. 159k (a)(i-iv) of the Child Protection Act 1999) and other key stakeholders, and be endorsed by the Interdepartmental Coordination Committee.

A report will be provided to the Premier three months following the announcement with a framework for a contemporary child death review process for Queensland.

Amendments will be required to the Child Protection Act 1999 to transfer responsibility for the child death case review panel to an independent government agency.

The review of the Child Protection Act 1999 will also provide an opportunity to reconsider the functions of the child death case review panel, including the determination of accountability, in consultation with the nominated agencies.

As part of designing a contemporary model for child death case review, best practice benchmarks and experiences of other Australian jurisdictions, as identified by the Queensland Family and Child Commission, must be considered.

This includes the following:

- *extending the scope of powers and the authority of the child death case review panel in the new independent agency*
- *reconsidering legislative timeframes, including the receipt of information from other agencies*
- *reporting to government and public audiences on outcomes of child death reviews*
- *extending the scope to include other government and non-government organisations in the model*
- *extending the panels' power to make recommendations and require agencies to take action*

- *reconvening as necessary to consider new information, regarding the death of a child, to support systemic changes*
- *reconsidering selection, appointment of members and period of membership, and ongoing support, guidance and strong governance to the panel members*
- *providing appropriate resourcing for secretariat, panel operation and agency reviews*

Legislation will be required to compel nominated agencies who have provided service delivery to the child to undertake an internal review.

Each nominated agency may be required to:

- *establish an internal process for reviewing their involvement with children known to the child protection system who have died. These reviews should promote learning and analysis of internal decision making, consideration of systems issues, and collaboration with other agencies*
- *initiate this process whenever it has been determined that a child known to the child protection system and the agency dies*
- *provide the agency responsible for child death case review panels with the terms of reference for the internal reviews, and a copy of the internal review reports, including any findings and recommendations*
- *report regularly to the agency on progress in implementing any recommendations.*

The revised model should also consider giving the child death case review panel members the additional capacity to undertake own-motion reviews (based on their own expertise and observations of what is needed). This would enable the panel to identify trends in all child deaths in Queensland and complete a review into service delivery to prevent future deaths.

Appendix A

Queensland agencies' child death review mechanisms

The Department of Education and Training

The Department of Education and Training does not have any legislative or policy requirement to review its involvement with school students who have died. It focuses on providing support to school community members—students, staff and parents.

Where the death involves a child in the protection system, the Department of Education and Training cooperates with the Department of Communities, Child Safety and Disability Services. When asked, it will provide information about the student to the Department of Communities, Child Safety and Disability Services to inform the child death review process.

The Department of Justice and Attorney-General

The Department of Justice and Attorney-General provides several services of relevance to children and young people. Some of the main ones are through the Office of the Public Guardian and through youth justice services.

Office of the Public Guardian

The Public Guardian provides important services to safeguard children and young people:

- community visitors visit children in out-of-home care and help them by
  - listening to them and supporting them
  - helping them to work through problems and issues
  - checking the place they are living and that their needs are being met
  - getting them information about people and services that can help them
- child advocates help children in the child protection system by
  - ensuring their views are heard and considered when decisions are made that affect their care arrangements
  - providing support in court conferences and organising legal and other representation
  - applying to the tribunal or court about changes to a placement, a contact decision—contact with parents and siblings, or a change to a child protection order
  - helping resolve disputes with others, including making official complaints to the police, health authority or the Queensland Ombudsman
  - helping resolve issues with their school regarding suspensions or exclusions from class.

The Public Guardian does not have any legislative or policy requirement to review its prior involvement with a child or young person who dies.

Youth justice

The Department of Justice and Attorney-General does not have any legislative requirement to review its involvement with a child or young person who dies and was in the youth justice system. It has a procedure for staff to follow when a young person in the youth justice system dies.

The procedure states that if the young person dies by suicide, the regional director (of the region concerned) may consider arranging an independent practice review.

The purpose of a practice review is to:

- ensure accountability and transparency in the youth justice services' decision-making, practice and procedures
- identify improvements in youth justice systems, policies and practices
- facilitate ongoing learning and development in the area of suicide risk management
- acknowledge quality service provided by youth justice service centre staff involved in the case.

Importantly, practice reviews are not mandatory. They only relate to suicide deaths, not other causes of death. It is unclear how they provide transparency, as regional directors are not required to provide them to any external entity.

The procedure also includes notifying the Department of Communities, Child Safety and Disability Services if it is also involved with the young person. Another procedure allows youth justice service staff to share information with the Department of Communities, Child Safety and Disability Services for:

- reporting harm and or risk of harm to young people
- a child death review.

However, this only occurs if the Department of Communities, Child Safety and Disability Services asks for information.

The Queensland Police Service

The Queensland Police Service is responsible for investigating crime, which in some circumstances, includes the deaths of children.

It does not have any legislative or policy requirement to review its prior involvement with a child or young person who dies.

The Office of the State Coroner

Under the *Coroners Act 2003*, coroners are responsible for investigating reportable deaths that occur in Queensland.

The investigation determines the identity of deceased persons, when and where they died, how they died and the medical cause of death. The coroner may decide to hold an inquest and make recommendations to prevent similar deaths.

However, coroners are not able to progress an inquest until the conclusion of criminal proceedings for an offence, including any appeal started within the timeframes allowed for an appeal. This could make it difficult to quickly identify systemic issues that need to be addressed.

Domestic and Family Violence Death Review Unit

The Domestic and Family Violence Death Review Unit helps coroners to investigate the death of a child when:

- the death is a 'reportable death', and
- the child had prior involvement with the child protection system.

Coroners refer to these cases as child protection deaths. The Department of Communities, Child Safety and Disability Services is required to implement its two-tier review process for these child deaths. It is also required to provide both review reports to assist the coroner with the investigation.

The unit assists the coroner by reviewing the department's internal review report on the child's death and the child death case review panel's report. The unit aims to extend on, not duplicate those reviews. It considers the actions of the entire child protection system, including police, health, education and the non-government system. The unit provides specialist child protection advice to coroners in relation to systems, policies and practice.

The types of child protection deaths the unit considers are much broader than domestic and family violence-related deaths. Child protection deaths include those where a child may have had severe disabilities or died of an illness or accident. They also include deaths categorised as Sudden Infant Death Syndrome and Sudden Unexplained Death of Infant. These deaths may involve considering issues like:

- neglect prior to the death
- timely access to appropriate medical care
- parental capacity to supervise and protect.

There is some overlap between processes for reviewing child protection and domestic and family violence-related deaths, for example, when a child homicide or suicide occurs within the context of domestic and family violence, and there has been prior contact with the child protection system.

These cases are considered to be both a domestic and family violence death and a child protection death. They fall within the scope of the Domestic and Family Violence Death Review and Advisory Board, as well as being subject to investigation by the coroner.

Domestic and Family Violence Death Review and Advisory Board

The new Domestic and Family Violence Death Review and Advisory Board is responsible for the systemic review of domestic and family violence deaths in Queensland. These deaths include homicides and homicide-suicides that have occurred in a domestic or family relationship. They also include suicides of a perpetrator or victim of domestic and family violence.

The board was a key recommendation from the Special Taskforce on Domestic and Family Violence Final Report, *Not Now, Not Ever: Ending domestic and family violence in Queensland*.

The board's functions are to:

- analyse data and apply research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland
- conduct research to prevent these types of deaths
- write reports to identify key lessons and elements of good practice in preventing domestic and family violence deaths in Queensland
- make recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

In reviewing deaths, the board's primary function is to identify issues with service systems, not investigate the circumstances of individual deaths. The board can gather further information if necessary, and review open coronial matters and cases where criminal proceedings are ongoing.

Appendix B

Reform of child protection in Queensland

Over the last fifteen years, Queensland's child protection agency has been changed several times and has moved between various departments. These changes were mainly due to investigations and inquiries, but some arose from state machinery of government changes and national reforms. Since 2002, Queensland's approach to child death reviews has also changed.

Figure B1 summarises the key investigations, inquiries and reforms that have changed the department's name, structure and focus.

Figure B1

Date	Reforms
Prior to 2002	The Department of Families provided child protection services. It also reviewed child deaths with no external involvement.
2002 and 2003	The Queensland Ombudsman conducted major investigations into the deaths of two children known to the Department of Families—Brooke Brennan and Baby Kate. The Ombudsman made recommendations to the department, Queensland Health and the Queensland Police Service. These included setting up external oversight of departmental child death reviews. Each agency accepted their recommendations.
January 2004	The Crime and Misconduct Commission completed a public inquiry and released the report: *Protecting Children: an inquiry into the abuse of children in foster care*. The government accepted all 110 recommendations and released a blueprint for implementation.
February 2004	The government implemented machinery of government changes to give effect to the Crime and Misconduct Commission's recommendations. A new Department of Child Safety and a Department of Communities replaced the Department of Families.
August 2004	The Commission for Children and Young People and Child Guardian established the independent Child Death Case Review Committee to provide external oversight of the Department of Child Safety's internal child death reviews.
March 2009	Following the 2009 state election, the government implemented new machinery of government changes. The Department of Communities absorbed the functions of the abolished departments of Child Safety, Disability Services, and Housing, as well as the sport and recreation functions of the previous Local Government, Sport and Recreation department.

Date	Reforms
March 2012	Following the 2012 state election, the government implemented new machinery of government changes. The Department of Communities was renamed as the Department of Communities, Child Safety and Disability Services and a number of its functions were transferred to other newly formed departments.
July 2012	The government established the Queensland Child Protection Commission of Inquiry to review the child protection system.
July 2013	The inquiry released the *Taking responsibility: a roadmap for Queensland Child Protection* report. It included 121 recommendations to reform the child protection system over the next 10 years. These included changes to child death review processes.
July 2014	The government changed legislation to give effect to some of the inquiry's recommendations. These included abolishing the Child Death Case Review Committee and replacing it with new child death case review panels. The Minister for Child Safety appointed the inaugural members to the pool of approved panel members.
February 2015	The Special Taskforce on Domestic and Family Violence in Queensland delivered its report to the Premier of Queensland. The *Not Now, Not Ever: Ending domestic and family violence in Queensland* report made 140 recommendations aimed at ending domestic and family violence.
August 2015	The government released its response to the *Not Now, Not Ever: Ending domestic and family violence in Queensland* report and accepted all of the recommendations.
December 2015	The government finalised the *Domestic and Family Violence strategy 2016–2026* and first action plan for 2015–16.
Between July 2016 and June 2019	The government will progressively roll out the National Disability Insurance Scheme across Queensland.

This appendix outlines these reforms in more detail. It also discusses the changes to Queensland's child death review processes.

2002–2003 Queensland Ombudsman investigations

In 2002 and 2003, the Queensland Ombudsman released two major reports on investigations into the Department of Families and Queensland Health about the deaths of two children.

Both reports found practice and systemic failures in those agencies' responses to concerns for the children's safety and wellbeing

Brooke Brennan investigation

Brooke Brennan was nearly three years old when she died from internal injuries. The Supreme Court of Queensland convicted her mother's then partner of Brooke's murder and sentenced him to life in prison.

Circumstances surrounding Brooke Brennan's death

At the time of Brooke's death, she was living with her mother and her mother's partner.

On 12 July 1999, a general practitioner referred Brooke to hospital. He advised the hospital that some of Brooke's injuries could be non-accidental.

Doctors reviewed Brooke in the emergency department. She had multiple bruises to her body and a broken little finger. The doctors discussed the likely cause of Brooke's injuries with her mother.

The doctors admitted Brooke to the paediatric ward overnight. They contacted a doctor specialising in child abuse, who was a member of the local Suspected Child Abuse and Neglect team. He agreed to review Brooke the next morning.

Early the next day, Brooke's mother removed her from the hospital. A nurse notified hospital security and they searched for Brooke but did not find her. The hospital advised the Suspected Child Abuse and Neglect team doctor who was to review Brooke that morning. The doctor said he immediately attempted to contact both the Queensland Police Service and the department, but was unable to contact either agency for some hours.

The doctor reported that he spoke with police in the early afternoon and requested help to find Brooke, but they refused his request. The doctor notified the department later that afternoon.

The then Department of Families immediately sent two officers to Brooke's address. They arrived at about four o'clock that same afternoon. According to the officers, they knocked on the front door and called out, but no one answered. They then spoke to a neighbour, who directed them to the back of the home. They found the back door open and could hear a radio playing. One officer entered to see if Brooke or her mother were inside, but found no one. The officers left after searching nearby for some time.

The department referred Brooke's case to the Suspected Child Abuse and Neglect team for discussion on 22 July 1999, nine days after Brooke's disappearance. At this meeting, the Suspected Child Abuse and Neglect team recommended no further action by any of the Suspected Child Abuse and Neglect team agencies. The department did not try again to locate Brooke.

On the morning of 25 July 1999, ambulance officers found Brooke lifeless, with severe and extensive bruising to her body. Resuscitation attempts were unsuccessful. Doctors later determined that she died from internal injuries caused by considerable external force.

The Queensland Ombudsman's findings included that:

- the Suspected Child Abuse and Neglect team doctor's verbal referral and request to the police was ineffective—he should have documented them
- lines of communication between Queensland Health, the police and the department were inadequate
- the department had failed to act, some 16 months before Brooke's death, on a memo from the area office's intake team. It advised about resource constraints impacting on the team's ability to effectively perform child protection work
- the department had allocated inadequate resources to the area office to meet its statutory obligations
- both Queensland Health and the department failed to refer Brooke's case to the first available Suspected Child Abuse and Neglect team meeting after her mother removed her from hospital. This was despite the department's assessment that her case '… required urgent action as the child was clearly at imminent risk of further physical injury, was under three years of age and clearly very vulnerable'
- the department's decisions about Brooke's case were inadequate and unreasonable—the department should have taken further action to ensure she was safe
- the department's internal child death review did not comply with its policy and procedure
- the department did not take immediate action to implement the internal child death review's report or make any changes to departmental procedures for child protection.

The Ombudsman recommended, among other things, that the department:

- review its procedures for referring child protection matters to Suspected Child Abuse and Neglect teams to ensure they were prioritised and urgent matters were referred to the first available Suspected Child Abuse and Neglect team meeting
- engage an independent expert to review whether the area office was currently adequately resourced to meet its statutory child protection obligations
- review its lines of communication with Queensland Health and the police to ensure a rapid response in priority child protection cases.

Baby Kate investigation

At the time of her death in 2001, 'Baby Kate' was ten weeks old. The department had recently returned her to the care of her intellectually impaired mother 'Lisa'.

Circumstances surrounding Baby Kate's death

Before Baby Kate's birth, the department recorded concerns about Lisa's ability to care for a baby. Lisa had certain intellectual and physical impairments. She had previously been in foster care.

Baby Kate was born on 30 June 2001. Queensland Health noted that Lisa needed '… a lot of support and encouragement with her parenting skills'.

A few days later, nursing staff saw Lisa shake Baby Kate and swear at her. On 6 July 2001, a doctor recorded concerns about Lisa's ability to care for her child:

> Lisa is struggling. This is day seven post-natally and I have concerns about her ability to maintain the care of the child. She seems to bond minimally with Kate, only doing the minimum for her. Kate's crying irritates her. [He referred to her medical conditions.] She seems willing to learn but is easily frustrated and has very little spontaneous interest. I have global concerns for both mum and baby.

The doctor notified the department of these concerns. Two officers went to the hospital to assess the situation. Lisa acknowledged that she needed help caring for Baby Kate, especially with night feeding, but she indicated that her partner, John would help her.

The Suspected Child Abuse and Neglect team reviewed the case. It recommended, among other things, that the department '… talk to John about committing to Lisa and Baby Kate going home'. Hospital staff provided the department with their assessment of John and Lisa's parenting skills. The department decided to allow John and Lisa to take Baby Kate home. It started a child protection follow-up case—allowing the department to work with the family voluntarily.

Some four days after discharge, the department learned Lisa and John had ended their relationship and Lisa intended to move to Brisbane with Baby Kate to stay with Lisa's former foster family.

The Suspected Child Abuse and Neglect team reviewed the matter on the same day. It closed the case based on advice from the department that it would assess Lisa's parenting and would also consider a long-term placement for her and Baby Kate.

The department referred Lisa and Baby Kate to a residential facility operated by a non-government organisation in Brisbane. Lisa and Baby Kate lived at this facility for approximately four weeks until Baby Kate's death. One evening Lisa found Baby Kate dead in her cot.

The police provided a form to the health facility, which carried out Baby Kate's post-mortem. The form stated that the death was 'non-suspicious'. The police had not carried out a detailed investigation at that stage.

The next day, the police interviewed Lisa about Baby Kate's death. Lisa advised that when she put Baby Kate in the cot, she covered her body and head with a woollen blanket and two adult jumpers. The police did not provide any information from the investigation to the health facility.

When the facility completed the post-mortem some weeks later, it recorded the cause of Baby Kate's death as Sudden Infant Death Syndrome (SIDS).

Two weeks after Baby Kate's death, the department commenced an internal review of its management of Baby Kate's child protection case. The review took three weeks. It '… found that no negligence had occurred in relation to the management of the case by departmental staff'.

The Queensland Ombudsman's findings included that:

- the decision to allow Lisa and John to remove Baby Kate from the hospital was based on inadequate assessment of the risk of harm
- communication between the department and Queensland Health was inadequate
- the decision to leave Baby Kate in Lisa's care when the relationship between Lisa and John ended was wrong
- the department did not give enough weight to the legal requirement that the welfare and best interests of the child are paramount
- the department gave undue weight to the principle that the department's approach should be the least intrusive—and that this approach may be widespread, with potentially dangerous consequences for the safety of children
- departmental record keeping was inadequate
- the internal child death review was inadequate
- no suitably qualified person external to the department assessed the adequacy of internal child death reviews
- the case highlighted the need for a specialist external body to supervise the conduct of child death reviews, including determining the type of review to be undertaken.

The Ombudsman also noted doubt about the recorded cause of death—SIDS is a 'diagnosis of exclusion'. This means that the facility should not record the cause of death as SIDS unless it has excluded all other possible causes. A more appropriate finding in this instance would have been 'undetermined'. The difference is significant because the coroner relied partly on the SIDS finding in recommending no inquest.

The Ombudsman recommended, among other things, that the department:

- evaluate the training provided to departmental officers responsible for undertaking child protection assessments to identify whether increased emphasis should be given to conducting risk assessments and considering all relevant information for that purpose
- undertake a statewide audit of record keeping practices and provide training to offices identified in the audit as having inadequate record keeping practices
- review whether resourcing was sufficient to enable officers to maintain appropriate records—and if not, provide administrative or other support to assist officers.

To improve child death review processes, the Ombudsman also recommended:

- an entity external to the department monitor and review internal child death investigations
- the Commissioner for Children and Young People chair the child death review entity
- the state coroner be a member of the entity
- the entity be able to
  - direct that a child death review be conducted and specify the type of review (internal or external)
  - approve persons as child death external reviewers and maintain a register of them
  - appoint persons from the register to supervise the conduct of external reviews
  - make recommendations to the agencies with child protection responsibilities about policies and procedures that could prevent or reduce child deaths
  - report annually to parliament in relation to child deaths that had been the subject of review.

2004 Crime and Misconduct Commission Inquiry

In January 2004, the Crime and Misconduct Commission released its report: *Protecting Children: an inquiry into the abuse of children in foster care*.

Circumstances leading to the commission's inquiry

In late May 2003, a woman made disclosures to the department about her time in foster care. She alleged that an approved foster carer and the foster family's visitors and friends sexually abused her. The sexual abuse included acts of sodomy and indecent dealing and procuring the woman (then a child) to commit indecent acts with other children. The abuse happened over a period of 13 years. The woman stated that the family also sexually and physically abused other children in their care. Some of these children were still living with the family.

Later, the media released documents about alleged abuse involving other children placed with this family. The material suggested apparent failures by the department to deal with these allegations. There was intense media interest and questions about the knowledge of, and action taken by Ministers responsible for the portfolio at the relevant times.

In June 2003, the department appointed a consultant, Ms Gwenn Murray to audit abuse notifications made against foster carers.

In August 2003, the commission commenced Operation Zellow. It was a misconduct investigation into the original allegations that:

- various employees of the department had failed in their statutory duties and obligations to protect children placed in the family's care
- successive Ministers and directors-general had failed to act appropriately to protect children placed with the family.

Because of Ms Murray's audit findings, the commission commenced a second investigation, called Operation Ghost. That investigation considered allegations of abuse in a different foster family. The commission did not release the reports on these operations publicly.

It also commenced a broader public inquiry.

The commission concluded that the child protection system had failed Queensland children in many important respects. It found that rather than a few poor decisions by individual officers, there was organisational failure. There was failure to equip officers at all relevant levels of the department with the information, skills and resources to make the right decisions in the best interests of children in care.

The commission made 110 recommendations to reform Queensland's child protection system. The key one was to create a new Department of Child Safety exclusively focused on protecting children. Other recommendations covered matters like:

- increasing the workforce of family service officers by 160
- adopting an empirically rigorous means of calculating workloads and projecting future staffing numbers
- enhancing training and professional development for field staff as a matter of high priority
- employing staff with specialist investigative skills and an understanding of child neglect and abuse issues to investigate complex notifications about abuse of children in care
- creating a position of Child Guardian to sit within the Commission for Children and Young People to oversee the provision of services provided to, and decisions made about children within the department's jurisdiction—including investigating complaints and proactive monitoring and auditing
- requiring each department with a role in the promotion of child protection to report publicly each year on its delivery of child protection services
- developing a new Suspected Child Abuse and Neglect team model with appropriate levels of funding and regular reviews of functioning
- improving the management of foster carers, case planning and case work.

It also made a number of recommendations aimed at improving outcomes for Aboriginal and Torres Strait Islander children and young people.

In relation to child deaths, the commission found that the Queensland Ombudsman's investigations showed a clear need for an independent review mechanism—to scrutinise the circumstances surrounding the death of any child:

- who was in care, or
- who had come to the attention of the department, particularly if there was speculation the child died as a direct result of abuse or neglect.

It recommended:

- the department continue to review child deaths but include independence in the review process—experts and Aboriginal and Torres Strait Islander advisors where relevant
- a new Child Death Case Review Committee undertake detailed reviews of departmental internal and external case reviews—supported by the Commission for Children and Young People.

2004 Department of Child Safety

In February 2004, the government implemented machinery of government changes responding to the commission's recommendations. It abolished the Department of Families and created a new Department of Child Safety. It transferred responsibility for all other functions of the former Department of Families to the Department of Communities.

The Department of Child Safety's only function was to provide child protection services.

2004 Child Death Case Review Committee

In August 2004, the former Commission for Children and Young People and Child Guardian set up the independent Child Death Case Review Committee. The committee's role was to oversee the department's internal reviews and make recommendations to improve service delivery to children and young people.

Between 2004–05 and 2012–13, the committee examined the deaths of 532 children and young people, including five cases where there was a link between the department's actions or inactions and the child's death. Each year, the committee summarised its work in an annual report tabled in parliament. The committee's annual report for the 2012–13 year reported:

- it had considered the department's reviews of the deaths of 76 children and young people
- 47 of those children (63 per cent) were from families in which substance abuse was an issue

- 36 of them (47 per cent) were from families in which domestic violence co-existed with parental substance misuse
- for three children, the committee identified a link between the actions or inactions of the child protection system and the children's deaths
- two of the three children were fatally assaulted after the department failed to identify and appropriately respond to risks in the home.

In 2012–13, the committee endorsed 84 of the department's internal review recommendations and made 29 additional ones to improve department policy and practice.

In the previous year, the committee endorsed 91 recommendations made by the department in its internal reviews. It made an additional 46 recommendations aimed at improving the department's policy and practice.

Examples were that the department:

- provide a copy of the committee's report to staff undertaking a review of the Regional Intake Service—the department missed opportunities to engage a child and a family in appropriate support
- use the learnings from this case to implement appropriate professional development for the staff of the two Child Safety Service Centres to address the practice issues of
  - identification and assessment of cumulative harm
  - assessment and impact of domestic violence
  - assessment and impact of chronic parental substance abuse
  - maintaining the focus on the best interests of the child throughout intervention and at all key decision-making points
- use this case to promote learning about complex families—draw attention to the assessment of ongoing child protection concerns, consideration of cumulative harm and decision-making about ongoing intervention.

2009 Department of Communities

Following the state election in March 2009, the Premier, the Honourable Anna Bligh MP announced a major streamlining of government departments. The government reduced 23 departments to 13.

One key change was to abolish the Department of Child Safety and transfer its functions to the Department of Communities. The Department of Communities also took on a number of other functions from other abolished departments. The department had a broad range of responsibilities including:

- child safety
- youth justice
- housing and homelessness
- community participation
- sport and recreation
- disabilities
- the Commonwealth home and community care program and community mental health
- multicultural affairs
- Aboriginal and Torres Strait Islander policy and services.

2012 Department of Communities, Child Safety and Disability Services

Following the state election in March 2012, the Premier, the Honourable Campbell Newman MP announced a reorganisation of government departments. The government expanded 13 departments to 20.

As part of the machinery of government changes, the Department of Communities was renamed as the Department of Communities, Child Safety and Disability Services and the following functions were transferred from the department:

- sport and recreation
- social housing
- youth justice
- community mental health
- multicultural affairs
- Aboriginal and Torres Strait Islander Services.

2013 Queensland Child Protection Commission of Inquiry

In July 2013, the Queensland Child Protection Commission of Inquiry released its final report *Taking responsibility: a roadmap for Queensland child protection*.

The inquiry found the perception of a system under stress was justified. Over the previous decade:

- child protection intakes had tripled
- the rate of Aboriginal and Torres Strait Islander children in out-of-home care had tripled
- the total number of children in out-of-home care had more than doubled
- children in care were staying there for longer periods.

The inquiry identified three main causes of system failure:

- too little money spent on early intervention to support vulnerable families
- a widespread risk-averse culture that focused too heavily on coercive instead of supportive strategies and overreacted/overcompensated for hostile media and community scrutiny
- a tendency from all parts of society to shift responsibility onto the department.

The inquiry made 121 recommendations to reform the child protection system. The government accepted all the recommendations.

It also recommended changes to the child death review system, namely:

- expanding the review scope to include children who had suffered a serious physical injury
- reducing the length of time, from three years to one, that the department had prior involvement with the child before the child's death was a trigger for a review
- allowing the Minister for Child Safety to request a review
- replacing the independent Child Death Case Review Committee with child death case review panels appointed by the Minister for Child Safety.

2014 Child death case review panels

In July 2014, as part of implementing the inquiry recommendations, the government changed Queensland's child death review processes. Those changes included the current two-tier system for reviewing departmental involvement with children and young people who have died or suffered serious physical injury.

Tier one is an internal review, known as a systems and practice review, with examination by the department's Systems and Practice Review Committee.

Tier two is an external review of the department's internal review by an independent child death case review panel.

The purposes of the reviews are to:

- bring about ongoing learning and improvement in departmental service provision
- identify departmental accountability.

They both focus on the department. They do not allow for findings about other agencies in the child protection system.

In late July, the Minister for Child Safety appointed the inaugural members to the pool of approved panel members. The first panel met in October 2014.

In 2014–15, nine child death case review panels reviewed the department's involvement with 54 children and young people who had died, and one who had suffered a serious physical injury. The review panels made findings aimed at systemic improvement in the department's service delivery and coordination with other agencies. No review panel found that the department's actions or inactions contributed towards the children's deaths or serious physical injury.

Each panel provided a final report to the department on the cases they reviewed. The department then provided the Minister for Child Safety with a report on the action it had taken, or intended to take, in response to each panel's report.

In 2015–16, 13 panels reviewed the department's involvement with 59 children and young people who had died, and seven who had sustained a serious physical injury. The department's annual report for this year does not identify whether any panel found that the department's actions or inactions contributed towards any of the children's deaths or serious injuries.

2015 Domestic and family violence reforms

The department is leading a ten-year reform program to realise the vision of a Queensland free of domestic and family violence. A series of action plans will support the Domestic and Family Violence Prevention Strategy 2016–2026. The strategy implements the recommendations of the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* report.

The government's second action plan builds on the first one for 2015–16. It covers a three-year period from July 2016 to June 2019.

Initiatives for the next three years include:

- specialist domestic and family violence courts
- integrated service responses with specialist teams to prioritise victims and their safety
- cultural transformation through a communication and engagement program to help change attitudes and behaviours of Queenslanders towards domestic and family violence.

The government has demonstrated its commitment to this second action plan, announcing in the 2016–17 budget $198.2 million over five years to tackle domestic and family violence. This brings total funding to date for the government's response to the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland* report to $233.8 million over five years.

Appendix C

Australian child death review mechanisms

The child protection framework to guide agency action and response to a child death is complex.

There is no single piece of child protection legislation or system that guides all states and territories. This results in varying thresholds for harm, and processes for investigating and responding to reports of harm. It also leads to varying processes in relation to the establishment and scope of child death review teams.

While most agencies with child death review responsibilities are required to maintain a register and undertake research to improve child death prevention strategies, factors including review scope and level of independence differ.[21]

Australian states' and territories' child death review teams have varied independence from government and differing capacities to evaluate the role of agencies and services. In some jurisdictions, this role extends to include agencies (other than the child protection authority) that were in the child's life prior to their death.[22]

Consultation with other states and territories

For the purposes of assessing the effectiveness of the Queensland child death review model, the Queensland Family and Child Commission (QFCC) review team met with representatives from a number of states and territories to explore the strengths of their individual child death review models.

The QFCC met with representatives from children's commissioners/guardians, child protection departments or agencies with child death review responsibilities in New South Wales, Victoria, South Australia, Western Australia and the Northern Territory.

Primarily, each consultation meeting addressed:

- the current Queensland approach to child death review processes
- an overview of the other jurisdiction's approach to child death review processes
- strengths within the other jurisdiction's system and any positive impacts on either systems or practice reforms
- opportunities for further development and strengthening of existing child death processes.

Through this consultation, the QFCC identified a number of key opportunities for Queensland to consider in strengthening our own child death review processes.

These include:

- the extensive legislative mandate which supports the child death review mechanisms operated by the New South Wales Ombudsman's office, including:
  - the Ombudsman's ability to refer certain deaths to the Health Department for close internal reviews (limited of course to the boundaries of the legislative framework)[23]

21 Newton, R, Frederick, J, Wilson, E, Dibben, M and Goddard, C, 2010, *Legislation and child death review processes in Australia: Understanding our failure to prevent child death*, University of New South Wales Law Journal, p.991

22 Newton, R, Frederick, J, Wilson, E, Dibben, M and Goddard, C, 2010, *Legislation and child death review processes in Australia: Understanding our failure to prevent child death*, University of New South Wales Law Journal, p.989

23 Email from the New South Wales Ombudsman, dated 3 February 2017.

  - opportunities to work with the state coroner for the purposes of establishing retrospective reviews of deaths. The New South Wales Ombudsman and the state coroner have undertaken one retrospective review of sudden and unexpected death of an infant (SUDI). The findings of this review were publicly released in the *New South Wales Child Death Review Team Report 2015*, an annual report requirement of the New South Wales Ombudsman
- the ability of the South Australian Child Death Review Committee to review all deaths of children in South Australia. This is supported by information sharing processes, which allow the South Australian Child Death Review Committee to work with the Births, Deaths and Marriages Department to cross-check available data
- the broader mandate of the South Australian Child Death Review Committee. This allows the committee to consider deaths that may not have been known to the child protection department but potentially should have been, in addition to requesting information from a range of agencies. This is only possible by legislation, which allows for broader consideration of a range of child deaths that may have characteristics of vulnerability, for example, homelessness or significant illness
- the work of the South Australia Child Death Review Committee in establishing sub-committees based on member specialty. The sub-committees proactively instigate own-motion reviews based on child deaths identified through data analysis. For example, members with health expertise may investigate child deaths related to asthma and prepare a report to disseminate their findings.

Western Australia, like Queensland, is currently operating within a state of significant reform. However, discussions with the Western Australia Ombudsman's office, which has responsibility for formal child death review processes, indicated a thorough and robust system for external child death review including

- the Western Australia Ombudsman's office's external review process is completed in two distinct ways:
  - individual reviews—not publicly released, however, recommendations are monitored through a phased approach and build on other recommendations previously made
  - own-motion reviews—using a complementary analysis of patterns and trends of child deaths, with a strong link to the state coroner's office. Own-motion review reports are tabled in Western Australia Parliament given the broader scope to consider actions of a range of government agencies. This allows for transparency and accountability of any recommendations made
- the Western Australia Ombudsman's office approach to monitoring the recommendations made through their individual review function. This monitoring uses a phased approach, which provides clear guidance to agencies on their responsibilities in relation to child death review recommendations. It also communicates clear and transparent escalation requirements. The QFCC suggests contact be made with the Western Australian Ombudsman's Office to practically identify whether a similar model could be implemented in Queensland

- the Western Australia Ombudsman's Office's consideration of the need to reflect secondary services in any future child death review process, including how child death related review responsibilities for these types of agencies can be formally reflected, for example, through legislation or contractual reference. The agency with responsibility for reviewing the external child death review process in Queensland (following this QFCC report) should consider this further in consultation with the Western Australian Ombudsman's Office.

In talking with our jurisdictional partners, QFCC identified many interesting opportunities. These are some of them.

We in Queensland can gain a lot by considering all of the approaches the other states and territories are taking. We should particularly look at the results they are achieving, both in terms of sustained practice and sector reform, and, most importantly, in delivering positive outcomes for vulnerable children and their families.

What was clear after meeting with the majority of states and territories in Australia was that there is a need for all jurisdictions to work together, in an open, transparent and frank way to collaboratively establish what a contemporary, best practice child death review model might look like.

The QFCC suggests national strategic groups, such as the Australian Children's Commissioners and Guardians group, to take leadership of these types of cross-jurisdiction discussions on key child protection matters.

Attachment A

Queensland Government

Premier of Queensland
Minister for the Arts

For reply please quote: *Social Policy/NMC – TF/16/8947*

11 JUL 2016

Executive Building
100 George Street Brisbane
PO Box 15185 City East
Queensland 4002 Australia
Telephone [redacted]
Email ThePremier@premiers.qld.gov.au
Website www.thepremier.qld.gov.au

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission
PO Box 15217
CITY EAST QLD 4002

RECEIVED
11 JUL 2016
Queensland Family and Child Commission

Dear Ms Vardon

Like you, I was shocked to hear about the tragic circumstances surrounding the death of Mason Jet Lee. Instances such as this reinforce that there is more that can be done and must be done to ensure the safety of our most vulnerable Queensland citizens.

I was particularly disturbed with the information that has recently come to hand in relation to this case.

I am aware that in the wake of this disturbing case there will be a series of reviews and reports undertaken by both the Department of Communities, Child Safety and Disability Services (DCCSDS) and Queensland Health. In addition to these reviews and reports I understand there is an ongoing police investigation and a separate coronial investigation will take place.

In your oversight role for the child protection system, I am writing to ask that you work with all reviewers, including the internal and external DCCSDS reviews and Queensland Health, to ensure that all reviews are undertaken with speed and in a thorough manner. It will also ensure that those elements of interest to the Queensland Family and Child Commission are captured within the Terms of Reference.

Your expert oversight will ensure all reviews and reports are able to deliver the outcomes and guidance needed to make the system changes needed to protect our vulnerable children. I would also appreciate if you could give this matter your highest priority.

Yours sincerely

ANNASTACIA PALASZCZUK MP
PREMIER OF QUEENSLAND
MINISTER FOR THE ARTS

Attachment B

Queensland Government

Queensland
Family & Child
Commission

Telephone: [redacted]
Reference: OPC/D16/12071
Your Reference: *Social Policy/NMC – TF/16/8947*

18 August 2016

The Honourable Annastacia Palaszczuk MP
Premier of Queensland and Minister for the Arts
PO Box 15185
CITY EAST QLD 4002

Dear Premier

Thank you for your letter dated 11 July 2016 requesting the Queensland Family and Child Commission (QFCC) oversee reviews held by the Queensland Government into the circumstances leading to the tragic death of Mason Jet Lee.

The QFCC has commenced work on this important review by requesting details of internal departmental reviews, including plans, timeframes, policies and documentation.

The objective of the QFCC's oversight in this instance is to establish whether the reviews undertaken and resulting reports delivered are sufficiently scoped, thorough and responsive. QFCC will also ensure any recommendations made regarding whole-of-system improvements are appropriate and evidence-based.

A copy of the terms of reference for this review is attached for your information.

The QFCC oversight is considering current legislation, governance frameworks and methodologies for agency reviews, and assessing each agency's review processes to ensure the review into the death of Mason Lee is prioritised. The QFCC will also review the information, findings and recommendations of individual agencies to identify opportunities for whole-of-system recommendations, with a particular interest in information sharing.

An interim assessment of the adequacy of process and reviews to date will be provided to you by 16 September 2016.

Upon completing the review, the QFCC will provide you with a final report for consideration. It is expected this report will outline any further actions recommended as a result of the individual agencies' reviews.

Regular briefings on the progress of the review will be provided to your office, the Department of the Premier and Cabinet and other key stakeholders.

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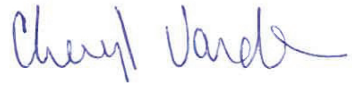
Brisbane Qld 4000
PO Box 15217,
Brisbane City East Qld 4002
Telephone [redacted]
Facsimile [redacted]
Website www.qfcc.qld.gov.au
www.talkingfamilies.qld.gov.au

I have written to the Directors-General of the Department of Communities, Child Safety and Disability Services and Queensland Health, and to the Commissioner of the Queensland Police Service, to advise them of the terms of the reference and to seek their cooperation in the review process.

If you or your officers have any queries in relation to this matter they may contact me on [redacted] or [redacted]; or [redacted], Assistant Commissioner, on [redacted]

Yours sincerely



Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission

cc:
Dave Stewart, Director-General, Department of the Premier and Cabinet (DPC)

Attachments:
1. Terms of Reference: QFCC Review 8/2016 – response to the death of Mason Lee

Terms of Reference
QFCC Review 2/2016

17 August 2016

Review background

On 11 June 2016, Mason Jet Lee was found deceased in his home. Police reported the injuries to Mason were horrific and could be found from head to toe. In the time since the initial report of Mason's death there have been a large number of claims made about the sustained and violent trauma and abuse suffered by Mason prior to his death.

On 11 July 2016, the Premier wrote to the Queensland Family and Child Commission (QFCC) asking the QFCC to:

- work with all reviewers, including the internal and external Department of Communities, Child Safety and Disability Services reviews and Queensland Health, to ensure all reviews are undertaken with speed and in a thorough manner, and
- provide oversight to ensure all reviews are able to deliver the outcomes and guidance needed to make the system changes required to protect our vulnerable children.

The objective of the QFCC's oversight in this instance is to establish whether the reviews undertaken and resulting reports are sufficiently scoped, thorough and responsive, and appropriate and evidenced-based recommendations are made to consider any necessary whole-of-system improvements.

Terms of reference

On behalf of the Premier of Queensland, the QFCC will work with other agencies to provide oversight of the quality of the reviews and recommendations made to ensure these reflect the system changes needed to protect our vulnerable children.

The terms of reference of this review are to:

1. Review the legislation, governance frameworks and methodologies for agency reviews to ensure they are thorough, effective and impartial.
2. Review the application of internal and external agency review processes for Mason Lee to ensure the review is prioritised.
3. Review the information, findings and recommendations of individual agencies to provide oversight and identify trends and opportunities for whole-of-system recommendations, particularly those related to information sharing.

Out of scope

- Section 9(2) of the *Family and Child Commission Act 2014* states it is not a function of the QFCC to investigate the circumstances of a particular child, young person or family.
- The Queensland Police Service and Coronial investigations will not be considered as part of this review.

Queensland
Family & Child
Commission
qfcc.qld.gov.au | talkingfamilies.qld.gov.au

Queensland
Government

Review process and management

1. The review will be undertaken in a timely and comprehensive manner and will proceed in accordance with the principles of natural justice.
2. The review is to be contained to the scope outlined in the terms of reference. Any other issues not directly related to that scope which are brought to the reviewers' attention should be raised with the Principal Commissioner, QFCC prior to any expansion of the review.
3. The reviewers are delegated the authority to access any information that will assist with the review. Where information is required from other government agencies it is to be sought in writing under s.27 of the *Family and Child Commission Act 2014*.
4. The reviewers will only meet with persons who are reasonably believed to be able to provide direct information that is credible, relevant and significant to the matters under review. A consultation plan and schedule will be provided to the Principal Commissioner, QFCC for endorsement prior to the commencement of the review.
5. A draft report which specifically addresses the terms of reference and proposed recommendations will be provided to the Principal Commissioner, QFCC. A final report will be provided to the Premier.
6. Regular briefings and progress reports will be provided to the Principal Commissioner, QFCC and other key stakeholders.
7. Strict confidentiality in relation to the issues will be maintained. All information relating to the review which is by its nature confidential, will not be disclosed, communicated, published or permitted to be disclosed, published or communicated except as necessary for the proper conduct of the review and preparation of the report.

Cheryl Vardon
Principal Commissioner
Queensland **Family and Child** Commission

Queensland Government

Queensland
Family & Child
Commission

Telephone: [redacted]
Reference: OPC/ D16/12138

18 August 2016

Mr Michael Hogan
Director-General
Department of Communities, Child Safety and Disability Services
GPO Box 806
BRISBANE QLD 4001

Dear Mr Hogan Michael

On 11 July 2016 the Premier wrote to me requesting the Queensland Family and Child Commission (QFCC) oversee reviews held by the Queensland Government into the circumstances leading to the tragic death of Mason Jet Lee.

The objective of the QFCCs oversight in this instance is to establish whether the reviews undertaken and resulting reports delivered are sufficiently scoped, thorough and responsive. The QFCC will also ensure any recommendations made regarding whole-of-system improvements are appropriate and evidence-based.

The QFCCs oversight work has commenced and is considering current legislation, governance frameworks and methodologies for agency reviews, and assessing each agency's review processes to ensure the review into the death of Mason Lee is prioritised. The QFCC will also review the information, findings and recommendations of individual agencies to identify opportunities for whole-of-system recommendations, with a particular interest in information sharing.

An interim assessment of the adequacy of process and reviews to date will be provided to the Premier by 16 September 2016.

A copy of the Premier's letter and the terms of reference for this review is attached for your information.

The QFCC will provide a final report to the Premier. It is expected this report will outline any further actions recommended as a result of the individual agencies' reviews.

I look forward to continuing to collaboratively progress this review.

Level 22, 53 Albert Street,
Brisbane Qld 4000
PO Box 15217,
Brisbane City East Qld 4002
Telephone [redacted]
Facsimile [redacted]
Website www.qfcc.qld.gov.au
www.talkingfamilies.qld.gov.au

If you or your officers have any queries in relation to this matter they may contact me on [redacted] or [redacted]; or [redacted], Assistant Commissioner, on [redacted]

Yours sincerely

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission

Attachments:
1. Letter from the Premier to the Principal Commissioner, QFCC, dated 11 July 2016
2. Terms of Reference: QFCC Review 8/2016 – response to the death of Mason Lee

Queensland Government

Premier of Queensland
Minister for the Arts

For reply please quote: *Social Policy/NMC – TF/16/8947*

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11 JUL 2016

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Queensland Family and Child Commission
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I am aware that in the wake of this disturbing case there will be a series of reviews and reports undertaken by both the Department of Communities, Child Safety and Disability Services (DCCSDS) and Queensland Health. In addition to these reviews and reports I understand there is an ongoing police investigation and a separate coronial investigation will take place.

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Your expert oversight will ensure all reviews and reports are able to deliver the outcomes and guidance needed to make the system changes needed to protect our vulnerable children. I would also appreciate if you could give this matter your highest priority.

Yours sincerely

ANNASTACIA PALASZCZUK MP
PREMIER OF QUEENSLAND
MINISTER FOR THE ARTS

Terms of Reference
QFCC Review 2/2016

17 August 2016

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On 11 July 2016, the Premier wrote to the Queensland Family and Child Commission (QFCC) asking the QFCC to:

- work with all reviewers, including the internal and external Department of Communities, Child Safety and Disability Services reviews and Queensland Health, to ensure all reviews are undertaken with speed and in a thorough manner, and
- provide oversight to ensure all reviews are able to deliver the outcomes and guidance needed to make the system changes required to protect our vulnerable children.

The objective of the QFCC's oversight in this instance is to establish whether the reviews undertaken and resulting reports are sufficiently scoped, thorough and responsive, and appropriate and evidenced-based recommendations are made to consider any necessary whole-of-system improvements.

Terms of reference

On behalf of the Premier of Queensland, the QFCC will work with other agencies to provide oversight of the quality of the reviews and recommendations made to ensure these reflect the system changes needed to protect our vulnerable children.

The terms of reference of this review are to:

1. Review the legislation, governance frameworks and methodologies for agency reviews to ensure they are thorough, effective and impartial.
2. Review the application of internal and external agency review processes for Mason Lee to ensure the review is prioritised.
3. Review the information, findings and recommendations of individual agencies to provide oversight and identify trends and opportunities for whole-of-system recommendations, particularly those related to information sharing.

Out of scope

- Section 9(2) of the *Family and Child Commission Act 2014* states it is not a function of the QFCC to investigate the circumstances of a particular child, young person or family.
- The Queensland Police Service and Coronial investigations will not be considered as part of this review.

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Review process and management

1. The review will be undertaken in a timely and comprehensive manner and will proceed in accordance with the principles of natural justice.
2. The review is to be contained to the scope outlined in the terms of reference. Any other issues not directly related to that scope which are brought to the reviewers' attention should be raised with the Principal Commissioner, QFCC prior to any expansion of the review.
3. The reviewers are delegated the authority to access any information that will assist with the review. Where information is required from other government agencies it is to be sought in writing under s.27 of the *Family and Child Commission Act 2014.*
4. The reviewers will only meet with persons who are reasonably believed to be able to provide direct information that is credible, relevant and significant to the matters under review. A consultation plan and schedule will be provided to the Principal Commissioner, QFCC for endorsement prior to the commencement of the review.
5. A draft report which specifically addresses the terms of reference and proposed recommendations will be provided to the Principal Commissioner, QFCC. A final report will be provided to the Premier.
6. Regular briefings and progress reports will be provided to the Principal Commissioner, QFCC and other key stakeholders.
7. Strict confidentiality in relation to the issues will be maintained. All information relating to the review which is by its nature confidential, will not be disclosed, communicated, published or permitted to be disclosed, published or communicated except as necessary for the proper conduct of the review and preparation of the report.

Cheryl Vardon
Principal Commissioner
Queensland **Family and Child** Commission

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Queensland Government

Queensland
Family & Child
Commission

Telephone: [redacted]
Reference: OPC/ D16/12072

18 August 2016

Mr Michael Walsh
Director-General
Department of Health
GPO Box 48
BRISBANE QLD 4001

Dear Mr Walsh Michael

As you are aware from our meeting and my letter dated 28 July 2016, on 11 July 2016 the Premier wrote to me requesting the Queensland Family and Child Commission (QFCC) oversee agency reviews into the tragic death of Mason Jet Lee.

A copy of the terms of reference for this review has now been finalised and is attached for your information.

I look forward to receiving the information as requested on 28 July 2016 and continuing to collaboratively progress this review.

An interim assessment of the adequacy of process and reviews to date will be provided to the Premier by 16 September 2016.

If you or your officers have any queries in relation to this matter they may contact me on [redacted] or [redacted], or [redacted], Assistant Commissioner, on [redacted]

Yours sincerely

Cheryl Vardon

Cheryl Vardon
Principal Commissioner
Queensland Family and Child Commission

Attachments:
1. Terms of Reference: QFCC Review 8/2016 – response to the death of Mason Lee

Level 22, 53 Albert Street,
Brisbane Qld 4000
PO Box 15217,
Brisbane City East Qld 4002
Telephone [redacted]
Facsimile [redacted]
Website www.qfcc.qld.gov.au
www.talkingfamilies.qld.gov.au

Terms of Reference
QFCC Review 2/2016

17 August 2016

Review background

On 11 June 2016, Mason Jet Lee was found deceased in his home. Police reported the injuries to Mason were horrific and could be found from head to toe. In the time since the initial report of Mason's death there have been a large number of claims made about the sustained and violent trauma and abuse suffered by Mason prior to his death.

On 11 July 2016, the Premier wrote to the Queensland Family and Child Commission (QFCC) asking the QFCC to:

- work with all reviewers, including the internal and external Department of Communities, Child Safety and Disability Services reviews and Queensland Health, to ensure all reviews are undertaken with speed and in a thorough manner, and
- provide oversight to ensure all reviews are able to deliver the outcomes and guidance needed to make the system changes required to protect our vulnerable children.

The objective of the QFCC's oversight in this instance is to establish whether the reviews undertaken and resulting reports are sufficiently scoped, thorough and responsive, and appropriate and evidenced-based recommendations are made to consider any necessary whole-of-system improvements.

Terms of reference

On behalf of the Premier of Queensland, the QFCC will work with other agencies to provide oversight of the quality of the reviews and recommendations made to ensure these reflect the system changes needed to protect our vulnerable children.

The terms of reference of this review are to:

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Cheryl Vardon
Principal Commissioner
Queensland **Family and Child** Commission