Review Process

The purpose of a departmental systems and practice review is to achieve continuous improvement through reviewing Department of Communities' involvement with a child under the *Child Protection Act 1999* where it received information about the child in the three years prior to their death. Reviews are conducted under chapter 7A of the *Child Protection Act 1999*.

The terms of reference for a review are:

- Critically analyse the factors which significantly enhance or hinder the Department of Communities' service delivery to the Subject Child under the *Child Protection Act 1999* in relation to protecting the child from harm and supporting the child's individual needs and identity.
- Critically analyse the success of Department of Communities' engagement with other agencies under the *Child Protection Act 1999* in providing quality service delivery to the Subject Child.

The reviews undertaken into the deaths of the two children in question were undertaken by external consultants.

Methodology

Information pertaining to the department's service delivery to the Subject Children in question is gathered for analysis by the review, including all electronic data and paper based file material held by the department in relation to the Subject Child.

Additional documents, records and information are provided by external agencies such as the Queensland Police Service, Queensland Health and service provider/s from the non-government sector. Autopsy reports or coroner's report are also considered by the reviewers.

The review gathers further information from individual and group discussions with the case workers and other staff who were identified as being involved in, or contributing to, service delivery. Discussions are held with workers from other agencies to gain further information for analysis.

The legislative framework including the principles underpinning the *Child Protection Act 1999*, policies, procedures and the relevant practice manuals are considered to inform decisions about service delivery to the Subject Child. The department's involvement with the family is also considered to inform decision making about service delivery to the Subject Child.

The review analyses the information collated to determine the key practice events. A key practice event is one that significantly enhanced or hindered service delivery to the Subject Child. In determining the key practice events, factors considered also included the impact of the practice on the Subject Child, the potential for systemic learnings and the amount of information available about the event.

Child Death Case Review Committee

The Department of Communities provides their review and relevant documents to the Child Death Case Review Committee pursuant to s 246D of the *Child Protection Act 1999*.

The Committee uses this information and information obtained from the Queensland Child Death Register to conduct its review.

The Committee was established under Chapter 6 of the Commission for Children and Young People and Child Guardian Act 2000 and operates independently when performing its functions. It is not under the control or direction of any other entity, including the Commission for Children and Young People and Child Guardian or the Department of Communities.

The Committee considers the original review pursuant to s89T of the *Commission for Children and Young People and Child Guardian Act 2000*. The original review is assessed in accordance with the Committee's review criteria, a statutory instrument developed under s89S of the *Commission*

for Children and Young People and Child Guardian Act 2000 and gazetted in the Queensland Government Gazette on 14 November 2008.

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

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

The original review is considered by a quorum of the Committee members as prescribed by s 89N of the *Commission for Children and Young People and Child Guardian Act 2000*. The legislation establishes the required composition of this panel of experts as drawn from the fields of paediatrics, mental health, investigations and child protection. Members are appointed for a term of three years.

The recommendations and actions as a result of reviews of two cases are set out below.

Case 1 System and Practice Review

Recommendations	**Actions**
1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on learnings.	**Completed.** A de-identified copy of the review was sent on 15 October 2009 to all involved for their learning, development and continuous improvement.

Case 1 Child Death Case Review Committee (CDCRC) Report

Recommendations	**Actions**
The CDCRC made no additional recommendations but stated that the Committee is of the opinion that the recommendation of the System and Practice Review is appropriate.	No action required.

Case 2 System and Practice Review

Recommendations	**Actions**
1. The review report be provided to all staff who participated in the review to allow critical discussion and reflection on the learnings.	**Completed.** A de-identified copy of the review was sent to all involved for their learning, development and continuous improvement.
2. A summary of key learnings from the report be developed and disseminated via Practice Support Unit to all senior practitioners.	**Completed.** A summary of key learnings was sent to Practice Support Unit to disseminate to all Senior Practitioners.

Case 2 Child Death Case Review Committee (CDCRC) Report

Recommendations	**Actions**
1. The Committee recommends that Child Safety Services consider whether disciplinary action, performance	Subsequent to receipt of this CDCRC Report, the Department referred four officers to the CMC who referred the

management and/or professional development strategies should be considered for three officers, in relation to their alleged handling of the subject child's case as outlined in the original review and in this report.	matter back to the department as suitable to deal with, subject to the CMC reviewing any investigation report before finalisation. An external investigations agency was commissioned and authorised to conduct an investigation into the matter. The CMC was advised of the outcomes of this report and advised they agreed with the investigation report and its recommendations. In relation to these four officers: • two were subject to disciplinary processes . These processes have concluded and action has been taken; one was demoted and removed from front line services and the other was removed from front line services; • one was cleared of any wrong doing; • one has subsequently resigned from the Department and no further action has been taken.
2. The Committee recommends that Child Safety Services take specific measures to ensure that four relevant staff understand the inappropriateness of their decisions for the future when assessing a child's abuse disclosures, such that if faced with a similar situation in the future each would respond in an appropriate manner. This should encompass the issues identified within the original review such as being seen to support the alleged perpetrator as opposed to the child, the affect on the child when their disclosures are not adequately responded to and staff's ability to appropriately assess and respond to abuse disclosures. The Committee is satisfied for Child Safety Services to determine the most effective method to comply with this recommendation.	Given the course of action above, relevant staff are aware of the consequences and through the process reminded of appropriate practice. The officers are not currently working in similar roles and should they return to similar roles in the future further training would be undertaken with these officers in relation to appropriate practice.
The Committee recommends that the findings and learnings outlined in this report and the original review be brought to the attention of the Regional Director Child Safety Services to facilitate the implementation of the Committee's recommendations.	Completed

Referral to Crime and Misconduct Commission

If there is possible staff misconduct, the matter is referred to the Crime and Misconduct Commission for consideration.

Public Reporting

The Child Death Case Review Committee is required to report on its function and provide this to the Minister for Community Services by 31 October each year for subsequent tabling in Parliament.

There have been six Queensland Child Death Case Review Committee Annual Reports tabled in the Queensland Parliament.

Service delivery reform undertaken by the Department since 2008-09 as part of continuous self-improvement relevant to these cases

The department has a policy and procedures for the assessment and response to self-harm and suicide risk. The procedures include the development and regular review of a self-harm or suicide risk management plan, in conjunction with agencies or individuals who may already be supporting a young person.

As a result of vulnerable young people in our system committing suicide there was strengthening of procedures around suicide risk and the need for safety planning when a young person has expressed suicidal ideation. Those procedures were released in 2008.

Child Safety Services staff have access to a range of practice resources on self-harm and suicide risk to assist them with decision making and case management.

A range of resources are also available within the department relevant to sexual abuse assessment including:

- The Child Sexual Abuse practice paper.
- The *Child Sexual Abuse – Things you need to know* publication available to the public on the website and hard copies in CSSCs.
- Numerous specialist skills modules available on the infonet for self-directed or facilitated learning and development.

- The Sexual Abuse Counselling Service (SACS) – provides counselling to children who have been sexually abused and a consultancy service to CSSC staff (i.e. advice regarding assessment; information/literature regarding sexual abuse; and state-wide referral information).

A review of the Sexual Abuse Counselling service has been undertaken and the service delivery refocussed on the following functions:

- information, referral and phone support to members of the public in relation to sexual abuse or sexual behaviour;
- consultation in relation to sexual matters that present to CSSC's;
- case advise to CSSC's. This involves provision of case recommendation on how to manage cases of young people and children in care who have experienced sexual abuse or present with sexualised behaviour;
- training and mentoring to support NGO's dealing with cases of sexual abuse;
- group work for young people who have been sexually abused; and
- individual counselling for children in care who have been sexually abused or have problem sexual behaviour. Members of the public are offered urgent support and referral.

All these services are provided statewide.

The SCAN system has been reviewed to focus on complex cases such as these that require a coordinated multi agency response.

Central Region implemented a practice improvement plan for Maryborough CSSC, which focused upon training activities for Child Safety Officers and the reorganisation of work processes in order to service vulnerable children and their families effectively.

Supervision processes have been enhanced and Team Leaders have attended *Step Up To Leadership* Training. The Team Leaders are supporting their professional development through participation in Regional Team Leader Forums and having up to date Achievement and Capability Plans.

Systems and Practice reviews relating to these two young people were discussed at Systems and Practice Review Committee with the Regional Director and the reports were distributed to the CSSC for consideration and learning.

Team Leaders and the Senior Practitioner led a number of practice reflection groups to examine and discuss the reviews relating to these two particular young people.

Maryborough CSSC engaged an experienced psychologist, to conduct a two day workshop focussing on sexual assault and its impacts and working with adolescents with high risk behaviours.

In 2010 the Department and representatives from the Domestic Violence Sector co facilitated the delivery of domestic violence training to Senior Practitioners, Team Leaders, Family Group Convenors and Court Coordinators state-wide. This initiative was conducted in Central Region and is important for the development of the risk assessment skills of practitioners.

Managing disclosure of sexual abuse and harm of children and young people is covered in multiple points in CSO training. The importance of listening and responding appropriately to young people's disclosures is strongly reinforced to staff. This training includes:

During the three week face to face training program in Phase 2 of training, officers:
- undertake a one day interviewing children workshop
- undertake a half day risk assessment workshop
- provided with significant literature related to interviewing and communicating with children and young people

During Phase 3: Five to six month workplace learning
Verification of competence
- Support children and monitor their care in a placement

Workplace Learning Guide
- Module 7 Engaging with children and young people

During Phase 4: One week of face to face consolidation workshops
- Half day CREATE workshop – engaging with children and young people
- Half day risk assessment workshop

Further, where it is alleged that a criminal offence has been committed and CSOs undertake joint interviews with the Queensland Police Service, CSOs undertake *Interviewing Children and Recording Evidence* (ICARE) training. This involves a one week competency based training program delivered jointly by the department and the QPS.

Underpinning all of the above training is the principle that the interests and well being of the child are paramount in all decisions.

A Memorandum of Understanding between Child Safety Services and Child and Youth Mental Health Services was established in 2010.

This MOU has facilitated greater partnership and collaboration between the services to address the mental health needs of vulnerable children and young people.

The Evolve Interagency Services program may also assist children and young people (including those with a disability) with complex behaviours by providing them with expert therapy and behavioural support.

Evolve provides a service consistent with the child's or young person's level of need and may include strategies to address suicidal thoughts or intent or other high risk behaviours.

Evolve clinicians will work with children and young people and their support network, to reduce frequency and intensity of high risk behaviour, improve their emotional and mental health wellbeing and develop and enhance skills to participate in school and the community.