



Advice to the Minister for Health and Human Services

A Child Death Review Process for Tasmania

September 2006

The Commissioner for Children is an independent, statutory office responsible to the Parliament of Tasmania. The Commissioner's functions include promoting the rights and well-being of children along with examining the policies, practices and services provided for children and any laws affecting their health, welfare, care, protection and development.

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Foreword

The purpose of this paper is to:

- determine whether there is a need for a child death review process in Tasmania;
- identify desirable features of a child death review process;
- assess whether existing mechanisms for scrutinising child deaths are sufficient to answer the need for a child death review process; and (if needed)
- propose a child death review model for Tasmania.

The child protection system exists to protect children from risk of abuse or neglect posed by their parents or carers. It is a serious adverse event for the child protection system when a child dies as a result of abuse or neglect. It raises the possibility that the child protection system in some way failed that child, either by failing to identify that the child was at risk, or by failing to take appropriate action in response to an identified risk.

Most Australian jurisdictions have established a permanent child death review process to review certain child deaths. In each jurisdiction the population of deaths reviewed can be categorised as "child abuse" or "child protection" deaths. That is, child deaths attributed to abuse or neglect or deaths of children formerly known to the child protection authority, regardless of the cause of death¹.

The primary aim of the child death review process is to identify whether any failings of the child protection system may have in some way contributed to a child's death. Based on the lessons learned from individual deaths, the child death review body is able to recommend ways to improve departmental practice, policy, legislation or interagency relationships to reduce the likelihood of future deaths occurring in similar circumstances and to better serve all children who come into contact with the system.

¹ There is some variation in the precise scope of child death reviews in different jurisdictions. This will become clear later in this paper.

The principal purpose of the child death review process is therefore to provide a mechanism for reviewing the effectiveness of the child protection system.

Child death review processes were introduced in other jurisdictions in response to an increase in awareness and concern over child abuse and child homicides, increased demand for accountability and transparency in the child protection system, perceived limitations of existing mechanisms for scrutinising the circumstances of child deaths and the need to learn from experience ways to reduce the incidence of preventable child deaths, particularly deaths caused by abuse or neglect.

The need for a permanent child death review process is no less pressing in Tasmania than it is in other jurisdictions. The proportion of children reliant on Child Protection Services in Tasmania is comparable to national figures. In 2005, the proportion of child deaths where the child fell within the child abuse or child protection populations was significant². The child protection system has become increasingly subject to public criticism, with heightened demands for an increase in accountability and transparency.

Tasmania does not have a permanent and independent child death review process. There are, however, a number of mechanisms for scrutinising child deaths at some level. These vary in their nature, scope and purpose.

In addition there has recently been an external inquiry into the death of a child known to Child Protection Services, convened at the request of the Minister for Health and Human Services (the Minister)³. While this was a one-off review, it is conceivable that future reviews will be requested on an ad hoc basis in the absence of a permanent child death review body. These reviews, supplemented by the coronial process, come closest to answering the need for an independent child death review process in this State.

² Data recorded by Paediatric Mortality and Morbidity Sub-Committee (see Chapter Two).

³ The Department of Health and Human Services (the Department) is the agency responsible for child protection in Tasmania, through Child Protection Services. The *Children, Young Persons and Their Families Act 1997* provides the statutory basis for the care and protection of children and young people in Tasmania.

Both the coronial process and occasional child death reviews are limited in their capacity to build a complete and reliable picture of the child protection system. This inhibits their ability to make judgements about entrenched problems within the child protection system and to make sound recommendations for strategic, long-term reform.

Tasmania has the advantage of being able to choose the best features from a variety of child death review models employed in other jurisdictions. The simplest model involves a single, independent body established in legislation which carries out the entire review. A more complex model involves two tiers of review; an internal, departmental inquiry with oversight provided by an external and independent body. In each jurisdiction there is also variation regarding the basis on which the review body is established, its scope, powers, reporting and membership.

This Advice is the primary work of Ms Amy Fearnley-Sander from my office, who undertook the work with diligence, skill and commitment.

Chapter One provides an introduction to this paper. It explains that child death review systems can involve two distinct functions, “child death reviews” and “child death research”. The chapter defines and contrasts these two functions and explains that the scope of this paper is confined to an examination of child death review processes. These definitions are important to understanding the parameters of this paper. The child death research function is *not* examined in this paper. The chapter also explains the background to this paper.

Chapter Two explores the question of whether there is a need for a permanent child death review process in Tasmania. To answer this, the chapter first looks at the reports that recommended the establishment of child death review systems in other Australian jurisdictions. The aim is to identify why these systems were considered necessary in other jurisdictions. The chapter then considers the Tasmanian context to assess whether the need for a child death review process is as compelling in this State.

Chapter Three examines the key features of child death review bodies in other jurisdictions and considers their merits and disadvantages. There are two aims here. The first is to generate discussion about the key features of an effective child death

review process, in order to assess whether existing mechanisms for scrutinising child deaths in Tasmania answer the need for a child death review process. The second is to inform decisions about the design of a new review process, if existing mechanisms are considered inadequate. The chapter also identifies factors specific to Tasmania that may affect the best choice of model for this State.

Chapter Four describes existing mechanisms for scrutinising child deaths in Tasmania. These include child death research carried out by the Council of Obstetric and Paediatric Mortality and Morbidity (the Council); internal child death reviews carried out by the Department (there have been two since the proclamation of the *Children, Young Persons and their Families Act 1997*)⁴; serious incident investigations at the Royal Hobart Hospital; coronial investigations and the recent external child death review convened at the request of the Minister.

The strengths and limitations of these processes are discussed, drawing on the key features of child death review processes in other jurisdictions (covered in Chapter Three). The chapter concludes with a description of the historical approach to child death reviews in Tasmania.

The paper concludes in **Chapter Five** with four options for carrying out future child death reviews in Tasmania. The chapter discusses the risks associated with each option.

The first option is to retain the current approach. This involves relying on current mechanisms for scrutinising child deaths, principally the coronial process. While there is some possibility that future child death reviews may be convened at the discretion of the Minister on an ad hoc basis, there is no certainty around this.

The second option is to build on existing organisations and processes to strengthen the current approach to child death reviews in Tasmania. This option would involve amendment to the *Perinatal Registry Act 1997* to strengthen the capacity of the

⁴ This number is based on advice received from the Department of Health and Human Services on 22 September 2006.

Paediatric Mortality and Morbidity Sub-Committee (the Paediatric Sub-Committee) to oversee an independent child death review process.

The third option is to appoint an advisory panel under section 84 of the *Children, Young Persons and their Families Act 1997* to provide advice to the Secretary of the Department of Health and Human Services (the Secretary) with respect to child deaths within a defined scope. While this option has the advantage of practicality, its key disadvantage is that it lacks independence and transparency.

The fourth and preferred option is to establish a permanent and independent child death review process. The recommended features for this new process were drawn from child death review models in other jurisdictions, examined in Chapter Three. While no single model was considered ideal for Tasmania, the child death review processes in New South Wales and South Australia provided the greatest influence for the recommended model.

David K. Fanning
Commissioner for Children
Tasmania

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Glossary of Terms

Child death review process	Process for carrying out reviews into the circumstances leading up to individual child deaths.
Child death review	A review into the circumstances leading up to an individual child's death.
Child death research or the "research function" of the child death review system	A function carried out by a body within a child death review system, which involves collating, coding and analysing child deaths from all causes and carrying out general research into child mortality and morbidity.
Child death review system ⁵	A system that includes both a child death review process and child death research.
The Council	Council of Obstetric and Paediatric Mortality and Morbidity (Tasmania)
The Department	Department of Health and Human Services, Tasmania (unless otherwise stated)
The Minister	The Minister for Health and Human Services, Tasmania (unless otherwise stated)
The Paediatric Sub-Committee	The Paediatric Mortality and Morbidity Sub-Committee (Tasmania)
The Secretary	The Secretary for Health and Human Services, Tasmania (unless otherwise stated)

⁵ It should be noted that this terminology ("child death review system" and its two functions, "child death reviews" and "child death research") is specific to this paper and does not necessarily reflect the terminology used in every jurisdiction mentioned. For example, in some jurisdictions the term "child death review process" is interchangeable for "child death review system" and the research function is not seen as part of the child death review system. These terms have been chosen for the purpose of comparing different child death review processes and systems across Australia. See Scope and Definitions, Chapter One.

Chapter One: Introduction

1.1. Scope and Definitions

This paper looks exclusively at processes for carrying out child death reviews. However, it should be noted that child death reviews make up only part of most child death review systems. In most Australian jurisdictions, the child death review system has two distinct functions.

The first function is to carry out reviews into the circumstances leading up to individual child deaths. In this paper, this function is referred to as the “child death review process” and the reviews are referred to as “child death reviews”. The aim of child death review processes is generally to determine whether improvements to departmental practice, policy, legislation or interagency relationships could reduce the risks of future deaths occurring.

Only some jurisdictions have a child death review process. In each of these jurisdictions, the process focuses on deaths attributed to abuse or neglect or deaths of children formerly known to the child protection authority⁶. In this way, the child death review process serves as a mechanism for providing quality assurance and review of child protection systems.

The second function of child death review systems involves collating, coding and analysing child deaths from all causes and carrying out further research into child mortality and morbidity. This process does not look in detail at the circumstances of individual deaths. This is referred to as “child death research”, or the “research function” of the child death review system. The aim of the research function is to better understand causes of child mortality and morbidity to help prevent or reduce child deaths. Recommendations for reducing the incidence of child deaths are aimed at the community, private agencies and government. The focus is much broader than the child protection system.

⁶ See footnote 1.

All Australian jurisdictions have in place, or are establishing, bodies that are responsible for child death research. In Tasmania this function is performed by the Council of Paediatric and Obstetric Mortality and Morbidity (the Council). The focus of the Council tends to be clinical, with recommendations generally aimed at health professionals.

In much of the literature available on child death review systems, the two functions (review and research) are both referred to as child death reviews. This is further complicated by the fact that in some jurisdictions both functions are carried out by the same body, whereas in other jurisdictions the functions are separated among two or more child death review bodies.

There are close synergies between the review and the research functions of child death review systems. The rationale for separating the two functions and prioritising the child death review process in this paper is that the current absence of a review process requires urgent consideration. While there may be cause to improve and build on the child death research function that is currently carried out by the Council, this issue is considered less urgent and is not addressed in this paper.

Any reference to a “child death review system” in this paper is intended to connote a system that includes both a review and a research function.

1.2. Background

Historically, responsibility for examining and preventing child fatalities has fallen on law enforcement and coronial, social service and public health systems working in isolation. Consequently, uniform systems for review of child deaths have been slow to develop which has resulted in a lack of centralised or systematic collection and analysis of data on child mortality.

Increasing community and professional awareness and concern about child deaths, in particular child homicides, has resulted in the gradual appearance of child death review processes throughout the world.

As mentioned above, all Australian jurisdictions are on the way to having a child death review system with a research function in relation to all child deaths. Victoria, New South Wales, Queensland, South Australia and Western Australia also have a

child death review process⁷. Tasmania is the only State without an established child death review process⁸.

In early 2005 the death of a young child, who was known to Child Protection Services, within the Department of Health and Human Services (the Department), prior to his death, came to the attention of the Commissioner for Children, David Fanning (the Commissioner). The circumstances of the death highlighted the need to examine the involvement of the different government agencies and service providers in that child's short life.

The Commissioner initiated discussions with the Secretary regarding the need to review this death. In February 2006, the Secretary appointed a team to conduct this review. The Commissioner also noted his concern at the lack of a permanent child death review process in the State.

In June 2005, the Commissioner again raised his concerns about the lack of a permanent child death review process with the Minister, the Honourable Lara Giddings. Following this, the Minister formally requested the Commissioner to provide advice regarding the need for a child death review process and options for establishing this process.

⁷ The Australian Capital Territory and the Northern Territory do not currently have an independent child death review process in place (as defined in Chapter One), although both jurisdictions are in a state of transition. For this reason they are not examined in this report. See page 7.

⁸ There have been two child death reviews internal to the Department of Health and Human Services since 2000 (see footnote 4). It would seem that these reviews have been ad hoc rather than process-driven. Also, these reviews are internal matters and as such do not compare with the external child death review processes established in many other jurisdictions. See Chapter Four.

Chapter Two: Is there a need for a child death review process?

2.1. Reasons for the growth in child death review processes in Australia and the United Kingdom

2.1.1 Introduction to Reports

This section looks at a selection of reports which recommended the establishment of a permanent child death review process in other jurisdictions. The aim is to understand why other jurisdictions adopted a child death review process⁹.

In some cases, the call for a child death review process arose out of an individual inquiry into a child death. In other cases, general reviews of child protection services or child death statistics led to the establishment of a child death review process.

The child death review process currently operating in Victoria has developed over time. In 1985, internal inquiry panels were established to investigate child deaths and serious injuries for children who had been the subject of child protection interventions. A Ministerial inquiry process was established in 1989 and operated alongside the internal inquiries until this dual process was discontinued in 1993 because of the duplication involved. In 1995 the current Victorian Child Death Review Committee was established, with modifications in 1995 and 1996.

In New South Wales the Child Death Review Committee of the Child Protection Council reviewed a sample of child deaths attributed to abuse or neglect between 1989 and 1991. The purpose of this review was to comment on the effectiveness of the child death review process in place at the time and on the effectiveness of existing policies and practices for identifying and responding to children at risk. The

⁹ Some reports recommended a child death review system as a whole (including both the review and research functions described in Chapter One), others focus exclusively on the need to establish a child death review process.

review culminated in a report (*Preventing Child Homicide*), which recommended the establishment of a permanent child death review committee with a legislative basis¹⁰.

The South Australian Government announced a comprehensive child protection review in March 2002, chaired by Robyn Layton QC (the *Layton Report*)¹¹. One of the five major structural reforms recommended was the establishment of a Child Death and Serious Injury Review Committee.

In Western Australia, an inquiry into the death of a young girl in an Aboriginal community (the *Gordon Inquiry*) was triggered by a coronial inquest that raised questions about the practice of various government departments¹². The purpose of the inquiry was to examine the actions of government agencies in responding to family violence and child abuse. One of the recommendations in this report was the establishment of a child death review process.

In Queensland, two separate reports led to the establishment of the child death review process. In 2003, an inquiry by the Queensland Ombudsman into the death of a baby girl in the care of her intellectually impaired mother (the *Baby Kate Report*) called for the establishment of an independent child death review mechanism¹³.

In the same year, the Crime and Misconduct Commission conducted an inquiry in response to a number of complaints about the foster care and child protection systems in Queensland, including an increase in the number of notifications and a high number of re-substantiations. The inquiry culminated in the publication of the *Protecting Children Report*¹⁴. The report was based on misconduct reviews into

¹⁰ *Preventing Child Homicide: A report from the New South Wales Child Protection Council's Child Death Review Committee*, NSW Child Protection Council, 1995.

¹¹ *Our Best Investment: A State Plan for Advancing and Protecting the Interests of Children*, Robert Layton QC, March 2003.

¹² *Putting the Picture Together: Inquiry into Responses by Government Agencies to Complaints of Family Violence in Aboriginal Communities*, S. Gordon, K. Hallahan, D. Henry, July, 2002.

¹³ *A review into the adequacy of the actions of certain government agencies in relation to the safety, wellbeing and care of the late baby Kate, who died aged 10 weeks*, Queensland Ombudsman, October 2003.

¹⁴ *Protecting Children, An Inquiry into Abuse of Children in Foster Care, Crime and Misconduct Commission*, Queensland, 2004.

specific allegations of abuse of certain foster children as well as a public inquiry that examined more systemic issues concerning the provision of foster care. In June 2004 legislation was passed to implement the recommendations of the report, including the establishment of a child death review process.

In the Australian Capital Territory, the Commissioner for Public Administration held an inquiry into the protection of children and young people in care (*The Territory as Parent*)¹⁵. In May 2004, the Australian Capital Territory Government agreed in principle in its response to *The Territory as Parent* that an independent child death review committee be established. It was further agreed (in principle, and subject to further analysis) that the committee would sit within the Commission for Children and Young People once the Commission has been established. As at 30 June 2006 the ACT's existing Child Death Review Team (which carries out child death research and has a public health surveillance role) remains within ACT Health¹⁶.

In the Northern Territory there is currently no child death review process (besides the general coronial process). The *Caring for Our Children reform agenda*, introduced in August 2004, includes the development of new legislation (the draft *Care and Protection of Children and Young People Act*). The draft Act provides for the establishment of a Child Death Review and Prevention Committee. Although its precise mandate is yet to be determined, it is anticipated that the Committee will have a child death research role and will not carry out individual child death reviews.

In addition three other reports illustrate the need for, and benefits of child death reviews. These are the NSW Ombudsman inquiry, *Improving Outcomes for Children at Risk Of Harm – a Case Study (Improving Outcomes)*¹⁷; the first research report of

¹⁵ *The Territory as Parent: Review of the Safety of Children in Care in the ACT and of ACT Child Protection Management*, Cheryl Vardon, January 2004. Specifically, The Territory as Parent was commissioned to report on the "failure to fulfil statutory obligations under s162 of the *Children's and Young People's Act 1999*" in relation to the Department of Education, Youth and Family Services.

¹⁶ At the time the relevant part of *The Territory as Parent* was written, the Minister had announced the establishment of the Child Death Review Team, however it had not commenced operation. The team was established in April 2004 (one month prior to the release of *The Territory as Parent*). Its function is primarily public health surveillance. The team is chaired by the Chief Health Officer of ACT Health.

¹⁷ *Improving Outcomes for Children at Risk Of Harm – a Case Study*, NSW Ombudsman, December 2004.

the Advisory Council on the Prevention of Deaths of Children and Young People, *Patterns and trends in mortality of Western Australian infants, children and young people 1980-2002* (the *Freeman Report*)¹⁸; and *The Victoria Climbié Inquiry* (the *Climbié Report*) in the United Kingdom¹⁹.

Each of the reports examined in this paper either recommended the establishment of a child death review process or illustrate the important role of child death reviews as a quality assurance and accountability mechanism for the child protection system.

2.1.2 Content of the Reports

The reasons behind recommendations for establishing a child death review process varied across jurisdictions, but a number of key themes emerged from the reports examined. The reasons outlined below were taken from the reports, and were common to at least two jurisdictions in each case.

In summary, the key reasons given in these reports to support the case for establishing a child death review process, were:

- to learn lessons to reduce preventable deaths;
- existing mechanisms for scrutinising child deaths are limited;
- increased community concern over child deaths, especially child homicides; and
- the need to increase accountability and transparency.

¹⁸ In Western Australia, the Advisory Council on the Prevention of Deaths of Children and Young People was established following the Gordon Inquiry's call for a child death review system. The Advisory Council carries out child death research. The Council's first research report (the *Freeman Report*) strongly supports the case for a child death review process. The *Freeman Report* reviewed data on child deaths in Western Australia between 1980 and 2002 to identify all-cause and cause-specific mortality rates and to measure disparities between the mortality rates of Aboriginal and non-Aboriginal children. (*Patterns and trends in mortality of Western Australian infants, children and young people 1980-2002*, Freemantle, J., Stanley, F., Read, A., de Klerk, N., Advisory Council on the Prevention of Deaths of Children and Young People, the Department for Community Development, Government of Western Australia, 2004).

¹⁹ *The Victoria Climbié Inquiry*, Lord Laming, United Kingdom, 2003.

2.1.2 (i). Learning lessons to reduce preventable deaths

The most common reason given for establishing a child death review process relies on the idea that certain child deaths are, potentially, “avoidable” or “preventable”.

The *Layton Report* (SA) explained that “the prevention of deaths and serious injuries from causes that are amenable to change is a significant step towards improving child health and protection outcomes”²⁰. It goes on to describe these deaths as “avoidable” deaths.

The *Freeman Report* (WA) quoted Dr Helen Milroy, a Psychiatrist and a senior Aboriginal researcher, “to lose a child at any age is an absolute tragedy, for this to have been preventable is unforgiveable”²¹.

Preventable or avoidable deaths are those deaths where the causes are “amenable to change”. This would include deaths caused by accident or fatal non-accidental injury, including homicides attributed to abuse or neglect.

Some reports provided statistical evidence of significant rates of preventable deaths among children. The *Layton Report* (SA) recorded that in 1999 the main causes of death (38.1% of all deaths) for 0-14 year olds were accidents, poisoning and violence (“preventable” deaths)²². The *Freeman Report* (WA), which involved a review of all child deaths between 1980 and 2002, found that the main causes of childhood death were preventable.²³

The moment it is accepted that a death falls within the category of “preventable death”, the following questions immediately arise: how could it have been prevented? Why was it not prevented? What needs to be done to prevent future deaths in similar circumstances?

²⁰ *Layton Report* (SA), p. 18.2.

²¹ *Freeman Report* (WA), p. iii.

²² *Layton Report* (SA), p. 18.5.

²³ *Freeman Report* (WA), p. xxix. The main causes of preventable deaths were road traffic accidents and drowning.

The primary purpose of child death review systems, including both child death reviews and child death research, is to learn from experience ways to reduce the risk of future child deaths occurring in similar circumstances²⁴.

In every jurisdiction, the reports that called for the establishment of a permanent child death review process focus on the deaths of those children known to child protection services, or children whose deaths were caused by abuse or neglect.

The reason for this is not clearly articulated. There is an underlying assumption that of all preventable deaths, deaths caused by abuse or neglect demand further attention. This may be because these deaths, usually perpetrated by the parent or carer, evoke the greatest community concern²⁵. Helfer and Kempe articulated the reason for special concern where a child's death is attributed to the parent or carer:

*"The absolute dependence of infants and children upon parents and adult custodians renders them susceptible to a range of fatal maltreatment and neglect that defies the imagination of a thousand nightmares"*²⁶.

Another explanation for the particular concern and attention given to these deaths is the possibility of culpability on the part of the government for failing to protect children at risk.

The lessons that can be learnt from child death reviews apply for all preventable deaths (for example by informing the development of regulatory measures to reduce

²⁴ *Freeman Report* (WA), p. iii.

²⁵ *Preventing Child Homicide* (NSW), p. 26 reports that in cases of child homicide, children are usually killed by their parents or others known to them. In the sample of deaths studied in that review, the biological parent was suspected of committing the homicide in 55% of cases, while in an additional 27% of cases male parent-substitutes were suspected. According to Strang, H (1996) around 28 children die in Australia every year as a result of homicide. Of these, 19 deaths are attributed to parents or parent-substitutes. Furthermore, in Australia, child abuse homicides consistently equal or exceed deaths due to motor vehicle accidents, accidental poisonings, falls and drowning in the age group 0-1 years (Strang, H (1996) "Children as Victims of Homicide", *Australian Institute of Criminology Trends & Issues in Crime and Criminal Justice*, No 53 p 1 and p. 75 in *Layton Report* (SA), p. 18.3).

²⁶ Helfer, R.E and Kempe, R.S *The Battered Child*, 4th Ed., 1987 in *Preventing Child Homicide* (NSW), p. 5.

deaths by drowning), but are particularly pertinent where the government has a clear role in protecting children from harm, that is, where the child was previously known to the child protection system.

The child protection system exists to protect children from harm inflicted by others, so, as stated in *Protecting Children* (QLD):

“in the context of child protection and children in care, it [the death of a child] could ... represent the ultimate example of the system or its agents failing that child”²⁷.

The *Baby Kate Report* (QLD) explained the purpose of child death reviews in the child protection context:

“The child death review process is an important safeguard and accountability mechanism in the child protection system. Thorough analysis and assessment of case management decisions and actions are imperative when a child dies. The review process may identify significant deficiencies in existing practices and procedures and make recommendations to address those deficiencies and thus save the lives of other children in the future”²⁸.

Similarly, the *Layton Report* (SA) stated that:

“Analyses of child homicide and serious injury provide a unique opportunity to understand what is working and not working in child protection systems.”²⁹

In the United Kingdom, Lord Laming, conducting an inquiry into the circumstances of a young girl’s death caused by abuse and neglect (the Climbié Inquiry), emotively captured the reason for all child death reviews in the child protection context:

“It is the hope of the full inquiry team that the horror of what happened to Victoria will endure as a reproach to bad practice and be a beacon pointing the way to securing the safety and well-being of all children in our society.”

²⁷ *Protecting Children* (QLD) , p. 163

²⁸ *Baby Kate Report* (QLD), p. 105.

²⁹ *Layton Report* (SA), p. 18.4.

And

*“Unfortunately, none of us can bring Victoria back, but we can all try to ensure that some lasting benefit comes from her death, and that other children do not suffer a similar fate”.*³⁰

Preventing Child Homicide (NSW) collected data from a sample of child homicides attributed to, or suspected of being caused by abuse and neglect over a two-year period. Findings from this review suggest that, in the majority of cases where children die as a result of abuse or neglect, clear warning signals were present that were, or should have been, noted by various government service providers³¹. This suggests that governments have a case to answer in many child homicides.

The child death review process can be an important part of providing evidence-based practice in child protection. Clearly, evidence-based program evaluation is preferable to *“accepting famous ideas just because they are famous”*³².

Evidence-based practice has been defined as *“the conscientious, explicit, and judicious use of best evidence in making decisions about the care of individuals”*³³ and can be provided by *“integrating individual practice expertise with the best available external evidence from systematic research as well as considering the values and expectations of clients”*³⁴. Tomison explained that evidence-based practice is commonly misunderstood to exclusively refer to controlled, experimental

³⁰ *Climbie Report* (UK), p. 16.

³¹ *Preventing Child Homicide* (NSW), pgs 25-36. These findings are discussed in Chapter Three. Briefly, the findings show that in all cases reviewed, the suspect was known to the child (with the vast majority being biological or substitute parents); in 59% of cases the suspect or their immediate family had been in contact with professional agencies (such as doctors, police, community workers, psychiatrists) before the killing; 27% of suspects had received psychiatric treatment prior to the killing; 27% of suspects had a history of substance dependence; in 26% of cases domestic violence featured as part of the family background; and in 41% of cases a previous history of physical abuse of the victim was established.

³² Sheldon 2001: 803 in *Current Issues in Child Protection Policy and Practice: Informing the NT Department of Health and Community Services Child Protection Review*, Tomison A., National Child Protection Clearinghouse, Australian Institute of Family Studies, p. 71.

³³ Sackett, Richardson, Rosenberg and Haynes 1997:2 in Tomison A., p. 71.

³⁴ Gambrill 1999:346 in Tomison A., p. 71.

studies, while in fact, he argues, *“the development and use of the evidence base involves developing as complete a picture as is possible, critically assessing the most reliable and valid information available”*³⁵.

The lessons learnt from child deaths can be part of taking an “evidence-based” approach to child protection reform. Findings from child death reviews can help to tell us whether our child protection system is working and whether it is becoming more or less effective over time. This is only one indicator of the overall effectiveness of the child protection system, but clearly a very important one.

In addition to reducing or preventing further child deaths, another reason given for establishing child death review processes is that the lessons learned from investigating individual deaths will benefit all vulnerable children who rely on the child protection system, thus improving the response to any degree of abuse or neglect, not just those events resulting in death³⁶. The *Baby Kate Report* (QLD) stated that:

*“many of the issues raised by child death inquiries have considerable implications for everyday good practice with children who have been non-fatally abused or at risk of maltreatment”*³⁷.

Reports that reviewed the circumstances of an individual child death illustrate the purpose and benefits of child death reviews. The reports highlighted significant failures within child protection systems and other relevant government services.

For example, *Improving Outcomes* (NSW), an inquiry into the death of a three year old showed that the New South Wales Department of Community Services (DoCS) had received seven reports directly concerning the boy and his six year old sister leading up to his death³⁸. The Ombudsman found that the involvement of DoCS with the boy’s family prior to his death demonstrated a failure to respond adequately to

³⁵ Tomison A., p. 72.

³⁶ *Preventing Child Homicide* (NSW), p. 10.

³⁷ *Annual Report of Inquiries into Child Deaths: Child Protection*, Victorian Child Death Review Committee, DHS, Victoria, 2002, p. ii in *Baby Kate Report* (QLD), p. 103.

³⁸ *Improving Outcomes for Children* (NSW), pgs. 4 and 20.

persistent risks of harm. It also found that the Police failed to adequately review the alleged sexual abuse of the boy's sister, which occurred prior to his death³⁹.

The Climbie Inquiry in the United Kingdom (referred to above) involved in an investigation into the death of a girl who had been in contact with various government authorities on numerous occasions prior to her death. The inquiry identified a series of systemic failures that contributed to the young girl's death, particularly with regard to the lack of management, leadership and accountability in the child protection system. The ensuing report (the *Climbie Report*) claimed that the death of Victoria was "*a gross failure of the system and was inexcusable*"⁴⁰ and that protecting Victoria "*required nothing more than basic good practice being put into operation*"⁴¹.

2.1.2 (ii). Inadequate existing mechanisms for scrutinising child deaths

Another common reason to explain the establishment of child death review processes in other jurisdictions was the inadequacy of existing mechanisms for scrutinising child deaths⁴². Pre-existing mechanisms for investigating child deaths included departmental reviews, hospital reviews, police investigations, coronial inquests or ad hoc inquiries into individual child deaths.

The short-falls of these review mechanisms included⁴³:

- their limited scope;
- their inability to identify or address widespread systems issues;
- the absence of a single agency with ongoing responsibility for all aspects of child death reviews;
- barriers to information-sharing;
- their focus on medical causes of death, rather than a focus on contributory factors and relevant social characteristics (in some cases); and
- the lack of accurate and reliable data (eg. numbers of children fatally abused and neglected) due to lack of uniformity of review method, confidentiality issues and inaccurate certification and recording of deaths.

³⁹ *Improving Outcomes for Children* (NSW), p. 26.

⁴⁰ *Climbie Report* (UK), p. 4.

⁴¹ *Climbie Report* (UK), p. 4.

⁴² *Layton Report* (SA), p. 18.6.

⁴³ *Layton Report* (SA), p. 18.10.

The *Territory as Parent* (ACT) noted that at the time of the report there was no single and comprehensive mechanism for collecting and recording information about child deaths in the Australian Capital Territory. Only deaths of children in the neonatal period, deaths referred by the Coroner and deaths resulting from child abuse were reviewed.⁴⁴

The *Baby Kate Report* (QLD) report found that the internal review of baby Kate's death undertaken by the Department of Families (in Queensland) was inadequate⁴⁵. The Ombudsman found that the internal departmental review process was unclear, that in this case the review was inadequate and that there was no suitable external review of departmental reviews to assess their adequacy⁴⁶. The report noted that it is in the public interest that a specialist external body oversee child death reviews, to ensure that system problems are identified and addressed.

Similarly the *Gordon Inquiry* (WA), which reviewed the death of a young girl in an Aboriginal community, found that the subsequent police investigation into her death was unsatisfactory⁴⁷.

The *Layton Report* (SA) and *Protecting Children* (QLD) considered the Coroner's role in relation to examining child deaths⁴⁸. The *Layton Report* (SA) concluded that while the Coroner has the power to investigate certain child deaths, no overall picture of the child protection system, or related government services, could be obtained via coronial inquests⁴⁹.

The *Baby Kate Report* (QLD) illustrated that while the Coroner's jurisdiction may cover some child deaths, it will not necessarily cover all child deaths where government agencies were involved with the child or his or her family. In this case, baby Kate's death did not happen whilst "in care", nor was it reported as being a suspicious or unnatural death (the death was wrongly reported by the Police as a

⁴⁴ *Territory as Parent* (ACT), p 111. See footnote 16.

⁴⁵ *Baby Kate Report* (QLD), p. iv.

⁴⁶ *Baby Kate Report* (QLD), p. iv.

⁴⁷ *Gordon Inquiry* (WA), p. 369.

⁴⁸ *Layton Report* (SA), p. 18.7; *Protecting Children* (QLD), p. 164-165;

⁴⁹ *Layton Report* (SA), p. 18.7.

“non-suspicious” death). Consequently, the death fell outside the scope of the Coroner’s jurisdiction.⁵⁰ The Ombudsman’s inquiry, on the other hand, found systemic problems in the Department of Families regarding the management of child protection cases, decision-making and communication between public agencies⁵¹. These findings, and accompanying recommendations, would not have been possible if the coronial process alone were relied on.

In New South Wales, prior to the introduction of a permanent child death review process and in the United Kingdom over the last thirty years, the response to child deaths has involved a series of one-off inquiries into individual cases. Experiences in both jurisdictions suggest that this approach is not very effective. Trends and system-wide issues are more difficult to identify⁵². Related to this is the risk that single, high profile case reviews could lead to knee-jerk and reactive attempts at child protection reform.

The general practice in England of conducting single, highly publicised inquiries has been subject to much criticism. At the time of the *Climbie Report* the Secretary of State for Health, Alan Milburn said:

“it is an all too familiar cry. In the past few decades there have been dozens of inquiries into awful cases of child abuse and neglect. Each has called on us to learn the lesson of what went wrong. Indeed, there is a remarkable consistency in both what went wrong and what is advocated to put it right”⁵³.

One-off or ad hoc child death reviews may contribute to the problem of crisis-led responses to child protection problems, directly opposed to the more considered and evidence-based approach to child protection reform. That is, in response to highly publicised events such as the death of a child who was within the child protection

⁵⁰ The Coroner’s jurisdiction covers “reportable deaths” which includes deaths in care, as defined in section 82, *Child Protection Act* (QLD), *Baby Kate Report* (QLD), p. 111.

⁵¹ *Baby Kate Report*, pgs 121-125 and *Annual Report Deaths of Children and Young People*, Commissioner for Children and Young People and Child Guardian, Queensland, 2004-05, p. 14.

⁵² *Preventing Child Homicide* (NSW), p. 10.

⁵³ House of Commons Hansard Debate, 28 January, 2003 in ‘Child Abuse Review’, Gough, D., Stanley N. (eds), *Journal of British Association for the Study and Prevention of Child Abuse and Neglect*, Vol. 13, No. 2, March-April 2004, p. 80.

system, governments tend to look for 'quick fixes', which can impair efforts to make more strategic plans for improving practice.

As Tomison suggests "to obtain that evidence requires the development of a body of knowledge that can only eventuate if governments and/or departments invest in programs and research with timelines that allow adequate assessment and a slower approach to the implementation of changes to practice"⁵⁴. A permanent, ongoing child death investigative process would create the opportunity for such a body of knowledge to build up, based on an analysis of the circumstances of child deaths over time.

On the one hand, the experience in England can be used to support the case for a permanent child death review process, as an alternative to the ad hoc inquiry process. Arguably, a permanent body would be better placed to provide ongoing advocacy for improvements to the child protection (and related) systems, and to monitor the implementation of its recommendations. It would also cut down on duplication of efforts in each case.

On the other hand, the English experience could be taken as a sign of the risks and limitations of a child death review process, whether ad hoc or permanent⁵⁵. The change of approach in New South Wales from ad hoc inquiries to reviews by a permanent child death review body is still relatively new, so that a reliable comparison of the two approaches is difficult to make.

⁵⁴ Tomison A., p. 73.

⁵⁵ Claims that the English inquiries have achieved little are refuted by some commentators and must be read with caution. In his paper "From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation Apart" (in *Child Abuse Review*, Gough D., Stanley N. (eds), March–April 2004, p. 82), Nigel Parton argues that the apparent repetition of problems identified and solutions recommended in child death reviews over the last thirty years does not necessarily mean that child death inquiries themselves are ineffective. He argues that "*far from inquiries failing to influence policy and practice over the last 30 years... they have probably been the most influential factor in bringing about change*". Instead, Parton explains the continuous series of child death inquiries as a mark of the increasing complexity of child protection systems, the cases they deal with and the nature of the work involved.

2.1.2 (iii). Increased community concern over child homicides

Another explanation for the need to establish a permanent child death review process is the increase in community and professional awareness and concern over child deaths, particularly child homicides. *Preventing Child Homicide* (NSW) cited this increasing concern as the reason for the gradual appearance of child death review processes all over the world⁵⁶. This explanation of the need for a child death review process also featured in the *Layton Report* (SA)⁵⁷.

Preventing Child Homicide (NSW) further suggested that adequately resourcing an effective child death review process would demonstrate the value of children in the priorities of the government and the community⁵⁸.

2.1.2 (iv). Increasing demand for accountability and transparency

Another reason for establishing a permanent child death review process is the need for scrutiny of government decisions and actions to promote accountability and transparency⁵⁹.

Lord Laming, in the *Climbie Report* (UK), considered that “the single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children”⁶⁰.

The *Baby Kate Report* (QLD) describes the child death review process as “an important safeguard and accountability mechanism in the child protection system”.⁶¹

Subjecting the decisions, actions and omissions of government agencies to external and public inquiry through a child death review process increases transparency and encourages greater accountability.

⁵⁶ *Preventing Child Homicide*, pgs. 5 and 9.

⁵⁷ *Layton Report* (SA), pgs. 18.4 and 18.8.

⁵⁸ *Preventing Child Homicide* (NSW), p. 18.

⁵⁹ *Protecting Children* (QLD), p. 163; *Baby Kate Report* (QLD), p. 111.

⁶⁰ *Climbie Report* (UK), p. 6.

⁶¹ *Baby Kate Report* (QLD), p. 105.

2.2. Is there a need for a child death review process in Tasmania?

In the previous section, the following reasons were given to explain the need for a child death review process:

- to learn from experience so that policy and practice can be improved to reduce the incidence of preventable child deaths, particularly deaths within the child abuse and child protection populations;
- increased community concern over child homicides demands that extra resources be put into prevention strategies; and
- accountability and transparency within the child protection system requires rigorous analysis of cases where the system may have failed to protect a child.

There is no reason why these explanations are any less persuasive in Tasmania, assuming that:

- the proportion of Tasmania's child population relying on the child protection system is comparable to national levels; and
- the proportion of child deaths in Tasmania that fall within the child abuse and child protection categories is comparable to national levels.

The number of children relying on the child protection system in Tasmania is comparable to national figures. At 30 June 2005, 6.1 per 1,000 Tasmanian children were the subject of a care and protection order (compared with the national figure of 5.2). At the same point in time, the rate of Tasmanian children in out of home care was the third highest in the country and equal to the national average at 4.9 per 1000 children.⁶²

Unfortunately there is very limited data available on numbers of child deaths in Tasmania where the child was known to Child Protection Services prior to their death. The Paediatric Sub-Committee has only recently adopted the practice of supplying the Department with an annual list of child deaths and requesting that the

⁶² *Child Protection Australia 2004-05*, Child Welfare Series no. 38, Australian Institute of Health and Welfare, 2006, pgs 38 and 50.

Department identify whether any of the children were known to Child Protection Services prior to their death.⁶³

The Paediatric Sub-Committee recorded 25 child deaths in 2005. Eight of the deaths (32%) were children known to Child Protection Services prior to their deaths. Three deaths (out of the total 25) were classified as injuries with suspected child abuse (12%)⁶⁴. In each of those three cases the child was previously known to Child Protection Services.

Due to the small number of deaths each year, data on numbers of deaths within the child abuse and child protection populations should be read with caution. However, based on data of child deaths in 2005 alone, deaths in these categories represent a significant proportion of child deaths. Arguably, this suggests that further scrutiny of these deaths is at least as relevant in Tasmania as in other jurisdictions.

As stated in the Department's *Our Kids Action Plan 2004-2007*⁶⁵:

"Given the increasing disquiet with regard to these indicators [of health and wellbeing of children] monitoring Tasmanian children's health and well being determinants and outcomes, as well as the performance of interventions, is essential".

The child death review process is a core mechanism for monitoring health and well being and the performance of Child Protection Services. Given that the numbers of children relying on Child Protection Services in this State are no different to other jurisdictions, there is no less cause for investing in a child death review process in this State than in other jurisdictions.

⁶³ Children were deemed to be "known" to the Department where they were subject to a notification or where any action was taken by the Department in relation to that child at any time prior to their death. This only relates to contact with Child Protection Services, not related service providers for children and families.

⁶⁴ These deaths were classified by the Paediatric Mortality and Morbidity Sub-Committee.

⁶⁵ *Our Kids Action Plan 2004-2007, Working Towards a Holistic Response for Tasmania's Children*, Department of Health and Human Services, Tasmania, November 2003, p. 10.

There is also no reason to presume that the Tasmanian child protection system is free of the kinds of entrenched system problems that have been identified in child protection systems elsewhere through child death review processes. On the contrary, the Tasmanian child protection system has been subject to intense public criticism in recent times. This reinforces the need for an external quality assurance mechanism such as a child death review process.

A final reason given in the previous section to explain the need for a permanent child death review process was that the limitations of existing mechanisms for scrutinising child deaths made trends and systems issues difficult to identify and learn from. The question of whether existing mechanisms for scrutinising child deaths in Tasmania are already sufficient to answer the needs for a child death review process is addressed in Chapter Four.

Chapter Three: Key features of a child death review process

This section examines the key features of bodies primarily responsible for child death reviews in Victoria, New South Wales, Queensland, Western Australia and South Australia. It discusses the merits and disadvantages of these features, taking into account factors specific to Tasmania⁶⁶.

Key features discussed are:

- The number of bodies involved in the child death review system (including both the research function and the review function described in Chapter One), and the number of layers in the child death review process.
- The scope of child death reviews in each jurisdiction. This includes a description of the population of child deaths and injuries within scope (reviewable cases), the capacity of each review body to make recommendations in relation to a broad range of child and family support agencies (multi-agency approach) and the capacity to make comment on the actions of individual workers (disciplinary matters).
- The degree of independence enjoyed by the review body.
- The basis on which the review body is established.
- The powers available to the review body to access relevant information and obligations to protect the confidentiality of this information.
- The breadth of representation and terms of appointment of members of the review body.
- The location of the review body or the source of administrative support provided to it.
- The relationship between the child death review process and the coronial process. The focus here is to identify ways to manage the two related processes to minimise duplication and to ensure that the child death review process does not interfere with the coronial process or any criminal investigation. The key issues are whether the child death review process can take place before the coronial process is completed; and if so whether

⁶⁶ See footnote 7.

the full report of the child death review body should be made available for use by the Coroner.

3.1. Overview of key features in other jurisdictions

3.1.1 VICTORIA

Number of Bodies Involved

In Victoria there are a number of official bodies involved when a child dies.

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity is a statutory body with a public health surveillance, reporting and research role in relation to all child deaths in Victoria. As such, it has responsibility for the research function of the child death review system (as defined in Chapter One).

The Office of the Child Safety Commissioner (Inquiries and Review Unit) carries out child death inquiries in certain circumstances. These inquiries are reviewed by the independent Victorian Child Death Review Committee (the Committee), which provides recommendations to the Minister for Children and the Minister for Community Services based on the Unit's report. Thus, the child death review process (as defined in Chapter One) may be described as a two stage process.

Scope

The scope of child death reviews in Victoria is confined to deaths of children and young people who were clients of the Department of Human Services Child Protection service at the time of their death or within three months of their death⁶⁷. All such deaths are routinely reviewed.

This includes children aged 0-17 years of age (inclusive), including still-births after 20 weeks gestation where the death was registered in Victoria or where the death was registered elsewhere, but the usual residence is in Victoria.

⁶⁷ *Annual Report of Inquiries into the Deaths of Children Known to Child Protection 2006*, Victorian Child Death Review Committee, 2006, p. 5.

Child death reviews focus on the child protection agency, however the Committee also has scope to consider and comment on the involvement of other Department of Human Services programs (eg mental health services, drug and alcohol, juvenile justice) and other agencies that were involved with a child protection client⁶⁸.

The Committee focuses on systemic issues and cannot comment on the actions of individual workers or make recommendations regarding disciplinary measures.

Office of the Child Safety Commissioner – Inquiries and Review Unit

Legislation

The Inquiries and Review Unit (the Unit) is located within the Office of the Child Safety Commissioner which has statutory responsibility for carrying out child death inquiries under the *Child Wellbeing and Safety Act 2005*. The Child Safety Commissioner reports directly to the Minister for Children and Minister for Community Services and is appointed under the *Public Administration Act 2004*. Thus, the Unit's inquiry process is external to the Department of Human Services – which has responsibility for child protection.

Functions

When a current or recent client of Child Protection services dies, the Department of Human Services notifies the Office of the Child Safety Commissioner. The death is entered on the Office of the Child Safety Commissioner's Child Death Register and an inquiry is commenced in accordance with the *Child Wellbeing and Safety Act 2005*.

This inquiry is carried out by the Unit. The Unit establishes the facts of the Child Protection case and examines whether the case management decisions and actions of the Department of Human Services and other agencies were adequate and appropriate in providing a service to the client.

For more comprehensive examination of issues arising from a group of deaths, the Minister for Children and Minister for Community Services, the Child Safety

⁶⁸ *Annual Report of Inquiries into the Deaths of Children Known to Child Protection 2006*, Victorian Child Death Review Committee, 2006, p. 5.

Commissioner or the Victorian Child Death Review Committee may request an analysis of a group of child deaths that share similar characteristics.

Powers, Obligations and Protections

Child death inquiries carried out by the Unit are facilitated by the *Child Wellbeing and Safety Act 2005*, which requires certain health and human services to provide information to the Child Safety Commissioner for the purpose of a child death inquiry. Parents of the deceased child are advised and provided with an opportunity to participate in the inquiry process, should they wish to do so.

The Act facilitates disclosure of sensitive information by health and welfare professionals by providing that disclosure does not breach any professional code of conduct/ethics, cannot be used to hold the person liable in respect of it and does not constitute a contravention of various other legislation that would otherwise prevent disclosure of the information⁶⁹.

Reporting

At the end of every inquiry, the Unit prepares a report with findings. A draft is forwarded to the Department of Human Services to comment on factual accuracy. The final report is provided to the Minister for Children and Minister for Community Services, the Secretary of the Department of Human Services and the Victorian Child Death Review Committee.

Membership

The Unit comprises a team of practice reviewers who are responsible for conducting case related research and coordinating all activities associated with the child death inquiry process. An external case analyst may be appointed to provide expert advice and opinion on case issues, prepare an analysis and develop findings.

⁶⁹ Section 36, *Child Wellbeing and Safety Act 2005*.

Victorian Child Death Review Committee

Legislation

The Committee is an independent ministerial advisory body. It is not supported by legislation.

Functions

The Committee provides a multidisciplinary external review of all child death inquiry reports prepared by the Unit. The Committee may endorse the findings of the inquiry reports and develop recommendations for action as required. These recommendations may be case specific or may address systemic issues that arise from a cluster of individual reviews.

The Committee has a role in identifying themes, trends or patterns that emerge from the review of child death inquiries. It provides expert advice to the Minister for Children and Minister for Community Services on policy, procedure and practice issues arising from the child death inquiries. It also receives feedback on the implementation of service system reforms.

Powers, Obligations and Protections

The Committee relies on the material provided to it by the Unit and has no power to gather further material.

Reporting

The Committee reports and provides advice to the Minister for Children and the Minister for Community Services on the child death inquiry process. The Committee also prepares an annual report for the Minister for Children and Minister for Community Services, which the Minister tables in the Parliament.

Membership

The Committee has a multi-disciplinary membership with representatives from both government and non-government sectors. It includes professionals from health, welfare, justice and academic fields. There were 10 members in 2005.

Members are appointed and may be removed by the Minister for Children. The appointment of the Chairperson is endorsed by Cabinet.

Resources and Administrative Support

The Office of the Child Safety Commissioner provides secretariat support to the Committee.

Relationship with Coronial Process

In Victoria the child death review process may take place before any related coronial process is concluded. However it is unclear whether the Coroner can access the full report of the Committee if this is completed before the coronial inquiry has closed. A representative of the State Coroner's Office is currently a member of the Committee⁷⁰. The Act clearly states that it does not limit or affect any power or function of the Coroner or member of the Police force to investigate the death of a child⁷¹.

3.1.2 NEW SOUTH WALES

Number of Bodies Involved

In New South Wales there is a single-tiered, independent child death review process. The Ombudsman is responsible for carrying out these reviews. The Ombudsman also carries out child death research in relation to child abuse and child protection deaths.

The Department of Community Services (DoCS), which is responsible for child protection in New South Wales, also reviews the circumstances of deaths of children previously known to the Department. Reviews are carried out by employees of the DoCS, within the Child Deaths and Critical Reports Unit. The Unit prioritises cases most likely to involve systemic issues and will not necessarily review the deaths of all former child protection clients.

The Ombudsman's child death reviews are separate and independent from the DoCS' internal reviews, although the Ombudsman is provided with the departmental report.

⁷⁰ *Annual Report of Inquiries into the Deaths of Children Known to Child Protection 2006*, Victorian Child Death Review Committee, p. 10.

⁷¹ Section 33(6), *Child Wellbeing and Safety Act 2005*.

In addition, the child death review system in New South Wales includes the Child Death Review Team (within the NSW Commission for Children and Young People). This team is responsible for the research function of the child death review system. It analyses data on deaths from all causes, but does not carry out individual child death reviews.

The Ombudsman

Legislation

The Ombudsman is an independent office established under the *Ombudsman's Act 1974*. The child death review and research function was added to the Ombudsman's jurisdiction by Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. The NSW Ombudsman has had jurisdiction over reviewable deaths since 1 December 2002.

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* sets out the scope and functions of the Ombudsman's child death review role; allows for the establishment of a child death Advisory Committee; provides powers to access information; overrides privacy and confidentiality provisions that would otherwise restrict access to sensitive information; limits disclosure of this information by the Ombudsman to maintain confidentiality and requires that the Ombudsman report annually to Parliament.

Scope

The Ombudsman has scope to inquire into "reviewable deaths" of children aged 0-17 (inclusive), whose deaths occurred in New South Wales⁷².

Reviewable child deaths include deaths where:

- the child was in care at the time of death;
- the child was subject to a report under the *Children and Young Persons (Care and Protection) Act 1998* within three years of their death or a sibling was subject to such a report;

⁷² Deaths of usual residents of New South Wales, where the death occurred interstate, are not within scope.

- the child's death may have been due to abuse or neglect or where the death occurred in suspicious circumstances;
- the child was in the custody of a detention centre, correctional centre or lock-up at the time of death;
- the child was living in residential care provided by a service provider funded under the *Disability Services Act 1993* at the time of death; or
- the child was part of a target group under the *Disability Services Act 1993* and was receiving assistance from certain service providers to live independently in the community.

The Ombudsman carries out a preliminary inquiry in relation to every death in this population to determine whether further investigation is warranted. The Ombudsman then has discretion to carry out a further inquiry into these deaths, in considerable detail, where appropriate⁷³.

While the Ombudsman focuses primarily on systemic issues within the child protection system, it is possible to comment on the actions of individual workers and to recommend appropriate measures in the event of serious misconduct or unreasonable actions.

The Ombudsman can make findings and recommendations in relation to policy and practice within any government department or service provider (not only DoCS) in relation to reviewable deaths.

Functions

The Ombudsman reviews deaths within scope to identify patterns and to make recommendations to improve the policies and practice of government and service providers. It also monitors implementation of its recommendations.

The Ombudsman also undertakes further research and maintains a register of reviewable child deaths. The Ombudsman and the Child Death Review Team maintain separate registers, and facilitate information exchange via a protocol where appropriate.

⁷³ *Reviewable Deaths Annual Report 2003-04*, NSW Ombudsman, pgs. 39-40.

Powers, Obligations and Protections

The Ombudsman has extensive statutory powers for accessing relevant information. All the powers of investigation available to the Ombudsman for general investigations also apply to child death reviews. The Ombudsman has unrestricted access to the records of DoCS, the State Coroner and any other government agency or service provider in relation to the review of child deaths. The Ombudsman regularly conducts preliminary inquiries and further investigations into reviewable deaths under sections 13AA and 19 of the *Ombudsman Act 1974* (respectively). The Ombudsman can potentially use powers under the *Royal Commission Act 1923* which enable the Ombudsman to require people to give evidence under oath and to produce relevant material, although these have not been used to date.

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* also protects persons and service providers who supply information to the Ombudsman from liability for defamation or in other civil proceedings or from breaching any professional code of conduct on the basis of the information provided⁷⁴.

Reporting

Legislation requires that the Ombudsman report directly to Parliament on an annual basis. The Ombudsman also gives reports on individual case reviews to relevant Heads of Agency and Ministers. These reports are not public as they identify the parties involved. Occasionally the Ombudsman will release a special child death review report to Parliament. Such reports are de-identified as they are in the public domain.

Membership

Child death reviews are carried out by relevant staff in the Community Services Division of the Ombudsman's office. The Ombudsman has also established an advisory committee of experts in the fields of child health and child protection to assist in the review of deaths and to provide advice on complex child death matters, policy and health practice issues⁷⁵.

⁷⁴ Section 40, *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

⁷⁵ *Reviewable Deaths Annual Report 2003-04*, NSW Ombudsman, p. 8.

Resources and Administrative Support

The child death review function is located within and resourced by the Ombudsman's office.

Relationship with Coronial Process

The Ombudsman's review can take place whilst the coronial process is still underway. The Ombudsman informs the Coroner when an investigation is intended. There is a cooperative relationship between the Coroner and the Ombudsman which facilitates exchange of information. The Ombudsman informs the Coroner of reviewable deaths where it appears this has not already been done and supplies the Coroner with a monthly schedule of deaths that have been identified as reviewable.

Under section 39 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the Ombudsman has discretion to provide information to a public authority or service provider where the Ombudsman thinks it appropriate to do so. This section enables the Ombudsman to provide information to the Coroner for the purposes of a coronial investigation into a reviewable death⁷⁶. The Coroner is required, pursuant to section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, to give the Ombudsman full and unrestricted access to relevant records in the Coroner's control relating to reviewable deaths, which may be used to inform the child death review process⁷⁷.

3.1.3 QUEENSLAND

Number of Bodies Involved

Queensland's child death review system involves multiple bodies, with different roles. The main process for reviewing child deaths is dual-tiered and involves reviews

⁷⁶ As a matter of law however, section 35 of the *Ombudsman Act 1974* provides that the Ombudsman is not compellable to provide documents or give evidence. This means that the Ombudsman is not required to give evidence or produce documents in response to any subpoena issued by the Coroner pursuant to section 35 of the *Coroners Act 1980*. Where DoCS has carried out an internal child death review the report is made available to the Coroner.

⁷⁷ Section 38, *Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2*. This provision overrides any law that restricts or denies access to records.

carried out by the Department of Child Safety (DoCS) in the first instance with oversight provided by the Child Death Case Review Committee (the Committee). The Ombudsman and the Crime and Misconduct Commission can also conduct child death reviews in some circumstances.

In addition, the Child Death Review Team, established under the *Commission for Children and Young People and Child Guardian Act 2000* undertakes the research function of the child death review system.

The description below focuses on the Committee as this is the principal, independent child death review body.

Scope

Both DoCS and the Committee have scope to review the deaths of 0-17 year olds (inclusive), where the child was known to DoCS within three years preceding death⁷⁸. This only includes deaths registered in Queensland, not deaths of usual residents where the death occurs interstate.

The Committee can only make recommendations in relation to DoCS but can comment on the relationship between the DoCS and other entities that were involved with the child and their family.

The Committee also has scope to make recommendations about whether disciplinary actions should be taken against officers or employees of DoCS in relation to their involvement with a child.⁷⁹

⁷⁸ This means circumstances where DoCS was aware of concerns for the child's safety or had taken action in relation to the child. This includes not only formal notifications but the receipt of any information regarding concerns for the child, regardless of whether action was required.

⁷⁹ *Child Death Review Committee Annual Report 2004-05*, Queensland, p. 15.

Department of Child Safety

Legislation

The initial child death review, undertaken by DoCS, operates under a legislative framework. Chapter 7A of the *Child Protection Act 1999* requires the Chief Executive of that department to review child deaths within scope.

Functions

DoCS reviews the deaths of children within scope and provides a report to the Committee within six months of being aware of the death.

The Director-General decides the extent of the review and terms of reference. The *Child Protection Act 1999* gives some guidance as to the terms of reference.

Powers, Obligations and Protections

DoCS can ask for relevant information from other agencies such as police, health and education. The *Child Protection Act 1999* protects persons giving information to DoCS for the purpose of child death reviews from breaching any code of conduct or ethics or from liability for giving the information and for this purpose. This section applies despite any other Act.⁸⁰

Reporting

DoCS provides its report to the Committee.

The Chief Executive of DoCS, who is responsible for the internal reviews, reports to the Minister for Child Safety.

Membership

In some cases, the internal reviews are carried out by departmental staff, while others are carried out by external reviewers contracted by DoCS.

Resources and Administrative Support

The initial inquiry process is internal to the DoCS.

⁸⁰ Section 246E and F, *Child Protection Act 1999*.

Child Death Case Review Committee

Legislation

The Committee is an independent body established under the *Commission for Children and Young People and Child Guardian Act 2000*. It has its own child death review functions under the Act, separate from those of the Commissioner for Children and Young People and Child Guardian.

The *Commission for Children and Young People and Child Guardian Act 2000* establishes the functions, membership, procedures and reporting obligations of the Committee. It also requires that the Commissioner provide adequate administrative support to enable the committee to carry out its functions effectively and efficiently. The Act requires that the Committee act independently.

Functions

The Committee oversees the internal child death review process carried out by DoCS⁸¹. Its aim is to increase accountability and improve effectiveness of decision-making in the child protection system. The Committee makes recommendations to DoCS to improve policies and practice and relationships between agencies.

The *Commission for Children and Young People and Child Guardian Act 2000* requires that the Committee establish a list of review criteria to be used in carrying out its reviews of the preliminary inquiry by DoCS. The Review Criteria are published in the Gazette and are contained in the Committee's 2004-05 Annual Report.

The Committee is also responsible for the monitoring implementation of its recommendations. The Act enables the Committee to make a report to the Minister for Child Safety if it is not satisfied that the Chief Executive of DoCS has taken appropriate steps to implement the Committee's recommendations.

Powers, Obligations and Protections

Despite its legislative basis, the Committee has no real investigative powers. It relies on the material provided to it by DoCS. This includes DoCS' report and all

⁸¹ *Child Death Review Committee Annual Report 2004-05*, Queensland, p. 2.

documentation collected for the making of that report (from within and external to DoCS). The Committee can also require DoCS to supply a supplementary report⁸². It can use this power to require DoCS to collect further information where it is thought that the information on which the preliminary inquiry was based was insufficient or incomplete.

The *Commission for Children and Young People and Child Guardian Act 2000* imposes obligations on the Committee to maintain the confidentiality of information obtained for the purpose of a review, by restricting disclosure of this information⁸³. It also protects persons who give the Committee information from liability for defamation⁸⁴.

Reporting

The *Commission for Children and Young People and Child Guardian Act 2000* requires the Committee to report annually to the Minister for Child Safety who must table the report in Parliament.

Membership

As required by the *Commission for Children and Young People and Child Guardian Act 2000*, the Committee has a multi-disciplinary membership, including both government and non-government representatives. Areas of expertise represented include child health, forensic pathology and reviews, social work and others⁸⁵. The Commissioner for Children and Young People and Child Guardian is the Chair, but acts independently of his or her usual role. There is at least one Aboriginal and one Torres Strait Islander member. The Coroner may be appointed. There are generally 5-7 members on the Committee.

⁸² *Child Death Review Committee Annual Report 2004-05* (QLD), p. 18.

⁸³ Section 89X, *Commission for Children and Young People and Child Guardian Act 2000*.

⁸⁴ Section 89Y, *Commission for Children and Young People and Child Guardian Act 2000*.

⁸⁵ Current membership includes the Commissioner and Assistant Commissioner for Children and Young People and Child Guardian, the Commissioner of Police, the State Coroner, a paediatrician, a social worker a psychiatrist and an Indigenous and a Torres Strait islander representative, both government employees (*Child Death Review Committee Annual Report 2004-05* (QLD), p. vii – x).

The Act contains provisions requiring members to disclose conflict of interests with matters considered by the Committee.

The Minister for Child Safety appoints and removes members, but the grounds for removal are limited by the Act. The Minister also determines the fees and allowances granted to members. The Committee can also use the expertise of external advisors in individual cases.

Resources and Administrative Support

Legislation requires that the Committee be provided with sufficient administrative support to enable it to carry out its functions and exercise its powers. This support is provided by the Commission for Children and Young People and Child Guardian.

Relationship with Coronial Process

Child death reviews carried out by DoCS and the Committee can take place before the conclusion of the coronial process. Legislation requires that where the review relates to a “reportable death” within the Coroner’s jurisdiction, DoCS must provide a copy of the preliminary inquiry report and the Committee’s final report to the Coroner for use in the coronial process⁸⁶.

However, the Committee’s report must not include any information identifying or likely to lead to the identification of any individual, except for the deceased child⁸⁷.

The Coroner also provides the Commissioner for Children and Young People and Child Guardian with a copy of the police report of death and coronial findings and comments once the coronial process is complete. This is used to add to the Commissioner’s child death register and to inform the analysis of groups of child

⁸⁶ Section 246H, *Child Protection Act 1999 and Child Death Case Review Committee Annual Report 2004-05*, p. 15. Section 89X, *Commission for Children and Young People and Child Guardian Act 2000* restricts disclosure of information obtained by the Committee, but enables disclosure to the State Coroner to assist with a coronial review.

⁸⁷ Section 89U, *Commission for Children and Young People and Child Guardian Act 2000* provides that Committee’s report must not identify any individual (although a separate document prepared for the Chief Executive of Child Safety can identify the deceased child). However, section 246H *Child Protection Act 1999* requires that, if the report does not identify the child to whom it relates a separate document must be provided identifying the child.

deaths. The exchange of this information is managed by a memorandum of understanding⁸⁸. In addition, the State Coroner and the Commissioner for Police are members of the Committee.

3.1.4 WESTERN AUSTRALIA

Number of Bodies Involved

The Western Australian child death review process is dual-tiered, involving an internal inquiry by Department of Community Development (DCD), overseen by the external Child Death Review Committee (the Committee).

The Advisory Council on Prevention of Deaths of Children and Young People is also part of the child death review system. It undertakes the child death research function of the child death review system.

Scope

Both DCD and the Committee review deaths of children at the request of the Minister for Community Development or Director-General, where:

- The child (aged 0-17, inclusive), or their sibling was previously the subject of an allegation of child maltreatment or a child concern report recorded by DCD with 24 months of the child's death;
- The child's family had a number of contacts with DCD within the previous 24 months that established a pattern;
- The child was in the care of DCD or a request for departmental involvement in an out of home care placement for the child had been made within the past 24 months.

The Committee's scope is limited to commenting on the operations of DCD. It can, however, comment on the relationship between this department and other government agencies.

⁸⁸ *Child Death Case Review Committee Annual Report 2004-05*, p. 13.

The Committee cannot comment on the performance of individual departmental officers, but can highlight concerns about the actions of individuals, which will then be addressed by the Director-General.

Department of Community Development

DCD undertakes a preliminary, internal review into deaths of children within scope.

Child Death Review Committee

Legislation

The Committee was established by Order of the Governor in Executive Council under section 22 of the *Community Services Act 1972*. The Order establishes the objects, functions, membership structure and powers of the Committee.

Functions

The Committee conducts child death reviews by reviewing DCD's internal child death inquiry report along with relevant case files. The purpose of the review is to provide a quality assurance mechanism for particular departmental cases where a child has died. It facilitates accountability in DCD.

When conducting reviews, the Committee considers the operation of relevant departmental policies, procedures and organisational systems in individual cases and identifies effective systems for implementation.

Powers, Obligations and Protections

The Committee does not have any power to require information. It relies on the report and material provided to it by DCD following the preliminary inquiry. The Committee can however ask DCD to provide additional information. If there were a problem receiving sufficient information the Committee could potentially draw this to the attention of the Director-General, Minister for Community Development or Ombudsman.

The Committee has its own procedures for ensuring that material obtained for the purpose of child death reviews is held securely and that access is restricted. Members are also subject to a code of conduct regarding secure maintenance and use of child death information.

Reporting

The Committee reports annually to the Minister for Community Development and Director-General, with outcomes made available to the public. The last two annual reports were tabled in Parliament. Annual reports are de-identified to protect the privacy of parties involved.

Membership

There are currently four Committee members. All current members have a background in psychology and social work.

Members are nominated by the Committee and DCD and discussed with the Minister for Community Development before being endorsed by Cabinet. Members can be dismissed by either the Chair of the Committee or the Minister, with Cabinet to be notified.

Resources and Administrative Support

The Committee is physically located within DCD which also provides administrative and research support.

Relationship with Coronial Process

Information regarding the relationship between the child death review and coronial processes in Western Australia is pending advice from the Advisor/Manager of the Child Death Review Committee (WA).

3.1.5 SOUTH AUSTRALIA

Number of Bodies Involved

The child death review process in South Australia is basically single-tiered. The Child Death and Serious Injury Review Committee (the Committee) conducts both child death reviews and child death research.

The Department of Families and Communities (Adverse Events Committee) may inquire into the deaths of children known to it, but this does not occur on a routine basis.

Child Death and Serious Injury Review Committee

Legislation

The Committee is a Ministerial Advisory Committee, newly established through an amendment to the *Children's Protection Act 1993* (the Act). It is still considering processes for the review of deaths and serious injuries and the definition of serious injury.

The amended Act establishes the scope, functions, powers, procedures, membership and reporting obligations of the Committee. It also requires the Minister for Families and Communities (DFC) to provide the Committee with adequate resources to carry out its functions and exercise its powers.

Scope

The Committee has scope to review a broad range of deaths. Legislation provides that, for certain kinds of death, the Committee “should” carry out a review, while for other kinds of death, the Committee “can” carry out a review. Ultimately, the Committee has discretion whether to review a death within scope. That is, not all deaths of children, even those known to the child protection authority, would necessarily be reviewed.

The Committee *should* review the death/serious injury of a child aged 0-17 years (inclusive) where:

- The death/injury was due to abuse/neglect or there are grounds to suspect this;
- There are grounds to believe that the death/injury might have been prevented by systematic change;
- There had been within three years before the incident, a notification to DFC of suspected abuse or neglect of the child or a member of the child’s family;
- The child was, at the time of death or serious injury, under the guardianship, or in the custody of the Minister for Families and Communities or in custody/detention or in the care of a government agency; or
- The case had been referred by the Coroner.

The Committee *can* review:

- deaths of *all* children aged 0-17 years (excluding still-births). This includes deaths registered in the State as well as deaths of usual residents of South Australia where the death occurred interstate.
- Serious injuries of *all* children aged 0-17 years. The definition of “serious injuries” is not yet established and is not defined in the legislation.

Through its reviews, the Committee examines the practices and involvement of any relevant government agency, not just that of the department responsible for child protection.

The Committee does not have scope to recommend disciplinary measures in relation to individual departmental workers involved with the child.

Functions

The Committee reviews cases within this scope to identify legislative or administrative means of avoiding the recurrence of similar events and makes recommendations to the Minister for Families and Communities. It also monitors implementation of those recommendations. The Committee also carries out general child death research and maintains a child death database.

Powers, Obligations and Protections

Legislation provides that the Committee may request documents relevant to a review from any person. It is an offence to fail to comply. However parents, relatives or foster parents do not have to comply, nor is it an offence to fail to comply if the information will incriminate the person, or if the information is covered by legal professional privilege. The legislation also enables the Committee to enter into arrangements with government agencies for the passing on of relevant information.

Legislation facilitates the review process by overriding laws or codes that would otherwise prevent disclosure of confidential information to the Committee.⁸⁹ It also ensures that the confidentiality of information provided to the Committee is maintained, by restricting disclosure of the information and restricting access to the

⁸⁹ Sections 52U and 52V, *Children's Protection Act 1993*.

Committee's database⁹⁰. Members have also approved guidelines and processes for collection, storage and retrieval of confidential and sensitive information.

Reporting

Legislation requires that the Committee report to the Minister for Families and Communities on an annual basis and that this report must be tabled in Parliament.

Membership

The Committee has a multidisciplinary membership including government and non-government representatives with expertise in health, justice, child forensics, psychology and advocacy. An Aboriginal representative and a youth advisor also sit on the Committee. There are 13 members. The Committee can also engage an expert to conduct a review or carry out any of its functions. The Act provides for members to be appointed and removed by the Governor.

Resources and Administrative Support

Administrative support is provided by the Department for Families and Communities.

Relationship with Coronial Process

The *Child Protection Act 1993* provides that the Committee must not carry out a child death review if there is a risk that this would compromise an ongoing criminal investigation. In addition, a child death review must not be carried out unless any coronial inquiry that is intended or is taking place has been completed, or unless the Coroner has requested the Committee to undertake that review⁹¹.

This means that in South Australia, there will be occasions when the coronial process is completed before the child death review begins and the Committee is able to use the Coroner's report to help with its own review⁹². There may also be occasions when the Committee undertakes its review before the coronial process is complete, or instead of the coronial process, at the request of the Coroner. Where this

⁹⁰ Sections 52T and 52X, *Children's Protection Act 1993*.

⁹¹ Section 52S(4), *Children's Protection Act 1993*.

⁹² Sections 52S(5) and 52(V), *Children's Protection Act 1993*.

happens, information obtained by the Committee that is relevant to a coronial inquiry must be passed on to the Coroner⁹³.

⁹³ Section 52X, *Children's Protection Act 1993*.

3.2. Strengths and limitations of key features of child death review processes in other jurisdictions

As shown above, the features of child death review processes vary quite significantly across jurisdictions⁹⁴. This section discusses merits and disadvantages of key features, taking into account factors specific to Tasmania that may affect the best choice of model for this State.

3.2.1 Number of bodies involved

3.2.1 (i) Separation of child death research function and child death review function

Jurisdictions differ in the number and purpose of bodies involved in the child death review system as a whole. Chapter One explained the distinction between child death reviews and child death research. Both are functions of child death review systems. Some jurisdictions split the two functions between different bodies. In other cases there is overlap between child death review and child death research roles.

In Queensland and Western Australia, the research and review functions are allocated to different bodies. In South Australia, the same body is responsible for both the review and research functions.

In New South Wales and Victoria the review body has a limited research function in relation to deaths attributed to child abuse or deaths within the child protection system. In addition, there is a separate body in both jurisdictions that has responsibility for the research function in relation to child deaths from any cause.

⁹⁴ Where in this chapter reference is made to the “review body” in each jurisdiction, this refers to the Victorian Child Death Review Committee (in Victoria); the NSW Ombudsman (in New South Wales); the Child Death Case Review Committee (in Queensland); the Child Death Review Committee (in Western Australia) and the Child Death and Serious Injury Review Committee (in South Australia).

The advantage of giving a single body responsibility for both the child death review and research functions is that this is likely to achieve some efficiencies of scale. Both functions will commonly require information from the same sources (Births, Deaths and Marriages, the Coroner and police, the department responsible for child protection and other agencies and service providers). Having both functions conducted by the same body would streamline information collection.

On the other hand, establishing a separate body for child death reviews may be more straightforward where there is already a body responsible for child death research and that body is not suited to the review role. In Tasmania, the Council of Obstetric and Paediatric Mortality and Morbidity (the Council) currently undertakes child death research and data analysis. Its capacity to take on the review role on a permanent basis is discussed in Chapters Four and Five.

There is a risk that adding individual child death reviews to the functions of a body set up specifically to carry out general child death research may overwhelm the resources of that body. This may result in one function being prioritised at the expense of the other.

3.2.1 (ii) Single or dual-tiered review process

Jurisdictions also differ in the number of layers involved in the child death review process. In some jurisdictions, the entire review is carried out by a single body. In other jurisdictions there is a dual-tiered process, usually involving an internal review overseen by an external review body.

Queensland and Western Australia have a dual-tiered review process⁹⁵. This approach has certain advantages. Firstly, giving primary responsibility for child death reviews to the department responsible for child protection is likely to prove a cost-effective option. Sourcing the costs for collecting and analysing material on a child's death from within the department will make the budget of the child death review body

⁹⁵ Similarly, Victoria has a two stage process. In Victoria however the first stage of the process is carried out by the Office of the Child Safety Commissioner and so is external to the department responsible for child protection (see page 54).

extend further. Secondly retaining, or establishing a departmental review process may help to promote transparency and accountability within the Department⁹⁶.

It is important that if a dual-tiered process is adopted, the independent body should have access to all material on which the preliminary inquiry relied and should also have the power to itself seek further information or to require the department to do so, where it considers the preliminary inquiry to have been inadequate. This power is critical to ensuring that the independent body has the capacity to oversee a thorough and rigorous review process. The Queensland review body is able to request supplementary reports from the department where it considers that the original departmental inquiry failed to collect all relevant information⁹⁷.

The dual-tiered approach is perhaps not such an obvious option for Tasmania as for other jurisdictions in which it was adopted. Whilst there have been two Departmental child death reviews since the proclamation of the *Children, Young Persons and Their Families 1997*⁹⁸, a departmental process has not been clearly established. The dual-tiered option would therefore require the establishment of two review processes; a departmental and an external process.

New South Wales and South Australia have a single-tiered review process carried out by an external body. An advantage of this approach is its simplicity. Clearly a single-step process would streamline the process for information gathering and analysis. This has the potential to increase the timeliness of recommendations arising from reviews.

Another argument in favour of the single-tiered approach is that it has greater potential to achieve the perception of complete independence and objectivity, which in turn will enhance the accountability and transparency both of the review process and the principal subject of reviews – the child protection system.

⁹⁶ *Protecting Children* (QLD), p. 166.

⁹⁷ *Protecting Children* (QLD), p. 165.

⁹⁸ See footnote 4.

3.2.2 Independence

There is no universally accepted definition of an "independent body". It is therefore difficult to categorically state which jurisdictions have a genuinely independent child death review process. It is useful at this point to consider some of the features of an independent body.

In the context of a child death review process, the primary purpose of independence is to ensure that findings and recommendations of the review body are not influenced by the interests of the government whose services are under review.

In order to ensure its independence there must be an effective separation between the review body and any other body with a vested interest in the child protection system. This separation must occur at an institutional and individual level.

To secure independence at an institutional level, the child death review process must be established in such a way that its scope, functions, powers and funding are sufficient to enable it to operate effectively and are secure from changes in political will. This is necessary in order that the body is genuinely free and able to make rigorous findings and recommendations without reference to political imperatives.

Establishing the review body in legislation is one way to secure the institutional independence of the review body. It can do this by fixing the review body's scope, functions, powers and mechanisms for appointment and removal of members so that they are secure from fluctuations in political will.

Legislation can also help to ensure the body is sufficiently funded. In Queensland and South Australia this is achieved through a specific provision imposing a requirement that the review bodies be adequately funded so that they can carry out their functions and exercise their powers. Short of this, the mere fact that the review body has statutory duties to fulfill creates a persuasive case for the provision of adequate funding by the government.

Openness and transparency can also help to secure the independence, and perception of independence, of the child death review body at an institutional level. This can be achieved through reporting processes that are public and open to

scrutiny. Ideally this involves reporting to Parliament rather than a Minister or Secretary of a government department.⁹⁹

The location of the review body or the administrative support it receives also affects its independence at an institutional level. To maintain the separation between the review body and the principal subject of review – the child protection system – ideally the review body should be located outside the department responsible for child protection. In the best case scenario, the child death review body would be located within, or attached to an office that is independent of government.

The appointment and terms of office for members of the review body will determine whether a level of individual independence is secured. It is important that all members be impartial and objective in carrying out their duties. Ideally this would mean that members have no personal or professional connection with the subject of review (the child protection system and related government services). This will not always be possible or desirable, particularly in a small jurisdiction.

Alternatively, the terms of office can require members to act independently in their role on the review body. In Queensland, legislation specifically requires this and also provides that members must disclose conflicts of interest with matters under consideration by the review body.

The manner of appointment is also important in ensuring that members are impartial and objective. Members must be appointed on the basis of merit. There must be no question that members are appointed because they represent a particular perspective, particularly a perspective that is favorable to the government. Ideally, appointment by the Governor or by Parliament would make the appointment process clear, transparent and free of bias. Appointment by the Minister is preferable to appointment by the Secretary, as the Minister is accountable to Parliament.

⁹⁹ The *Baby Kate Report* (QLD), p. 111 claimed that there are two essential features of a child death review process: consistency and transparency. These features are important to ensure public confidence in the child protection system. The report suggested that these features could be secured by giving the review body a legislative basis and independence from government and by requiring it to report to Parliament.

Finally, the mechanism for dismissing members is important in securing individual independence. It is important that the possibility of dismissal cannot act as a pressure on members to make findings favorable to the government. Fixed terms and dismissal by the Governor or Parliament would help to secure individual independence. Dismissal by the Minister is again preferable to dismissal by the Secretary, particularly if the grounds for removing members are limited by legislation rather than left to the Minister's discretion.

3.2.3 Legislation and Administrative Arrangements

As discussed above, a legislative basis can help to secure the independence of a review body. In New South Wales, Queensland and South Australia, the review body is established in legislation. In Western Australia, the review body is established by Order in Council, which also sets out the features of the body. In Victoria, the review body is established as a Ministerial Advisory Committee and has no supporting legislation.

Legislation can also increase the efficacy and timeliness of child death reviews. In Queensland there is a mandatory review period, thus putting pressure on the Government to adequately resource the body to enable it to perform its statutory duty in a timely manner.¹⁰⁰

Statutory powers to access relevant information can also assist with the timeliness of reviews by avoiding the need to rely on administrative arrangements for the receipt of departmental files and other relevant information. The report *Preventing Child Homicide* (NSW) considered administrative arrangements for information exchange to be potentially problematic¹⁰¹. Administrative arrangements depend on the cooperation and goodwill of individual departments, which may be affected by political and other pressures given the highly sensitive nature of child deaths.

¹⁰⁰Section 89 U, *Commission for Children and Young People and Child Guardian Act 2000* requires the review body to complete its review within three months of receiving the preliminary inquiry from the Department.

¹⁰¹ *Preventing Child Homicide* (NSW), p. 39.

The *Layton Report* (SA) and *Preventing Child Homicide* (NSW) both mentioned the importance of timely reviews¹⁰². Timely reviews are important to avoid loss of evidence, to ensure the safety of surviving siblings and to expedite improvements to the child protection system where needed, for the benefit of all vulnerable children.

Legislation can also be used to override other laws and protocols that would otherwise restrict disclosure of confidential information. It can also facilitate disclosure of information by health professionals and others by protecting those who supply information from liability for defamation or in other civil proceeding. Finally, it can ensure that the confidentiality of material obtained by the review body is maintained, by imposing obligations on the body regarding use, record-keeping and disclosure of the information.

Some disadvantages of giving a child death review process a legislative basis are that this will be a costly and potentially time-consuming option initially. Statutory-based functions and powers can also be inflexible (when narrowly defined) which could potentially limit the child death review body's options.

3.2.4 Powers

In those jurisdictions with a single-tiered child death review process (South Australia and New South Wales), the review body has comprehensive statutory powers to collect information from relevant sources.

Where the review process is dual-tiered (Victoria, Queensland and Western Australia), the external review body does not need extensive powers to access information as its purpose is to review the material and report provided by the preliminary review body. As noted earlier in this chapter, it is important that the body can ask for extra information where the internal review was inadequate or incomplete.

3.2.5 Reporting

Reporting processes contribute to the level of independence enjoyed by a child death review body. Clearly, if the findings and recommendations of the child death review

¹⁰² *Preventing Child Homicide* (NSW), p. 39; *Layton Report* (SA), p. 18.12.

body are made public and open to scrutiny the process will be more effective in holding the Government accountable to act on the issues identified by the body.

However, a fully open process may not be possible or desirable as it is likely to infringe the right to privacy of individuals involved in cases reviewed. This is not only detrimental to those individuals at a time of great stress, but may also jeopardise the review process by making individuals more reluctant to come forward with critical information. Therefore a balance needs to be struck between the need for openness and accountability and the need to respect the privacy of individuals involved.

In the jurisdictions examined, there are generally two levels of reporting. Periodically, or at the conclusion of each case review, the child death review body will generally report its findings and recommendations to the Minister or relevant Head of Agency. These reports identify the parties involved and for that reason are not made public.

In addition, the review bodies report annually to Parliament, either directly or through their Minister. These reports contain an analysis of information and findings arising out of reviews carried out through the year. The information is usually presented in general themes and issues. Parties involved are not identified. In some jurisdictions case-specific information is reported in “case studies” without identifying parties.

In New South Wales the Ombudsman may occasionally present a special report to Parliament during the year, detailing the facts of an individual case. These reports are de-identified to protect the privacy of parties involved. The advantage of this approach is that in extreme cases of system-failure the Government is publicly held to account in relation to individuals.

These layers of reporting help to achieve the balance between accountability and privacy. In a small jurisdiction it is likely to be difficult to de-identify case-specific information. The option of including de-identified case studies may therefore be unrealistic in Tasmania. Nevertheless accountability can be achieved through public reports that include findings and recommendations which are generalised in themes and issues rather than being case-specific.

3.2.6 Membership

As discussed above, the manner in which members of a review body are appointed and may be removed will affect the independence of the body. In South Australia legislation provides that members are appointed and can be removed by the Governor. In New South Wales the Ombudsman is also appointed by the Governor under legislation. In all other jurisdictions, members are appointed and can be removed by the Minister¹⁰³.

Representation is another interesting feature of membership. In most jurisdictions, the review body has a broad, multidisciplinary membership that includes both government and non-government representatives.

A multidisciplinary membership is particularly important if the scope of the review process enables the child death review body to consider the involvement of other agencies, in addition to the child protection authority.

The *Layton Report* (SA) and *Preventing Child Homicide* (NSW), emphasised the need for the review body to have a core membership to ensure continuity in the review process, rather than having independent experts appointed to carry out reviews on a one-off basis¹⁰⁴. As discussed earlier, continuity is necessary to build up a reliable picture of the child protection system over time. It also assists with ongoing monitoring of implementation of the review body's recommendations.

The *Layton Report* (SA) suggested that in addition to the core membership, the review body should have the ability to co-opt external advisors on a case-by-case basis, according to the type of expertise required given the circumstances of each case¹⁰⁵.

Review bodies in Queensland and South Australia have the ability to appoint expert advisors to assist with their functions in addition to a core group of members.

¹⁰³ In Western Australia appointments are endorsed by Cabinet and Cabinet is also notified when members are removed (either by the Chair of the Committee or by the Minister).

¹⁰⁴ *Preventing Child Homicide* (NSW), p. 20 and *Layton Report*, p. 18.14

¹⁰⁵ *Layton Report*, p. 18.11.

Similarly, in NSW, the Ombudsman has established an advisory committee comprised of experts in the child health and child protection fields, to provide advice in relation to child death reviews. The Western Australian Child Death Review Committee can seek expert or professional advice on a case-by-case or issues basis.

This approach would have advantages for a small jurisdiction with limited resources. It would allow for a small but permanent membership to ensure continuity, whilst ensuring that appropriate expertise is employed in each review through consultation with external advisors.

3.2.7 Location and Administrative Support

As discussed above, the location or administrative support provided to a review body will affect its independence. In New South Wales the child death review function is carried out by the independent office of the Ombudsman. In Queensland, the review body is located within and supported by the independent Commission for Children and Young People and Child Guardian (although its functions are separate from those of the Commission). In South Australia and Western Australia the review bodies are supported by a government agency. In Victoria, the review body is supported by the Office of the Child Safety Commissioner.

Creating a stand alone body with executive support provided by a government department could be a cost-effective option. It could also help to facilitate the collection of departmental records for the purpose of the review. However, this option has the disadvantage that this association with the government may taint its independent image.

Locating a new child death review body within an existing, independent office (or giving an existing body the new child death review function) would also maximise existing resources, office infrastructure and expertise. The review process would also benefit, in terms of public confidence, through its association with an already recognised, independent body.

Based on models in other jurisdictions, the options for attaching a new review body to an existing, independent office include use of the office of the Commissioner for

Children or the Ombudsman's office. The *Layton Report* (SA) also considered the possibility of locating the review body within the Coroner's office.

The functions of a child death review body would sit well with the role of the Commissioner for Children or the Ombudsman. However there is a risk that this would divert already limited resources away from these offices, diminishing their capacity to carry out their core functions. This has been the experience to some degree in New South Wales where the Commissioner for Children and Young People is responsible for the Child Death Review Team (which carries out the research function of the child death system in that State) ¹⁰⁶.

Locating the review body within the Coroner's office would have the advantage of exploiting existing investigative expertise. However, the role of the Coroner is much broader than the proposed scope of the child death review process and the primary purpose of coronial reviews is quite different. There is a risk that the objectives of the child death review process would be lost within the broader role of the office. Arguably the Coroner's office is not best placed to identify problems or gaps in the child protection system without expertise and qualifications specific to child health and child protection¹⁰⁷.

Alternatively, the Coroner's investigative expertise could be utilised, and duplications between the child death process and the coronial process could be avoided, by including the Coroner as a member of the review body. The relationship between the child death review and coronial processes is discussed further below.

The *Layton Report* (SA) concluded that, wherever the review team was located, it must be independent and should have a clearly defined role, separate from that of the office where it is located¹⁰⁸. Establishing a review body in legislation is one way of clearly articulating its independent role.

¹⁰⁶ *Layton Report*, p. 18.13.

¹⁰⁷ Chapter Four discusses the coronial process in more detail.

¹⁰⁸ *Layton Report*, p. 18.13.

3.2.8 Scope

3.2.8 (i) Reviewable Cases

The scope of reviewable child death cases is generally confined to deaths attributed to abuse or neglect and deaths of children formerly known to the child protection authority¹⁰⁹. The precise scope of reviewable cases in each jurisdiction varies around this theme.

The child death review processes in Victoria and Queensland have the narrowest scope for reviewable cases. This scope is confined to deaths of children who were clients of the child protection authority within a certain period of their death.

In New South Wales, Queensland and South Australia the timeframe for contact with the child protection system prior to death is three years. In Victoria, the timeframe is significantly less, with child deaths only being reviewed where the child was known to the child protection system three *months* before death. In Western Australia, the timeframe is 24 months before death.

The New South Wales, South Australian and Western Australian child death review processes have a broader scope of reviewable cases, relative to the other jurisdictions. Between them, the scope extends to circumstances where¹¹⁰:

- the child was in care or custody at the time of death/serious injury;
- the child, a sibling or a family member were previously known to the child protection authority;
- the cause of death/serious injury was suspicious or may have been due to abuse or neglect;

¹⁰⁹ For those bodies responsible for child death research on the other hand (as opposed to individual reviews) the scope is much broader. Child death research generally includes all child deaths within scope, regardless of cause. This signifies the distinct purposes of child death reviews and child death research. The review role is clearly and specifically focussed on critiquing the child protection system, whereas the research role has a much broader educational and public health surveillance role.

¹¹⁰ The scope of child death reviews is not exactly the same in New South Wales, South Australia or Western Australia. This list is a combination of the scope of reviewable cases in the three jurisdictions. For detail regarding the precise scope in each jurisdiction, see earlier in this chapter.

- the child was involved with disability services at the time of death (in certain circumstances);
- the death/serious injury may have been prevented by systemic change;
- the case had been referred by the Coroner.

In South Australia the scope of child death reviews is broader still; in addition to investigating child deaths and serious injuries within the child protection and child abuse population (as a priority), the review body also has discretion to review any child death and serious injury, although this is not mandatory.

The *Layton Report* (SA) and *Preventing Child Homicide* (NSW) provide some convincing arguments to support a broad scope for reviewable cases.

In relation to serious injuries, the *Layton Report* (SA) explains that these events can be just as informative as injuries resulting in a fatality. They can be accompanied by the same warning signals and contributing factors.

Reviewing the circumstances of serious injuries can, like child death reviews, identify system failures for the benefit of future children. In addition, these reviews can be expected to provide an opportunity for the child protection authority to take action to reduce the risks of further harm to the particular child.

The benefits of including serious injuries within the scope of a child death review process are particularly pertinent to small jurisdictions. The small numbers of child deaths in Tasmania are likely to make it difficult to identify trends and systemic issues over short periods of time. Adding serious injuries to the population reviewed will increase the size and reliability of data collected.

Serious injuries may also result in significant long-term costs for the community and for Government, in terms of the support that may be required to manage resulting disabilities or long-term effects. It is important to understand such injuries to fully understand the impact of abuse. Collecting data on rates and types of injury can also be useful to make adequate provision for support services.

Preventing Child Homicide (NSW) provides some support for the benefits of conducting child death reviews where the trigger for the review is that a *sibling* of that

child was previously known to the child protection authority. The report noted that some studies suggest that surviving siblings of child homicide may have also been abused¹¹¹. Common sense also suggests that if one child is at risk within the family, other children within the family are also likely to be at risk.

Giving a child death review body scope to examine cases where a sibling of the deceased child was previously known to the child protection authority would enable further information to be collected to establish whether sibling abuse is a strong indicator that a child is at risk and whether there is a need for a change in practice to recognise and respond adequately to this risk.

Preventing Child Homicide (NSW) recommended that reviewable deaths include those caused by, or suspected of being caused by abuse or neglect (regardless of any involvement of a service provider with the child or their family), in addition to deaths where the child was previously known to the child protection authority. Investigating deaths of this kind would enable the review body to assess whether there are any systems issues that are causing children at risk to go unnoticed and therefore unassisted by the system.

The report also noted the importance of including deaths caused by neglect within the scope of the review body. According to this report deaths caused by neglect are more common than deaths by abuse, but neglect is often not recognised as the cause. It may be difficult to identify these deaths, but information on deaths caused by neglect is at least as important as information on child deaths caused by abuse.¹¹²

The main argument against a wide scope of reviewable deaths is that it would increase the work load of the child death review body. This argument is particularly strong in Tasmania, where resources are likely to be limited.

Interestingly, both New South Wales and South Australia counter-act the potentially large case-load that would otherwise result from the wide scope of reviewable cases,

¹¹¹ *Preventing Child Homicide* (NSW), p. 34. However in the sample of deaths reviewed in the New South Wales report, none of the cases where the deceased child had siblings showed evidence of prior sibling abuse.

¹¹² *Preventing Child Homicide* (NSW), pgs. 20-21.

by giving the review body some discretion as to when to carry out a full review. That is, detailed reviews are not mandatory for all cases that fall within scope. This gives the review body a mechanism to control its workload.

For example, in New South Wales the review body is required to carry out a preliminary inquiry in relation to all deaths within scope, but it is left to the discretion of the body when to carry out a further investigation in more detail. This approach would conserve resources by enabling the body to make an informed decision about which cases were most likely to provide insights into systemic child protection issues, as opposed to incidental or one-off issues.

It may also be difficult to implement a child death review process with the breadth of scope used in New South Wales and South Australia (and to a lesser degree, Western Australia) because of a lack of information, obstacles to information exchange and definitional issues.

For example, establishing a consistent process to review the deaths of children where a sibling, rather than the child themselves, was previously known to Child Protection Services may be difficult to administer. Firstly, it may be difficult to identify a child's siblings (some siblings may have different surnames and different residential addresses depending on the structure of the family). Secondly, a child might be living with other children that are not necessarily siblings but who are, nonetheless, at risk from the same carer. This raises the question of how "sibling" would be defined to best capture the purpose of including sibling abuse as a trigger for a child death review.

The NSW Ombudsman canvassed this definitional issue in their Annual Report 2003-04. "Sibling" is not defined in legislation in that jurisdiction, so the Ombudsman has developed the following working definition for operational purposes:

*"The sibling must share one or more adoptive or biological parents of the child, who is the subject of the report. The sibling must also have the characteristic of ordinarily being a member of the same household as the deceased child on a full or part-time basis."*¹¹³

¹¹³ *Reviewable Deaths Annual Report 2003-04*, NSW Ombudsman, p. 37.

Definitional issues may also arise if serious injuries are included with the scope of a reviewable case. How would “serious injury” be defined, and who would determine whether injuries fall within the classification on a case-by-case basis? This would probably require a new process of classification and reporting to be implemented by all medical practitioners. The parameters around “serious injury” would need to be clearly defined to ensure consistency of classification.

Similarly, definitional issues may be an obstacle to investigating deaths caused by neglect, as neglect is not so easily identified as abuse. For example, where a child dies because of lack of parental supervision, would this be classified as neglect? In some cases, the lack of supervision may have been a one-off omission in an otherwise healthy relationship, in other cases it may have been part of a pattern of neglect.

3.2.8 (ii) Multi-Agency Approach

In the reports introduced in Chapter Two, it was commonly recognised that there is a need to look beyond the role of the child protection authority in relation to a child's death. It is necessary to understand how the broader system of support services for children and their families contribute to child wellbeing and protection.

In New South Wales, Victoria and South Australia the review body has the scope to comment on the involvement of other relevant service providers that were involved with the child or their family, in addition to the child protection authority.

In Queensland the review body can only make recommendations directed at the department primarily responsible for child protection. But it can make recommendations regarding the department's relationship and communication with other government departments, and in some cases, non-government entities.

There is ample evidence to show that there are common linkages between child abuse and neglect and parental problems such as domestic violence, substance abuse and mental health. The *Layton Report* (SA) and *Preventing Child Homicide* (NSW) also provided statistical evidence showing linkages between support services accessed by vulnerable children and their families.

The *Layton Report* (SA) cited the findings of a Virginian State Child Fatality Team Report (United States) that examined 58 suicide fatalities among children and young persons in 1994-95. Of these 17% had involvement with child protection services; 25% were involved with the juvenile justice system; 25% had received community welfare services; 47% performed below average to poor in school; 40% had received mental health services; and 21% were involved in custody disputes¹¹⁴.

Preventing Child Homicide (NSW) made the following findings based on a sample of child deaths attributed to abuse or neglect or suspected of being caused by abuse and neglect between 1989 and 1991¹¹⁵:

- in all cases reviewed, the suspect was known to the child (with the vast majority being biological or substitute parents);
- in 59% of cases the suspect or their immediate family had been in contact with professional agencies (such as doctors, Police, community workers, psychiatrists) before the homicide;
- 27% of suspects had received psychiatric treatment prior to the homicide;
- 27% of suspects had a history of substance dependence;
- in 26% of cases domestic violence featured as part of the family background; and
- in 41% of cases a previous history of physical abuse of the victim was established¹¹⁶.

These findings generally supported the results of other studies in Australia and overseas. The report also found that a lack of attention was paid to the needs of the child when professionals were involved with the problems of the parent¹¹⁷.

As the *Preventing Child Homicide* (NSW) report stated:

*“adequate decisions about children at risk cannot be made without all necessary information on a family and without the combined strengths and resources of relevant agencies”*¹¹⁸.

¹¹⁴ *Layton Report*, p. 18.12.

¹¹⁵ This sample only included deaths of children aged 0-14 years.

¹¹⁶ *Preventing Child Homicide* (NSW), pgs. 25-36.

¹¹⁷ *Preventing Child Homicide* (NSW), p. 52.

Similarly, the *Climbie Inquiry* (UK) concluded that:

*"It is not possible to separate the protection of children from wider support to families. Indeed, often the best protection for a child is achieved by the timely intervention of family support services."*¹¹⁹

And

*"effective support for children and families cannot be achieved by a single agency acting alone. It depends on a number of agencies working well together. It is a multi-disciplinary task."*¹²⁰

Several of the reports that were based on an individual death inquiry illustrate the importance of giving the child death review body the power to review the role of all agencies involved with the child or family. Important findings and recommendations arising out of those inquiries, in relation to a number of government agencies, would not have been possible if their scope were limited to observations about the child protection authority in isolation.

For example, the *Gordon Inquiry* (WA) examined the actions of government agencies in responding to family violence and child abuse in the context of a young girl's death. While contact between the girl and the Department of Community Development had been minimal, there were many contacts between the family and various departments, including Justice, Education, Housing, Aboriginal Medical Services and substance abuse programs¹²¹. The inquiry identified two key issues: the lack of a single agency taking a lead role in relation to the young girl's family and the lack of information-sharing between agencies. It claimed that there was a need to develop an approach to family violence and child abuse that goes beyond the efforts of individual agencies and recommended that complex cases be dealt with on a whole-of-government basis¹²².

¹¹⁸ *Preventing Child Homicide* (NSW), p. 51.

¹¹⁹ *Climbie Report* (UK), p. 7.

¹²⁰ *Climbie Report* (UK), p. 7.

¹²¹ *Gordon Inquiry* (WA), p. 371-372,

¹²² *Gordon Inquiry* (WA), p. 372-376. Another example is the *Baby Kate Report* (QLD) in which the Ombudsman examined the administrative actions of the Department of Families and the Department of Health in relation to the safety of a baby girl in the care of her mentally impaired mother. The

If effective support services for families are critical to achieving protection for vulnerable children, as the literature and statistics suggest, then arguably a child death review process must have scope to recommend improvements to related child and family support services, in addition to the child protection authority, if the process is to be successful in reducing the incidence of child abuse and deaths within the child protection system.

On the other hand, broadening the scope in this way could detract from a rigorous analysis of the role of the child protection authority, which clearly has primary and most direct responsibility for the safety of children at risk. This risk is particularly likely to be the case in a small jurisdiction such as Tasmania, where resources are limited. It could be argued that the coronial process is sufficient to consider the role of the broader network of service providers and that the focus of a specialist child death process should be more narrowly defined.

3.2.8 (iii) Disciplinary Matters

In all jurisdictions examined, the child death review process focuses on systemic issues. In Queensland and New South Wales, the review body is also able to comment on the actions of individual workers and to recommend disciplinary measures.

Giving the child death review body scope to comment on the performance of individuals has the potential to inhibit full and frank exchange of information between departmental workers and the review body. It could also distract the review process from focussing on wide-spread systemic issues, leading instead to blaming and scape-goating of individuals. Arguably this outcome would be less effective in efforts

Ombudsman also determined that the interaction between police officers and officers of other government departments in this case was so important as to require examination of the actions of police officers as far as possible (despite not having jurisdiction to fully examine the operational decisions of that agency). The Ombudsman made important recommendations for improving the quality of decision-making and administrative practice within Queensland Police Service, where this service interacts with other agencies responsible for child protection (*Baby Kate Report* (QLD), p. xv). The New South Wales inquiry *Improving Outcomes for Children* (p. 26) also identified limitations in the police investigative process and recommended that the New South Wales Police undertake a review of issues raised in the report (regarding the lack of rigour in the police investigation and inadequate recording and referral of information).

to prevent the recurrence of events of a similar nature. The potential for individual actions to be scrutinised by an external body may also lead to more risk averse decision-making among child protection case workers, which will not necessarily be in the best interests of the child.

On the other hand, if there is no departmental review of deaths of children previously known to the child protection authority, there may be no alternative mechanism for identifying malpractice among individual workers. While the focus of child death reviews should be on systemic issues, clearly individual accountability is important for the overall effectiveness of the child protection system.

A compromise solution may be for the responsible department itself to consider the need for disciplinary action. One option is to give the review body scope to recommend that the department review the actions of its staff, where disciplinary issues are identified in the child death review process. This is basically the approach taken in Western Australia, where the review body can raise concerns about the actions of individual departmental workers so that these concerns can be addressed by the Director-General.

This option was also used in the inquiry *Improving Outcomes for Children* (NSW). In this inquiry, the Ombudsman did not review in detail the decisions and actions of individual officers, but it did emphasise that the overall failings of the Department indicated a need to further examine the conduct of relevant officers so that appropriate managerial and remedial action, including training and education, could be taken. It suggested that the Department of Community Services (responsible for child protection) should undertake this review.¹²³

An alternative option is to leave consideration of the actions of individuals to the Ombudsman and the Coroner's Office.

3.2.9 Relationship with Coronial Process

If a child death review body is established it will be important to clearly articulate the relationship between this process and the coronial process. Firstly, it is important

¹²³ *Improving Outcomes for Children* (NSW), p. 22.

that the child death review process does not compromise or interfere with a coronial inquiry or any criminal investigation. Secondly, it is important to minimise duplication to avoid overwhelming persons involved in the case with requests for interviews and documentation from two separate review processes.

One option for managing the relationship between the child death and coronial processes is to enable the Coroner to have access to the child death review body's full report and the material on which it relied. This would relieve the Coroner of the primary burden of gathering and analysing information relating specifically to the role of Child Protection Services in the child's death. It could also add to the detail of the Coroner's findings in relation to system-failures where these occur. This option would largely resolve the potential problem of duplication. It would also enhance the coronial process and would benefit the child death review process by creating an extra source of public awareness for the lessons learnt from child death reviews.

However this option has the risk of compromising the child death review process. The child death review process will rely on departmental workers and other service providers giving full and frank information with regards to their involvement in a case. As the review clearly focuses on systemic issues, rather than individual responsibility, it is hoped that those involved will be uninhibited in providing this information.

If the findings of the child death review process are made available to the Coroner, individuals may not be so forthcoming. They may be reticent in divulging information to the child death review body due to a perception that this could expose them to cross-examination and potential criticism or adverse findings in a public and inquisitorial forum. In larger jurisdictions it may be possible to de-identify detailed findings to alleviate this risk. However, in a small jurisdiction this will be very difficult.

It is unlikely that detailed, case-specific findings of child death reviews will be publicly available, as this would compromise the privacy of individuals involved.

If the Coroner were given unrestricted access to case reports, this could raise questions about natural justice as persons mentioned in the report will not have an opportunity to view or rebut statements which could potentially influence the Coroner in the coronial process.

A related option is to include a representative of the coronial process in the membership of the child death review body. This option carries the same risk of associating the child death review process with the coronial process, discussed above. However, the benefits of this option arguably outweigh its disadvantages. Including a Coroner in the membership of the child death review body would ensure that there is effective communication between the two bodies, so that the risks of overlap and interference can be managed.

Another option is to withhold the fully detailed report of the child death review body from the Coroner's office, but to manage the two review processes in some way to minimise overlap and to prevent the child death review process from potentially compromising the coronial process or any criminal investigations that may be held.

This could be managed by postponing the child death inquiry until the completion of the coronial inquiry, if there is one. The advantage of this approach is that the child death review process can benefit from the extra information and analysis provided in the police investigation and Coroner's report. The significant disadvantage of this approach is that it would involve a major delay between the death and recommendations for improving policy and practice arising from the child death review.

Alternatively, the relationship between the two processes could be managed via protocols and effective communication channels between the two bodies. In reality, there may not be a great deal of overlap between the resources relied upon by the two review processes. Generally, the police investigation and coronial process do not go into much detail regarding case management and decisions of Child Protection Services, focussing instead on the circumstances immediately surrounding the death.

A protocol could establish a procedure for communication between the bodies to ensure that there is no significant overlap in interviews to be conducted and requests for information in any one case. The protocol could also clarify that where there is likely to be significant overlap, the coronial inquiry must take precedence. In this way, both processes could be carried out simultaneously, but with arrangements in place to manage the risk of one process compromising another, or overwhelming parties with requests for information.

The jurisdictions examined in this paper manage the relationship between the coronial process and the child death review process in different ways. In most jurisdictions there is nothing to prevent the child death review from taking place before the conclusion of any related coronial process. In some jurisdictions legislation enables or requires the child death review body to pass on information to assist in the coronial process. In Queensland the child death review report must be de-identified before it is passed on to the Coroner.

In New South Wales the *Coroner* is required to pass on information to assist with the child death review process, where the coronial inquiry is concluded first. In Queensland a protocol is in place to facilitate information exchange and a cooperative relationship between the two bodies. In Queensland and Victoria a representative of the Coroners office currently sits on the child death review body.

3.3. Considerations for Tasmania

Certain factors specific to Tasmania may impact on the best choice of model for a child death review process in this State. Three key factors are Tasmania's small population, limited resources (relative to some other States) and existing organisational structures. These structures include the Council of Obstetric and Paediatric Mortality and Morbidity (the Council), Paediatric Mortality and Morbidity Sub-Committee (the Paediatric Sub-Committee), Commissioner for Children (the Commissioner), Ombudsman and the Coroners Office.

Certain features of the child death review processes described in the first part of the chapter may be particularly well suited to Tasmania, given these three key factors. These issues have been discussed above, but it is useful to consider them collectively, under this heading.

3.3.1 Limited Resources

A dual-tiered approach, involving a preliminary review conducted by the Department overseen by an external child death review body has the advantage of utilising departmental resources and minimising the costs of operating a child death review body. However in Tasmania the departmental process for reviewing child deaths is not well-established or comprehensive and would need to be re-invigorated or re-designed if it were to be part of a rigorous child death review process. In view of this it may be just as straightforward and cost effective to establish a new, single-tiered and independent child death review process which is separate from Departmental child death reviews.

Another way to conserve resources without compromising the expertise of the child death review body is to appoint a small, core membership and in addition, give the body the capacity to appoint expert advisors to assist with individual cases where needed. This would instil continuity in the overall process whilst ensuring relevant expertise in each case, without requiring a large membership.

The *Layton Report* (SA) recommended that, given South Australia's limited resources (relative to jurisdictions like New South Wales) the review body in that State should link in with current committees and bodies responsible for examining child deaths

and serious injuries so that there is a capacity to build on and use resources that are already available. This link could, at least partly, be provided through representation on the review body¹²⁴.

3.3.2 Existing Organisational Structures

There is considerable expertise within Tasmania that is relevant to child death reviews. The Council, Paediatric Sub-Committee and Coroners Office in particular have expertise in child death matters. The Coroner and Ombudsman have expertise in investigations. The Commissioner has expertise in child protection matters generally and it is already part of the Commissioner's role to review the child protection system.

The work of these bodies is likely to have considerable synergies with the child death review process. This may mean that the review function would be best placed within one of these bodies.

Alternatively it may simply mean that there should be strong linkages between a new review body and these existing organisations, to maximise expertise and to manage the potential for duplication. These linkages could be achieved by including representatives of these organisations on the membership of the review body and/or through protocols for information exchange.

3.3.3 Small Population

Tasmania's small population of child deaths may make it difficult to identify trends and systemic issues and draw reliable conclusions based on data collected over short periods of time.

Giving the review body a wide scope that includes serious injuries, deaths attributed to abuse or neglect regardless of prior contact with child protection services and deaths where a sibling was previously known to child protection services would create a larger population of reviewable cases, enabling more reliable analysis of trends.

¹²⁴ *Layton Report*, p. 18.4.

Aggregating data over longer periods of time (years) to increase the population size under review is another way to address this problem. For example, the review body could base its recommendations on a cluster of individual case reviews over longer periods, rather than making recommendations on a case-by-case basis. However, this has the disadvantage of causing a delay between an event displaying a system failure and recommendations to address it.

Tasmania's small population also impacts on options for reporting of findings and recommendations arising from individual reviews. As discussed above, it will be difficult to de-identify case-specific information given the small population and numbers of child death reviews likely to be carried out each year.

For this reason individual review reports could not realistically be made publicly available without compromising individual privacy and jeopardising the review process. Removing names from the report will not sufficiently de-identify those involved in the case.

However it may be feasible to publicly report generalised findings and recommendations arising out of cases reviewed over the course of a year. This information can be quite specific in relation to issues identified within Child Protection Services, without including case-specific details.

Tasmania's small population also impacts on options available to manage the relationship between the child death review and coronial processes. If the detailed findings of individual reviews are withheld from the public (as suggested above), it will be difficult to give the Coroners Office unrestricted access to these findings. To do so would compromise the privacy of individuals, raise questions of natural justice and would also potentially jeopardise the child death review process.

This means that the coronial process and the child death review process will either need to proceed independently, or the child death review process must follow the coronial process. The Coroner cannot rely on the investigative work undertaken by the child death review body. To minimise duplication and to avoid interference between the processes there will need to be some arrangement to manage the two processes.

As discussed above, it is undesirable that the child death review process be postponed until the conclusion of any relevant coronial process as this will result in significant delays. Establishing protocols between Coroners Office and the child death review body and including a representative of the Coroners Office on the membership of the child death review body may be suitable ways of managing the two processes in Tasmania.

Chapter Four: Do existing mechanisms satisfy the need for a child death review process?

4.1. Overview of historical and contemporary approach

Child death reviews are not without precedent in Tasmania. Under the former *Child Protection Act 1974*, the Child Protection Board (now disbanded) was responsible for systematically investigating child deaths in certain circumstances. These were known as “critical case reviews”.

However, since the commencement of the *Children, Young Persons and Their Families Act 1997* in 2000, there has been no established child death review process.

Nevertheless, there are a number of mechanisms for scrutinising child deaths, at some level, in Tasmania. These mechanisms include:

- Child death research and data analysis by the Council and the Paediatric Mortality and Morbidity Sub-Committee;
- Occasional internal reviews of certain child deaths by the Department of Health and Human Services. Two of these have been carried out since the proclamation of the *Children, Young Persons and Their Families Act 1997*¹²⁵;
- Police investigations, coronial inquiries and inquests into child deaths in certain circumstances; and
- Medically-focussed Serious Incident Investigations at the Royal Hobart Hospital, overseen by the Serious Incident Panel.

A recent addition to these processes is an external review into an individual child's death convened by the Minister for Health and Human Services. This child was formerly known to Child Protection Services and the circumstances of his death highlighted the need to examine the involvement of government agencies and

¹²⁵ See footnote 4.

service providers in his short life. While this was intended to be a one-off review, it is conceivable that future reviews may be carried out on the same basis, in the absence of a permanent child death review process.

The current approach to understanding child deaths relies on all of these processes, rather than on a single and dedicated child death review process. Each mechanism has a different focus and scope. With the exception of the two departmental child death reviews and the recent external child death review convened by the Minister, none of these processes focus specifically on child abuse and child protection deaths. Nor are they specifically aimed at improving our understanding of the strengths and weaknesses of the child protection system.

This chapter describes each process in turn before discussing the strengths and limitations of the current approach overall. The chapter concludes by examining the historical approach to child death reviews in Tasmania, again discussing its strengths and limitations.

4.2. Current Approach

4.2.1 The Council of Obstetric and Paediatric Mortality and Morbidity

Legislation

The Council was established by the *Perinatal Registry Act 1994* (the Act). The membership, powers, functions and reporting obligations of the Council are set out in the Act.

Scope

The Council's scope includes maternal and perinatal deaths, congenital abnormalities in children born in Tasmania, injuries, illness or defects suffered by pregnant women or viable fetuses in Tasmania, births, perinatal health and child deaths in the age group 29 days to 17 years. Efforts are made to include resident deaths (regardless of place of death), within scope as well as deaths registered in the State.

Functions

The Council is responsible for child death research. Traditionally, it has not undertaken child death reviews (as defined in Chapter One). Rather, it has a public health surveillance and educational role.

The Council's focus is principally medical, providing information for education and instruction in medical theory and practice. It collects, analyses and reports data on all child deaths in Tasmania to make recommendations to help reduce the incidence of preventable child deaths from all causes. The majority of these recommendations tend to be aimed at health professionals and government.

Under the Act the Council must maintain a perinatal and other registers as it considers appropriate. Specifically, it must maintain a perinatal data collection for the purpose of collecting, studying, researching and interpreting information relating to deaths referred to it, including deaths of children aged 29 days to 17 years¹²⁶. It also reviews and reports on any other matters within its scope that are referred to it by the Minister or Secretary.

The Council has three sub-committees to assist in carrying out its functions.

Powers and Obligations

The Council can require any person to provide any information or document relevant to the performance of the Council's functions and can do all things necessary or convenient in connection with its functions and the exercise of its powers¹²⁷. Persons so requested are obliged to comply and may be penalised for failing to do so¹²⁸.

The *Perinatal Registry Act 1994* imposes obligations on the Council to protect the confidentiality of information provided for the purposes of the Act. The Council cannot disclose information except to certain parties and cannot be required to provide information to any court, tribunal, board or Agency. The Act also protects

¹²⁶ Section 6, *Perinatal Registry Act 1994*.

¹²⁷ Section 7, *Perinatal Registry Act 1994*.

¹²⁸ Sections 7 and 17, *Perinatal Registry Act 1994*.

Council members from personal liability for anything done, or any power exercised under the Act.

However, there is nothing in the Act that protects persons providing information to the Committee from liability for breaching any law or code that restricts disclosure of information, or liability for defamation.

Reporting

The Council reports annually to the Secretary, rather than to Parliament. Nonetheless, annual reports are published and are publicly available.

Membership

The Act prescribes the terms of office and manner of appointment and dismissal of members on the Council. The Minister appoints members and also has the power to remove them, but on grounds limited by the Act.

Appointment is for a fixed term specified in the instrument of appointment but not exceeding three years. Remuneration is determined by the Minister. The *State Service Act 2000* does not apply to members in their capacity on the Council (or its sub-committees). This helps to secure the independence of members.

Representation on the Council is also determined by the Act and consists of a mixture of government and non-government experts in perinatal, child and maternal health¹²⁹. Most members have a medical background. There are between 8 and 10 members on the Council.

Resources and Administrative Support

The Act requires the Secretary to make available to the Council the services of such persons employed by the Department as are necessary.

Despite this legislative obligation, the Council and its three sub-committees have been under-resourced in recent years, relying on a single, part-time staff member to provide executive support. Because of this under-resourcing, the most recent annual

¹²⁹ Section 9(2), *Perinatal Registry Act 1997*.

report to be released related to the year 2003-04 and was published in 2005. The Council may arrange for the services of a University of Tasmania employee to be made available to the Council, with the approval of the Secretary.

4.2.2 The Paediatric Mortality and Morbidity Sub-Committee

Legislation

Section 9 of the Act enables the Council to establish Committees to assist in performing its functions. The Paediatric Sub-Committee was established on this basis.

Scope

The Paediatric Sub-Committee's scope is all child deaths in the age range 29 days to 17 years (inclusive).

Functions

The Paediatric Sub-Committee collects, analyses and reports on data in relation to the deaths of children aged 29 days to 17 years (inclusive). It also reviews any other matter relating to paediatric mortality and morbidity referred to it by the Council. It classifies and reports on deaths in the following categories:

- Conditions determined at birth
- Acquired conditions
- Sudden Infant Death Syndrome
- Injuries (includes drowning)
- Cases still under review
- Unknown/indeterminate.

Traditionally, neither the Council nor the Paediatric Sub-Committee have undertaken detailed reviews into the circumstances of individual deaths.

Powers and Obligations

Under section 8 of the Act, the Paediatric Sub-Committee may exercise the same powers as the Council and is bound by the same obligations to maintain the confidentiality of information provided to it.

Reporting

The Paediatric Sub-Committee's annual report is incorporated into the Council's annual report to the Secretary.

Membership

Paediatric Sub-Committee members are appointed by the Council and include Council members and non-Council members, with Ministerial approval. There are currently five members – all but one, the Commissioner for Children, have medical backgrounds.

Resources and Administrative Support

As discussed above, the Council and its three sub-committees rely on a single, part-time staff member for executive support.

4.2.3 Recent Child Death Review

Legislation and Administrative Arrangements

In February 2006 the Minister convened a group to review the death of a child, purportedly under the auspices of the Paediatric Sub-Committee and section 9 of the the Act (the DC review)¹³⁰. Committees established in this way share the same powers and obligations as the Council under the Act¹³¹.

The DC review was the first of its kind under the *Children, Young Persons and Their Families Act 1997*. At the time the review team was established, there was an understanding between the Commissioner for Children and the Secretary that this was intended as an interim measure rather than a new and permanent function of the Paediatric Sub-Committee.

It is conceivable, but by no means certain, that in the ongoing absence of a permanent child death review process, future reviews may be carried out at the

¹³⁰The name DC review (Deceased Child Review) is used to protect the privacy of the deceased child's family and persons involved in this case.

¹³¹ It is not entirely clear whether the DC Review Team was established by the Council, as required by section 9 of the *Perinatal Registry Act 1997* as no record of a Council decision to establish the review team can be found.

discretion of the Minister. However, there is no established process for future reviews.

Scope

The DC review was undertaken at the request of the Minister. There is no defined scope for cases requiring a review of this kind. Instead the decision to hold a child death review is, at present, discretionary.

Even if further reviews are requested in future there is no certainty that all, or most, deaths attributed to abuse or neglect or within the child protection system will be reviewed.

Functions

Similarly, there is no established process for carrying out child death reviews. The terms of reference for the DC review related exclusively to this individual case.

The terms of reference for the DC review covered the consequences of contact, advice and decisions in respect of the child and his family, specifically in relation to:

- The Department (including Child and Family Services, Family Child Youth Health Services, Drug and Alcohol Services and Royal Hobart Hospital);
- Other service providers (GPs, Police, Tasmanian Aboriginal centre);
- The Department of Human Services, Victoria (which was temporarily responsible for the child);
- Any other service the Committee considers appropriate.

The functions of the review team were to examine:

- The discharge of duty of care, identification of risk and appropriateness of responses to those risks;
- Policies and protocols in relation to
- the identification and management of babies born with drug addictions with a particular focus on their care and protection;
- the interface between Drug and Alcohol Services' methadone program and private prescribers in relation to access to methadone;
- the management of multiple notifications on similar issues and the weight given to notifications made by professionals;

- communication within and between the services provided by the Department and external service providers in relation to the above matter.
- The adequacy of staff training and development in
- The identification of the symptoms of methadone overdose;
- Collaborative case management; and
- Assessment of parenting skills in clients with drug issues.

Powers and Obligations

Committees established by the Council under section 9 of the Act share the same powers and obligations as the Council. Assuming that the DC review team was duly established under section 9 it, too, would enjoy these powers and obligations¹³².

The DC review team primarily relied on the voluntary cooperation of clients, staff and service providers to participate in interviews and provide access to necessary information.

Reporting

The DC review team will report to the Minister and the Secretary. Recommendations will be made public, but it is not yet clear whether more detailed findings and the full body of the report will be publicly available.

Membership

The DC review team consisted of two members of the Paediatric Sub-Committee (the Commissioner for Children and the Director of Women's and Children's Clinical Services, Royal Hobart Hospital) and an external consultant. In addition there was an administrative chair of the review team, held by the Deputy Secretary of Human Services and Housing Division, Department of Health and Human Services.

If further reviews are requested in future, it is possible that the same members may be appointed to the task. It is equally possibly that a new team would be appointed. In the absence of an established process there is no ongoing membership to oversee reviews and to monitor implementation of recommendations.

¹³² See footnote 131.

Resources and Administrative Support

The DC review team was resourced to appoint one external consultant and received some administrative resources from the Department for the duration of the review.

4.2.4 Department of Health and Human Services – Internal Critical Case Reviews

Child and Family Services (Department of Health and Human Services) has carried out internal child death reviews on two occasions since the proclamation of the *Children, Young Persons and Their Families Act 1997*.¹³³ Both reviews were held in 2002.

The *Care and Protection Services Policy and Practice Guidelines, Reporting the death of a child in care to the Coroner* (the Guidelines) sets out a process to be followed after the death of a child who was a client of child protection¹³⁴. This involves reporting to the Coroners Office and also undertaking a Critical Case Review.

Under the Guidelines, the Director “will request a Critical Case Review” in the event of the death of a child protection client and will make arrangements for an independent person or panel to be engaged to undertake the review in accordance with terms of reference determined by the Director. The reviews are internal, not public.

Despite this requirement, only two child death reviews have been undertaken since the proclamation of the Act¹³⁵. It would appear that there is no clear and routine process for departmental reviews of child deaths. Those (few) reviews that have occurred were undertaken as a matter of discretion, not established practice.

Even assuming that the process for internally reviewing child deaths could be strengthened, departmental child death reviews do not obviate the need to establish a permanent child death review process in Tasmania. Departmental child death reviews have an important role in ensuring that the Department monitors and assesses its own performance on a regular basis. Most of the jurisdictions examined

¹³³ See footnote 4.

¹³⁴ These Guidelines are effective from 1 March 2006.

¹³⁵ See footnote 4.

in this paper carry out departmental child death reviews (as part of the principal child death review process, or in addition to it).

However, departmental child death reviews are not sufficient to answer the need for a rigorous and effective child death review process. The key limitation of the departmental review process is that it is not independent or transparent. As neither the process nor the outcomes are available to the public there is no way to ensure that findings are rigorous and impartial and no mechanism to ensure that the recommendations are implemented. Another disadvantage of the internal review process is that there is no permanent team to oversee the child death review process and to identify trends and issues that recur within the child protection system over time. Consequently, an external child death review process is also needed.

4.2.5 Coronial Inquiries and Inquests

Legislation

The Coroner also has a role in investigating deaths, including certain child deaths, under the *Coroners Act 1995*¹³⁶. The main purpose of coronial investigations is to learn from the circumstances surrounding deaths, fires and explosions with the aim of reducing the likelihood of similar deaths occurring in future.

Scope

The Coroner may investigate the circumstances of deaths that appear to be "reportable deaths". Reportable deaths include those that appear to be unnatural, unexpected or violent, or resulting from accident or injury; where the cause is unknown; where the child is under one year of age and the death is sudden or unexpected; where the person was in care or custody immediately before death¹³⁷; where the person's identity is unknown; where the death occurred while the person was escaping from a prison, detention centre, secure mental health unit or police custody; or whilst a police officer or correctional person was attempting to detain the person¹³⁸.

If possible, the Coroner's findings must include:

- the identity of the deceased;
- how the death occurred;
- the cause of death;
- when and where death occurred;

¹³⁶ In Tasmania, any Magistrate can act as a Coroner. References to "the Coroner" in this paper refer to any Magistrate acting in that capacity.

¹³⁷ Section 3, *Coroners Act 1995* defines "person held in care" as a person in the custody or guardianship of the Secretary (within the meaning of the *Children, Young Persons and Their Families Act 1997*) or in a secure mental health unit or other place controlled by the same authority (within the meaning of the *Mental Health Act 1996*).

¹³⁸ This is not an exhaustive list of "reportable deaths". It only includes those most likely to be relevant to child death reviews. See section 3, *Coroners Act 1995* for a complete list of reportable deaths. These deaths are only reportable where the death occurred in Tasmania, the body is in Tasmania, the cause of death occurred in Tasmania or the death occurred whilst the person travelled to or from Tasmania.

- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999*; and
- the identity of any person who contributed to the cause of death.

The Coroner must also make recommendations to help prevent further deaths and may make recommendations, or comment, on any other matter considered appropriate (including comment on public health or safety or the administration of justice). These recommendations are not binding in law. Where relevant, the Coroner must report on the care, supervision or treatment of a person whose death occurred immediately after they were in custody or care.

The Coroner has scope to comment on any government agency whose actions may have contributed to the circumstances leading to the child's death. He or she also has scope to comment on individual performance of duty where malpractice was evident, but cannot make a finding on the culpability of any person for an offence.

Functions

A reportable death is usually investigated by Police on behalf of the Coroner. This investigation can take 6-12 months or longer. At the conclusion of the Police investigation a file is forwarded to the Coroner. The Coroner makes a determination based on the police report as to whether an inquest is needed, otherwise the Coroner bases his or her findings on the police report.

Usually the police would become aware in the course of an investigation if the child was a former client of Child Protection Services, particularly if the death was unnatural. Where this is the case, the police would then obtain the case file and relevant information from Child Protection Services in relation to the child. However, there is no routine procedure for checking all child deaths against Child Protection Services' database and not all deaths of former Child Protection Services clients are investigated.¹³⁹

¹³⁹ For example in 2005 the Paediatric Sub-Committee recorded 25 child deaths. In one case, a child was a former child protection client but their death was not reported to or reviewed by the Coroner because the cause of death was classified as natural.

An inquest is usually held when the investigation has not uncovered sufficient evidence for a criminal prosecution, but there is a suspicion of homicide; where the person dies immediately after being in care or custody; whilst the person was attempting to escape from prison, detention centre, secure mental health unit or police custody; while a police officer or correctional officer attempted to detain the person, or where the Attorney-General or Chief Magistrate requires an inquest.¹⁴⁰

The coronial process is put on hold the moment a criminal investigation and proceedings begin in relation to the death. The coronial process can only resume at the conclusion of these proceedings which can take years. Consequently, system failures in the child protection system that may be revealed upon investigation of a child abuse death may not be made public through the coronial process for some years after the event.

Finally, the Coroner's findings, even in child homicide cases, tend not to examine in any great detail the actions or omissions of government service providers as contributing factors in the circumstances leading to the child's death. The focus tends to be on the more clinical aspects immediately surrounding the cause of death.

Powers and procedures

Under the *Coroners Act 1995*, certain persons are obliged to notify the Coroner or police of "reportable deaths" and must also provide relevant information¹⁴¹.

In carrying out the police investigation, the police can request reports, documents and statements from any individual associated with the case, including family. Where persons refuse to provide evidence an inquest may be called and witnesses may be found in contempt if they fail to provide evidence.

The police may obtain a warrant for information held by Child Protection Services in relation to a child who was a former client of Child Protection Services. This warrant enables Child Protection Services to provide the information without contravening privacy laws that may otherwise restrict disclosure of the information.

¹⁴⁰ For other circumstances that require an inquest, see section 24, *Coroners Act 1995*.

¹⁴¹ Sections 19 and 20, *Coroners Act 1995*.

Where an inquest is held, the Coroner may consider statements and affidavits, summon a person to attend as a witness or to produce documents, and enlist the assistance of counsel. Inquests must generally be held in open court. Rules of evidence do not apply.

Reporting

The Coroner may make a report to the Attorney-General on any death investigated, and must do so if there is a belief that an indictable offence has been committed. Annual reports are tabled in Parliament and include details on deaths in custody and recommendations made by the Coroner throughout the year.

Membership

Each Magistrate is a Coroner by virtue of his or her office¹⁴².

¹⁴² Section 13, *Magistrates Court Act 1987*.

4.2.6 Royal Hobart Hospital Serious Incident Panel

The Royal Hobart Hospital (RHH) has a serious incident investigation policy and procedure that regulates the investigation of any incident deemed high risk, or that demonstrates a system flaw with the potential for serious consequences for the RHH. Serious incidents may include the death of a patient.

All serious incidents are reported through the RHH incident reporting system and are categorised according to risk. The Mortality Review Committee categorises patient deaths after reviewing documentation. Certain deaths, including those with preventable elements in the control of the RHH, are referred to the Serious Incident Panel (SIP) if appropriate.

SIP may refer the incident to relevant parties for classification or to a project team, expert peer or internal management for analysis. Project teams convened for this purpose are supported by the Quality Improvement Unit, within the RHH. They are multidisciplinary and have expertise in the area of concern but must not have been involved in the incident under review. They recommend strategies for system change and provide a report to SIP.

SIP reviews the findings of the project team and recommends further action as appropriate. It refers any matter that appears to require performance management of employees for review by internal management or relevant professional regulatory bodies as appropriate. It directs findings to the Continuum of Care Committee or the Safe Practice and Environment Committee (within the RHH) for implementation of recommendations, ongoing management and evaluation of outcomes.

SIP report is privileged information under the *Health Act 1997* and cannot be divulged to the Coroner or any court¹⁴³. This is to aid full and frank disclosure of information to SIP. The Coroner may view recommendations of SIP, which are publicly available.

¹⁴³ Section 4, *Health Act 1997*.

Bearing in mind the purpose of child death reviews discussed earlier in this paper, it is quite clear that the RHH's serious incident investigation process does not sufficiently answer the need for a child death review process. The purpose of the investigations is to review policies and practices within the RHH that may have contributed to an incident within the hospital. This process would clearly not identify or address systemic issues within the child protection system that may have contributed to a child's death.

However, the SIP investigation process is interesting in that it provides a local example of a model on which the child death review process could potentially be based.

One of its limitations is that it has a medical focus and concentrates on the circumstances immediately surrounding the death in hospital. It also lacks full independence.

4.3. Discussion: strengths and limitations of the current approach

The current approach to understanding child deaths in Tasmania (with the aim of reducing their number) relies on a number of different processes, described above. The nature, scope and focus of these different processes vary significantly.

The primary purpose of the child death review process, in Australia at least, is to provide a mechanism for quality assurance and review of child protection systems. For this reason, in every Australian jurisdiction with a child death review process, the scope of reviewable deaths centres around deaths attributed to abuse or neglect and deaths within the child protection system.

Understanding this purpose, it is clear that most mechanisms for scrutinising child deaths in Tasmania do not, alone, fulfil the need for a child death review process.

The Council and Paediatric Sub-Committee contribute significantly to community and professional awareness of child mortality and prevention generally. However the Council has traditionally had a medical focus. It is not the role of the Council to review and analyse in any detail the involvement of service providers in the years preceding a child's death. The current representation on the Council is itself testament to this. Nine out of the eleven current members are medical specialists or allied professionals. There is little expertise currently serving on the Council in relation to child protection and service-systems issues.

SIP also performs a critical task by reviewing policy and practice within the Royal Hobart Hospital. While occasionally child deaths may be investigated through this process, the focus of the investigation is on the events immediately surrounding the death of the patient and the purpose is to improve practice within the hospital. It is not the role of SIP to review broader service systems outside the hospital or to consider non-medical events in the years leading up to the child's death.

Departmental child death reviews clearly have an important role in improving policy and practice in child protection. However, given the purely internal nature of these reviews, this process does not provide an independent mechanism for reviewing

policy and practice in Child Protection Services. For this reason the internal reviews do not provide a mechanism for accountability within the child protection system.

The coronial process and the recent external child death review convened by the Minister come closest to meeting the needs of a permanent and independent child death review process. The following discussion focuses on strengths and limitations of an approach to child death reviews that relies on occasional reviews convened by the Minister, supplemented by the coronial process.

4.3.1 Occasional Child Death Reviews: Strengths and Limitations

Strengths

One of the strengths of the arrangement for the recent DC review is that its terms of reference are broad. In particular the review team was able to examine the role of any government agency or service provider, not just Child Protection Services. As discussed in Chapter Three, a multi-agency scope is important given the increasingly complex client group and frequent co-morbidity of issues in child protection cases.

Certain characteristics of the DC review gave the Department a direct role in the review process. Firstly the Minister instigated the review and the Secretary was involved in determining its terms of reference. Secondly, the position of the Administrative Chair was held by a senior employee of the Department. Involving the Department in this way may help to facilitate the timely cooperation of departmental officers and access to departmental information. It may also make the Department more receptive to recommendations arising from the review and could encourage the Department to take a critical approach to its own operations and to recognise internal problems.

As discussed earlier in this chapter, the DC review is the only external child death review to occur since the commencement of the *Children, Young Persons and Their Families Act 1997*. While it was intended as a one-off review it is conceivable that the Minister may again use his discretion to call for similar reviews in future, in the absence of a permanent child death review process. There may be advantages to relying on occasional child death reviews held at the request of the Minister.

Firstly, this approach would have the advantage of flexibility. There is no determined scope, functions or membership for future reviews. If reviews do occur, this is likely to be at the discretion of the Minister, with the arrangement for each review determined on a case-by-case basis.

The lack of defined scope for reviewable cases would potentially enable a focus on cases most likely to highlight system-issues. It could also control the number of cases requiring review at any one time. This could help to keep the resource-costs of child death reviews low and manageable.

It is possible that future reviews will be carried out by the same team currently responsible for the DC review. But as there is no permanent or continuous membership, it is equally feasible that different professionals will be nominated. This again has the advantage of flexibility. If the facts of a case require particular expertise, relevant professionals can be appointed to carry out the review. This avoids the need for a large, permanent and multidisciplinary membership to reflect a range of expertise, which could be costly.

Limitations

Relying on occasional reviews convened at the discretion of the Minister would have a number of disadvantages. One of the key disadvantages is the lack of clear legislative parameters for future reviews. In the absence of a legislative framework, the scope, functions, membership and procedures of future reviews are likely to be determined from time-to-time by the Minister in consultation with the Paediatric Sub-Committee. While this approach has the benefit of flexibility (as referred to above) it lacks uniformity, continuity and transparency.

There is no consistent and unbiased process for determining when reviews will be carried out in future. Rather, any further reviews in the absence of a permanent child death review body are likely to be convened on an ad hoc basis at the discretion of the Minister. This could potentially compromise the reliability and comparability of data and information, making it difficult to identify reliable trends within the child protection system.

The absence of a defined scope for reviewable cases may also result in certain types of cases dominating the reviews. Naturally there will be more public pressure to hold

an inquiry in the particularly horrific or high profile cases. This may result in knee-jerk policy responses to apparent problems in the child protection system, which may in fact be one-off incidents. This is not the most effective and strategic approach to child protection planning and reform.

Another disadvantage of an approach based on occasional, ad hoc reviews is the lack of a permanent membership to provide continuity and long-term direction. The lack of a continuous membership and established processes may undermine the efficiency and effectiveness of the review process, as new review teams “re-invent the wheel” from case to case. It may also inhibit the development of cooperative relationships and networks that would facilitate the timely receipt of information from relevant agencies. It also means that there would be no continuous membership to oversee the process and to monitor implementation of recommendations by government.

To some degree the lack of continuity may be mitigated by strengthening the relationship between review teams and the Paediatric Sub-Committee (see Chapter Five). Currently, however, the Paediatric Sub-Committee has no real involvement with the review process.

The extent to which the Department is involved in the review process also compromises the appearance of independence, if not the practice. The Minister has a significant amount of discretion to determine when a review will take place and to define its scope. In addition, the Administrative Chair of the current review team is a senior employee in the Department. The potential conflict of interest in this arrangement is likely to become increasingly untenable if it is repeated in future case reviews.

Another limitation to the DC review, and any future review convened under the *Perinatal Registry Act 1994*, is that there is no provision in this Act that overrides other legislation or professional codes that restrict disclosure of sensitive or personal information. While this has not been a problem in the DC review to date, the lack of such a provision could potentially affect the willingness of departmental employees and other relevant persons to supply complete and accurate information in future reviews.

Finally, the terms of reference DC review, while broad, nevertheless confine the team to look at a set of quite specific issues. Before the review has begun, it may not be possible to identify all the issues that will emerge during a review. Pre-empting and confining the scope of the review to specific issues may impede a complete and rigorous assessment of the role of Child Protection and related services.

Arguably, it is preferable to craft broad terms of reference for a review process as a whole, leaving the detail about issues to be examined in specific cases to the review body to determine. For example, broader terms of reference could provide that the functions of child death reviews are:

- to review certain child deaths to identify whether systemic issues in Child Protection Services and related child and family support services may have contributed in some way to the failure to prevent the death of the child;
- to determine whether current procedures were adhered to and whether those procedures were adequate; and
- to make recommendations in relation to legislation, policy and practice with the aim of reducing or preventing future child deaths.

Statutory-based functions of a general nature would also add to the accountability and transparency of future reviews.

4.3.2 Coronial Inquiries and Inquests: Strengths and Limitations

Strengths

One argument against establishing a new child death review process is that the existing coronial process is sufficient to answer the need for child death reviews. The coronial process is a pre-established, well-recognised and independent mechanism for investigating certain deaths. It has the advantage of a wealth of expertise in investigations, established procedures and comprehensive powers for gathering relevant information. It has a relatively broad scope that includes deaths within the child abuse and child protection populations, although it does not necessarily include the deaths of *all* children who were former child protection clients.

It could be argued that to introduce a new mechanism for investigating deaths that already, for the most part, fall within the Coroner's scope, could duplicate and even interfere with the coronial process.

Alternatively, a dedicated child death review process could be seen as complementing the Coroner's investigative role. As stated by the New South Wales Ombudsman *"with cooperation between the two agencies [the Ombudsman and the Coroner] there is maximum opportunity to use information from individual deaths to monitor and review services and influence changes to systems and practices"*¹⁴⁴.

Undoubtedly, the potential cross-overs in work carried out by the Coroner (and police) and the child death review body would need to be managed. To avoid overwhelming persons with multiple requests for interviews and information, some arrangements would be needed to coordinate the lead role in relation to different aspects of each case and to manage information exchange. Chapter Four discussed ways in which other jurisdictions managed this relationship between the Coroner and the child death review body.

Limitations

Bearing in mind the very specific purpose of child death reviews, one of the key limitations of the coronial process as an alternative to a dedicated child death review process, is its breadth of scope. The breadth of issues considered in the coronial process may prevent a focus on the very detailed and complex matter of the role of the child protection system in each case. While the Coroner can make findings regarding the child protection system and related services, these findings tend to be relatively superficial in comparison with the detailed review that could be expected of a dedicated child death review body. The coronial process generally tends to focus on events immediately surrounding the death.

The coronial process is not well-placed to provide the continuity of oversight that would enable a reliable picture of the child protection system to build up over time. This is partly, again, due to the breadth of issues covered by the coronial process that takes the focus away from specific and complex issues within the child protection system. It is also partly due to the fact no single Coroner is responsible for all child death cases, which prevents the accumulation of experience in this area.

¹⁴⁴ *Reviewable Deaths Annual Report 2003-04*, NSW Ombudsman, p. 8.

A child death review process requires considerable expertise in the areas of child health and child protection. While the coronial process involves professionals with substantial expertise in investigations, expertise relevant specifically to child abuse and child protection deaths is limited.

Another limitation to the coronial process is the delay between the event (the child's death) and the findings. In many cases within the child abuse and child protection populations of child deaths, it is plausible to expect a criminal prosecution. This can mean that findings relating to the role of the child protection system may not be available for a long time after the event, by which time these findings may be irrelevant.

4.4 Historical Approach

Former Child Protection Board

Legislation

The Child Protection Board was established in 1991, under the former *Child Protection Act 1974*, to help prevent the maltreatment or further maltreatment of children by ensuring that proper arrangements were in place for their care and protection. One of its functions was to oversee “critical case reviews” of certain child deaths.

Scope

Critical case reviews were conducted where a child died as a result of abuse or neglect and where there had been previous departmental notification about abuse or neglect in relation to the family. This included any involvement, even if the circumstances related to only one notification involving abuse or neglect and these claims were not substantiated. Cases where a child had been seriously injured, or complex cases could also be reviewed¹⁴⁵. Critical case reviews focussed on systems-issues and did not comment on the actions of individuals.

¹⁴⁵ *Guidelines for Critical Case Reviews*, Child Protection Board, 1995.

Functions

The Board's functions were to coordinate, develop and monitor child protection policy and programs in Tasmania and to conduct community education and professional training programs.

The Board's child death review function involved calling for critical case reviews; appointing a critical case review committee; monitoring progress of the review; endorsing the findings and recommendations of the critical case review committee; making recommendations to the Secretary of the Department of Community and Health Services; collecting data on cases reviewed and initiating research where appropriate.

The purpose of critical case reviews was to examine serious and difficult cases, so that professional practice could be improved and the co-ordination of services enhanced.

Critical case reviews:

- assessed whether departmental policies and procedures including inter-departmental and inter-agency protocols were followed and whether departmental services were adequate;
- assisted other departments and agencies to identify gaps or inconsistencies in their policies, procedures, practices or services; and
- collected relevant data on cases reviewed to inform practice policies and procedures and to commission further research.¹⁴⁶

Critical case reviews usually involved interviews with case workers and other professionals. Family members could not be approached without the Board's permission.¹⁴⁷ Guidelines for Critical Case Reviews, adopted by the Board in 1995 (the Guidelines) required that reviews be completed within 12 weeks. The Board could request that the Secretary provide it with information on the implementation of recommendations.

¹⁴⁶ *Guidelines for Critical Case Reviews*, Child Protection Board, 1995.

¹⁴⁷ *Guidelines for Critical Case Reviews*, Child Protection Board, 1995.

Powers and Obligations

It is unclear what powers critical case review committees could exercise. The *Child Protection Act 1974* does not specifically give the Board and its committees any powers to require information from relevant parties. It is probable that the Board and critical case review committees relied on voluntary participation of departmental workers.

The Guidelines required critical case review committee members to observe strict confidentiality at all times. The secrecy provisions of the *Child Protection Act 1974* (sections 17A, B and C) also applied to the reviews. This prevented disclosure of information obtained through the review to any other person. The Guidelines required that records obtained by the committee be destroyed once the Board had accepted the committee's recommendations.

Reporting

The Child Protection Board made its recommendations and provided its annual report to the Secretary of the Department, rather than to the Minister or to Parliament.

Membership

Membership on the Board was determined by the *Child Protection Act 1974* and included representation from certain government departments (health, police, justice, education) and from the community¹⁴⁸.

Members were appointed by the Minister but were not subject, in their capacity as Board members, to the *Tasmanian State Service Act 1984*. The Governor determined their remuneration and allowances. The chair of the Board was the Secretary of the Department responsible for the *Child Welfare Act 1960*.¹⁴⁹

Critical case review committees consisted of at least three persons, appointed by the Board on a case-by-case basis. The Board maintained a register of suitably qualified persons for this purpose. These persons could be Board members or external

¹⁴⁸ Section 3(2), *Child Protection Act 1974*.

¹⁴⁹ Section 3, *Child Protection Act 1974*.

professionals from government or the community sector, but could not include persons who were closely associated with the case under review.¹⁵⁰

Resources and Administrative Support

The *Child Protection Act 1974* provided for the Board to be accommodated and supported by staff within the Department. The Act required that the expenses of the Board be met from funding provided by Parliament.

Critical case reviews were supported by the Board's executive officer.

¹⁵⁰ *Guidelines for Critical Case Reviews*, Child Protection Board, 1995.

4.5. Discussion: strengths and limitations of the historical approach

It is difficult to evaluate the effectiveness of this model in the absence of documentation of a review at the time it was in operation. Acknowledging this limitation, the key features of this model are considered below in the context of the earlier discussion around the desirable features of an effective and rigorous child death review process (Chapter Three).

Strengths

One of the strengths of this approach was that it achieved permanency and continuity while minimising the human resources needed for each review. It did this by allocating the time-consuming function of carrying out reviews to a small group, appointed on a case-by-case basis. Overseeing this process and monitoring implementation of recommendations by government, the Board provided permanency and continuity.

In the same way, this approach also enabled the review process to be informed by a diverse range of representatives (sitting on the Board), without requiring a significant time commitment from a large number of professionals. Instead, the time-consuming element of conducting reviews was minimised for everyone involved by rotating responsibility for reviews among a group of professionals on a critical case review panel register.

These strengths are particularly valuable in a small jurisdiction which has a limited pool of experienced professionals who are already stretched in their commitments.

Another strength was the scope of the critical case reviews. The scope is relatively broad compared with the scope of child death review processes currently in place in some other jurisdictions as it includes serious injuries. The Guidelines indicate that deaths would be prioritised over serious injuries. This enabled the Board to prioritise a narrow range of cases whilst giving it the capacity to review serious injuries at its discretion. This is one way of maintaining a small and manageable case load whilst including the capacity to review cases outside this scope where appropriate.

Another positive feature was that the Board had a legislative basis and the legislation clearly established the functions and membership of the Board. While the critical case review committees were not defined in legislation, the Board did establish clear guidelines which set out the scope, membership, functions and terms of reference of the critical case reviews as a whole, rather than on a case-by-case basis. Because of this, the critical case review process was more open and transparent than the current approach in Tasmania, where there is no established scope, function or membership for future child death reviews.

This argument is particularly strong in relation to the trigger for child death reviews. The Guidelines clearly defined cases that required review. The responsibility for calling for these reviews lay with a statutory body external to the Department responsible for child protection. Clearly this approach is more transparent than an approach that relies on occasional investigations convened at the Minister's discretion.

Other positive features of the critical case review process were the requirement that the Department report to the Board on the progress in implementing recommendations; statutory provisions protecting the confidentiality of information provided to case review committees; and the manner and terms of appointment of members to the Board which were established in legislation.

Limitations

One of the main weaknesses of the former child death review process was that it did not achieve complete transparency and independence from the Department. This is primarily because the Board reported to the Secretary, rather than the Minister or Parliament, and because the Chair of the Board was also the Secretary of the Department.

In addition, while the Board had a legislative basis, the review process would have been more transparent and accountable if the features of critical case reviews were established in legislation, rather than being based on guidelines developed by the Board.

Finally, an important limitation of this former approach was that the Board (and the critical case review committees) lacked statutory powers to require information from certain persons.

Chapter Five: Options for child death reviews in Tasmania

5.1 Option One – no change

5.1.1 What this involves

This option involves retaining the current approach of relying principally on the coronial process for child death reviews, with the potential for an occasional child death review convened at the discretion of the Minister for the Department of Health and Human Services.

5.1.2 What this requires

This option requires no change at this time.

5.1.3 Risks

This option risks:

- Exposing the government to criticism for being the only State in Australia without an external child death review process.
- Exposing the government to criticism for failing to implement a recommendation of the Royal Australasian College of Physicians (RACP) in its draft Child Protection Policy 2006, that child death review processes should operate in all Australian jurisdictions and New Zealand.
- Missing the opportunity to demonstrate the high value the government places on the life of a child, instead demonstrating a lack of commitment to improving the lives of all children.
- Missing the opportunity to improve the child protection system through the accumulation of evidence-based knowledge obtained over time in a uniform, impartial and independent manner.
- The development of what may be perceived to be a knee-jerk approach to child protection reform based on one-off child death reviews.
- Missing the opportunity to boost public confidence in the child protection system through an independent review mechanism which would help to impart accountability and transparency into the system.

5.1.4 Recommendation

This is not the preferred option.

5.2 Option Two – build on existing bodies and processes

5.2.1 What this involves

This involves developing and formalising the current ad hoc approach to child death reviews by strengthening the capacity of the Paediatric Sub-Committee to oversee child death reviews.

As an established body with a continuous membership and regular meetings, the Paediatric Sub-Committee could provide the permanency, continuity and uniformity that is lacking in the current approach.

The former child death review process carried out by the Child Protection Board and the current serious incident review process carried out by the Royal Hobart Hospital provide models for this option.

Based on these models, the Paediatric Sub-Committee could be made responsible for overseeing child death reviews. The Sub-Committee could:

- determine when a review is warranted (preferably within a scope defined in legislation);
- maintain a register of suitably qualified persons and appoint several of these to carry out reviews as they arise;
- consider and endorse the findings from each review;
- make recommendations based on single reviews or a cluster of reviews; and
- monitor implementation by government.

To strengthen the Paediatric Sub-Committee's capacity to undertake this role, some modifications to its current structure would be necessary. Firstly, it would be necessary to broaden representation on the Sub-Committee so that it is better equipped to identify and address problems specific to the child protection system.

To increase the transparency and accountability of the review process, it would be preferable for the Paediatric Sub-Committee's reporting requirements to be amended so that it reports to the Minister or to Parliament, rather than the Secretary of the Department of Health and Human Services.

Finally, to improve the review process under the *Perinatal Registry Act 1997*, powers to require information should be accompanied by provisions protecting those supplying the information from breaches of privacy laws, protocols or codes of conduct/ethics and any liability for defamation based on the material provided.

5.2.2 What this requires

This option could be achieved in two ways. Review teams could be convened and appointed from time to time, under section 9 of the *Perinatal Registry Act 1997*. Alternatively, the *Perinatal Registry Act 1997* could be amended to establish this review process on a permanent basis, by giving the Paediatric Sub-Committee the power and obligation to convene review teams from a register of professionals when case reviews are warranted.

The legislative option is preferred. By establishing the review process in legislation, provision can be made for delegation of the Paediatric Sub-Committee's powers and obligations to persons on the child death review register. Provisions securing the independence of Paediatric Sub-Committee members could also be made to apply to individual reviewers. The scope of reviews could be clearly defined, leaving some discretion to be exercised by the Paediatric Sub-Committee to call for full reviews within this scope when warranted.

The option of building on the current approach through better use of the Paediatric Sub-Committee would also require amendments to the *Perinatal Registry Act 1997* to broaden representation on the Sub-Committee. Additional amendments would be required to change the reporting obligations of the Sub-Committee and to better protect persons supplying information to review teams from liability for breaching other laws or codes.

Additional funding would be required to enable the Paediatric Sub-Committee to fulfil this new role.

5.2.3 Risks

This option risks¹⁵¹:

- Jeopardising the child protection focus of child death reviews. The Paediatric Sub-Committee has traditionally had a medical focus, which may persist despite amendments to its structure and membership.
- Encountering resistance from the Council of Obstetric and Paediatric Mortality and Morbidity to changes in its purpose, structure and membership and to the addition of a new function.
- Compromising the capacity of the Paediatric Sub-Committee to continue with its core functions (or vice versa, those core functions may drain the Paediatric Sub-Committee's resources at the expense of thorough child death reviews).
- Re-directing resources away from more immediate and direct attempts to respond to children at risk of abuse or neglect.
- Lengthy delays between a child's death and recommendations aimed at addressing system failures that may have contributed to that death, if the Paediatric Sub-Committee continues to be under-resourced.
- Being no simpler or most cost-effective an option than creating a new child death review process from scratch. This option is likely to require substantial legislative change if it is to be effective. In the long term, it may be more complex to make significant change to existing bodies and processes than beginning afresh, with linkages to those bodies and processes.
- Contributing to a reactive and conservative approach to child protection reform characterised by "defensive practice"¹⁵². This risk is greater in the case of one-off, ad hoc reviews, but there is also some support for the view

¹⁵¹ Many of the risks identified would apply equally to any form of permanent child death review process. Some of the risks identified would only arise if insufficient commitment is shown in establishing and supporting a fully independent, effective and rigorous child death review process.

¹⁵² Dorothy Scott discusses the perils of engaging in "defensive practice", that is a child protection system that over-extends itself, involving far greater numbers of children than their circumstances warrant. The danger of defensive practice is that it causes a great deal of unnecessary pain and harm to families and children that would have been better left outside the child protection net. Scott, D., "Sowing the Seeds of Innovation in Child Protection", *10th Australasian Child Abuse and Neglect Conference*, Wellington, New Zealand, February 2006, p. 8.

that any child death review process, which bases its recommendations for reform exclusively on negative rather than positive practice, may not be the best guide to child protection reform. On the other hand, the child death review process is only intended as one guide within a broader reform program and should be assessed in this context.

- Failing to deliver messages that are heard. Ultimately, the effectiveness of the child death review process will depend on the government's willingness to act on the recommendations of the review body.
- Creating a bureaucratic response to child protection reform by concentrating on organisational change rather than strengthening the capacity of frontline child protection staff to understand and manage complex cases and strengthening the capacity of primary care givers to reduce risks to children before they even enter the child protection system¹⁵³.
- Failing to attract sufficient numbers of suitably qualified persons with a diverse breadth of expertise, who have both the capacity and willingness to be appointed to the review body.
- Failing to identify system-wide trends in a timely fashion as the population of child deaths and serious injuries within scope may be so small that trends can only be identified over longer periods of time. This risk can be mitigated by giving the process a broad scope to increase the population of deaths and injuries that are reviewed.
- Exposing the government to public criticism when failures in the child protection system that may have contributed to a child's death are made known through the review process. The other side of this coin is that this process imparts accountability and transparency to the government's efforts to improve the child protection system. It presents an opportunity for the government to show strong leadership in acknowledging system-wide problems and taking steps to correct them based on the recommendations of an independent body.

¹⁵³ Reder, P "Making the Most of the Victoria Climbié Inquiry Report", *Child Abuse Review* Vol. 13: 95-114 (2004), p. 95 and Scott, D., "Sowing the Seeds of Innovation in Child Protection", *10th Australasian Child Abuse and Neglect Conference*, Wellington, New Zealand, February 2006, p. 10.

- Duplicating and/or interfering with the coronial process, *if* the relationship between the new review body and the Coroner is not effectively managed.

5.2.4 Recommendation

This is not the preferred option.

5.3 Option Three – advisory panels under the Children, Young Persons and Their Families Act 1997

5.3.1 What this involves

Section 84 of the *Children, Young Persons and Their Families Act 1997* enables the Secretary of the Department of Health and Human Services to establish advisory panels. An advisory panel can provide advice on matters referred to it by the Secretary, including on cases of abuse or neglect or suspected abuse or neglect.

One option for establishing a child death review process is to use the advisory panel process already provided for in legislation. An advisory panel could be appointed to provide advice to the Secretary on all child death cases within a prescribed scope.

To date the advisory panel system has not been much used. It would appear that an advisory panel has been appointed on a single occasion, to provide case management advice to the Secretary with respect to a complex case involving the placement of children under the Secretary's Guardianship.

This option has the advantage of practicality. As the legislative framework is already in place, the process could be implemented within a short timeframe.

The key disadvantage of this option is that it lacks independence. Under Schedule 3 of the Act, members are chosen and appointed by the Secretary (with some guidance in the Schedule with respect to the breadth of representation desirable). Members may also be removed by the Secretary "for any just cause or excuse". On the other hand, a certain degree of independence is secured by the provision that panel members are not subject to the *State Service Act 2000*.

This option also lacks transparency. The Act provides that advisory panels are to provide the Secretary with advice. In this way the review process would be internal to government, with findings and recommendations not necessarily made public. While this may improve the Department's understanding of internal issues, it fails to provide the accountability and transparency that is generally typical of child death review processes in other Australian jurisdictions.

5.3.2 What this requires

This would require a decision of the Secretary of the Department to establish an advisory panel under section 84 of the *Children, Young Persons and Their Families Act 1997* to provide advice to the Secretary regarding certain child deaths as they occur.

5.3.3 Risks

This option risks¹⁵⁴:

- Failing to provide a mechanism for accountability and transparency within the child protection system as the process is not independent and not in the public domain.
- Missing the opportunity to boost public confidence in the child protection system through an *independent* review mechanism.
- Failing to deliver messages that are heard. Ultimately, the effectiveness of the child death review process will depend on the government's willingness to act on the recommendations of the review body. While this risk is also associated with Options Two and Four, the risk is higher where the child death review process is outside the public arena.
- Re-directing resources away from more immediate and direct attempts to respond to children at risk of abuse or neglect.
- Contributing to a reactive and conservative approach to child protection reform characterised by "defensive practice" (see page 104).
- Creating a bureaucratic response to child protection reform by concentrating on organisational change rather than strengthening the capacity of frontline child protection staff to understand and manage complex cases and strengthening the capacity of primary care givers to

¹⁵⁴ See footnote 150.

reduce risks to children before they even enter the child protection system¹⁵⁵.

- Failing to attract sufficient numbers of suitably qualified persons with a diverse breadth of expertise, who have both the capacity and willingness to be appointed to the advisory panel.
- Failing to identify system-wide trends in a timely fashion as the population of child deaths and serious injuries within scope may be so small that trends can only be identified over longer periods of time. This risk can be mitigated by giving the process a broad scope to increase the population of deaths and injuries that are reviewed.
- Duplicating and/or interfering with the coronial process, *if* the relationship between the new review body and the Coroner is not effectively managed.

5.3.4 Recommendation

This is not the preferred option.

5.4 Option Four – create a new child death review process

5.4.1 What this involves

The preferred option is to create a new child death review process. This option could be achieved in a number of ways however the features described below are preferred. The features proposed draw on arrangements in other jurisdictions in Australia, rather than being based on any single model (see Chapter Three).

Free-standing committee supported by an independent office

A new child death review process could be achieved either by allocating the child death review function to an existing independent body with appropriate features (such as the Ombudsman or Commissioner for Children) or by creating a free-standing, independent committee supported either by a government department or by an independent body.

The preferred option is a free-standing, independent committee chaired by an independent statutory office-holder (such as the Ombudsman or Commissioner for

¹⁵⁵ Reder, P., (2004), p. 95 and Scott, D., 2006, p. 10.

Children), who also provides administrative and executive support. This option is preferred because it enables a multidisciplinary membership, rather than concentrating the skills of the review body in one area. It also avoids the risk that allocating this considerable function to an existing body may drain that body of its resources for carrying out its core functions. Providing the body with support from an independent agency will help to secure both the reality and the perception of independence. Legislation should also impose an obligation on the Minister to adequately fund the review body.

Legislative basis

The new review body could be established either as a Ministerial Advisory Committee (on the basis of an executive decision) or through legislation. A legislative basis is preferred. This would enable the review body's scope, functions, responsibilities and obligations to be clearly defined and to be placed squarely in public view. This in turn would improve the accountability and transparency of the process. Legislation would also facilitate the review process by providing statutory powers for requiring information, obligations for maintaining confidentiality of the information and provisions protecting persons supplying the information from contravening other laws or codes.

Single-tiered process

The new review process could be single-tiered or dual-tiered. The preferred option is to keep the principal child death review process separate from any departmental child death reviews. This option is preferred because it enhances the independence of the process and enables the review body to conduct its own review rather than relying on material provided to it by the Department.

Multi-disciplinary membership, appointed and removed by the Minister

The principal reason for preferring a free-standing committee (above), was to enable a diverse range of expertise to be represented on the review body. Broad membership is preferred to better enable the review body to understand and comment on the wide range of child and family support services that have a role in protecting vulnerable children.

A broad membership is also preferred because it will give a range of organisations and professionals a stake in the child death review process. This will help to ensure

that the recommendations of the body have an impact on all service providers and professionals in the child and family support area. Broad membership could include both government and non-government representatives in the areas of child health, welfare, social work, psychology, justice and academia.

Existing bodies currently involved in scrutinising child deaths or representing the interests of children could be represented on the review body to avoid duplication or confusion and to ensure that one process does not compromise the integrity of another. These bodies could include the Paediatric Sub-Committee, the Coroners Office and the Commissioner for Children.

The review body should also have the capacity to appoint investigators to conduct interviews and collate information relevant to each review. Case investigators would operate under the direction of the review body. This would minimise the labour required of members of the review body who are likely to be balancing their duties on the review body with other demanding professional commitments.

There are various options for the appointment and removal of members. Legislation may provide for members to be appointed by the Secretary, Minister or Governor. Removal of members may be a matter of unfettered discretion, or may be restricted to grounds set out in legislation. The preferred option is for members to be appointed and removed by the Governor or Minister with grounds for removal prescribed in legislation.

To enhance the independence of the review process legislation should clearly state that members are independent and are not subject to the *State Service Act 2000*, in their capacity as representatives on the review body.

Statutory powers, obligations and protections

If a single-tiered process is preferred (above), the new review body will itself need to obtain departmental files and other records and conduct interviews with relevant persons for the purpose of its reviews.

This could be achieved by way of an administrative arrangement for exchange of information between the body, the Department and other service providers. This would rely on the voluntary participation of departmental and other individuals.

Alternatively, information could be acquired through statutory powers to require information from certain persons.

The preferred option is to provide the review body with a legislative basis including comprehensive powers to require information from relevant persons; statutory obligations to maintain the confidentiality of information obtained; and provisions to override other laws or codes that would otherwise restrict the disclosure of confidential information to the review body.

Reporting obligations to the Minister and Parliament

The review body will need to report to the Secretary, Minister or Parliament at the conclusion of every review or from time to time. It will also need to report annually on its functions and activities.

The preferred option is that the review body supply its full report, findings and recommendations to the Minister at the conclusion of every case, or at the conclusion of a cluster of cases, as determined by the body. Given Tasmania's small population size, the full report of a review should not be made public. This is necessary in order to protect the privacy of individuals involved as anonymity cannot realistically be achieved simply by withholding names. The findings and recommendations, however, should be made public if this is possible without revealing the identity of participants. The findings may require some editing before they can be released. For the same reason, only the findings and recommendations (once they have been de-identified) should be made available to the Coroner for use in the coronial process.

It is also preferred that the review body report annually to Parliament, with an overview of its findings (de-identified) from reviews held during the year.

Broad scope with discretion regarding full reviews

One option for determining the scope of child death reviews is to give the review body full discretion regarding cases that require review. This option is not preferred.

The alternative option is to fix the scope in legislation (preferably), or if the body is established on the basis of an executive decision, within the content of that decision. This option is preferred because it achieves consistency in data collected from

reviews, which is necessary to make reliable statements about the child protection system and to compare data over time. It also enhances the transparency of the process.

In terms of the breadth of scope as defined in legislation, one option is to define a narrow scope, so that the case load of the review body is not overwhelming. An example of a narrow scope is all child deaths where the child was known to child protection services within a certain period prior to the child's death.

Alternatively, the scope may be broadly defined, while giving the review body some discretion to elect when a full case review is called for. This would mitigate the potentially overwhelming case load generated by a broad scope of reviewable cases.

A broad scope would include:

- Deaths or serious injuries of children where the child or their sibling was known to Child Protection Services within a certain period of the child's death/injury; and
- Deaths or serious injuries of any child caused by, or suspected of being caused by, abuse or neglect, regardless of any previous contact with Child Protection Services.

The preferred option is to give the review body a broad scope defined in legislation, with discretion to call for a full review as appropriate, within this scope. This would enable a more complete and reliable understanding of the operation of the child protection system.

In addition, the prescribed scope should enable the review body to comment on the role of any relevant service provider that was involved, or should have been involved, with the child or their family prior to the child's death (in particular, mental health services, drug and alcohol services and the family violence unit). This option is preferred because it recognises the increasing complexity of child protection cases and enables an understanding to develop regarding the way in which support services interact. This is important to ensure that systems work effectively together to identify and protect children from risk of harm.

In terms of the length of time between the child's death and their last contact with the Child Protection Service, a three-year period is preferred, consistent with practice in New South Wales, Queensland and South Australia.

5.4.2 What this requires

This option requires the enactment of legislation to establish a single-tiered review process carried out by a free-standing, multidisciplinary and independent body. An amendment to the *Children, Young Persons and Their Families Act 1997* may suffice.

This legislation would provide for:

- mandatory representation on the review body, reflecting a broad range of key service providers and agencies and including a representative from the Paediatric Sub-Committee, the Coroners Office and the Commissioner for Children;
- appointment of members and removal by the Minister or Governor on limited grounds;
- statutory powers to require information from certain persons;
- statutory provisions to protect the confidentiality of information obtained by the review body;
- statutory provisions to protect persons supplying information from breaching other laws or codes that restrict disclosure of information;
- obligation to report periodically to the Minister and annually to Parliament; and
- broad scope of reviewable cases, with some discretion regarding the need to carry out a full review.

This option will require consultation and the development of protocols between the new review body, the Coroners Office and the Paediatric Sub-Committee to ensure effective linkages between these various mechanisms for examining child deaths so that they complement, rather than duplicate or interfere with each other. This will also be achieved by including representatives from these bodies as members on the review body.

This option will also require initial funding to cover the development of legislation and establishment costs and ongoing funding.

5.4.3 Risks

This option risks¹⁵⁶:

- Requiring significant funds to pay for the development of legislation, establishment costs and ongoing resources.
- Taking a long time to establish, if not prioritised.
- Re-directing resources away from more immediate and direct attempts to respond to children at risk of abuse or neglect.
- Contributing to a reactive and conservative approach to child protection reform characterised by “defensive practice” (see page 104).
- Failing to deliver messages that are heard. Ultimately, the effectiveness of the child death review process will depend on the government’s willingness to act on the recommendations of the review body.
- Creating a bureaucratic response to child protection reform by concentrating on organisational change rather than strengthening the capacity of frontline child protection staff to understand and manage complex cases and strengthening the capacity of primary care givers to reduce risks to children before they even enter the child protection system¹⁵⁷.
- Failing to attract sufficient numbers of suitably qualified persons with a diverse breadth of expertise, who have both the capacity and willingness to be appointed to the review body.
- Exposing the government to public criticism when failures in the child protection system that may have contributed to a child’s death are made known through the review process. The other side of this coin is that this process imparts accountability and transparency to the government’s efforts to improve the child protection system. It presents an opportunity for the government to show strong leadership in acknowledging system-wide

¹⁵⁶ See footnote 150.

¹⁵⁷ Reder, P., (2004), p. 95 and Scott, D., 2006, p. 10.

problems and taking steps to correct them based on the recommendations of an independent body.

- Failing to identify system-wide trends in a timely fashion as the population of child deaths and serious injuries within scope may be so small that trends can only be identified over longer periods of time. This risk can be mitigated by giving the process a broad scope to increase the population of deaths and injuries that are reviewed.
- Lengthy delays between a child's death and the completion of reviews *if* the body is inadequately resourced. This may diminish the relevance of recommendations emerging from reviews.
- Duplicating and/or interfering with the coronial process, *if* the relationship between the new review body and the Coroner is not effectively managed.

5.4.4 Recommendation

This is the preferred option.